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FINAL DRAFT

Title:

STUDENT TEACHERS' CONCEPTIONS OF THE ETHICAL ASPECTS IN TEACHING AND LEARNING HEALTH MATTERS

ABSTRACT

Only a few studies have been conducted on how teacher trainees can be educated to deal with ethical issues, or on teacher trainees' conceptions of these issues. Using written essays, this study aimed to examine health education teacher trainees' (N=35) conceptions of the ethical aspects involved in teaching and learning health topics. A qualitative content analysis revealed three broad themes: health education as an ethical subject, the teacher as an ethical professional, and spaces for learning. The results reflect the content areas focused on in health education teacher training, but also provide new insights into topics that can be useful in developing teacher training.

Keywords: Ethics, teaching, learning, health education, conceptions, teacher trainees

1 INTRODUCTION

Teaching can be seen as a moral craft (Liston & Zeichner, 1987) in which teaching and ethics¹ are closely intertwined (Campbell, 2008). The value-laden nature of teaching lies in the ways in which it is entwined with a person's human nature: the hopes and wishes, dreams and aspirations of the pupils (Benade, 2008a). Hence, teachers have to work in favor of others and not merely in favor of themselves (Benade, 2008a). Teachers work as moral agents: they aim to develop moral understanding and character among their pupils, both through the topics they teach and through their own actions and ways of being (Campbell, 2004; see also Osguthorpe, 2008).

The recognition of teaching as an ethically sensitive profession is particularly important in so far as teachers are working with pupils "who are easy to influence and are not capable of defending themselves and their rights like grown-ups" (Räsänen, 2000, p. 170). The issue is especially salient in the teaching of subjects that focus on pupils' daily living, attitudes, and values, such as subjects with health-related content. According to the World Health Organization (1999, p. 5), teaching on health issues may have its greatest impact on precisely those pupils – of an impressionable age – who are young enough to be influenced by it. This means that although health teaching may positively contribute to the holistic development of the pupils (cf. Gillespie, 2011), including the creation of personal understanding and the clarification of individual values (Tones, 2002), one can see ethical tensions in the aim of *influencing* people, with the possibility that the teaching may have elements of indoctrination. Indoctrination can be present to the extent that the teaching focuses on cultivating certain beliefs and values (Hanks, 2008), and on promoting only fixed views, ignoring the exploration of alternative and even personal ways of understanding (see Sears & Hughes, 2006). One needs to be aware of how uneasy or indistinct the borderline can be with efforts at persuasion, or

¹ In this article we use *morality* and *ethics* interchangeably to refer to "justified or proper conduct" (Alexander 2005, p. 4).

with manipulation to adopt certain activities, such as medically-approved health behaviors (Tones, 2002; see also Norton, 1998). Considerations of this kind underline even more clearly the extent to which teaching on health matters should be seen as an ethically laden activity.

Teacher training has given only limited attention to the confluence of teaching and ethics (Cummings, Harlow, & Maddux, 2007; Sanger & Osguthorpe, 2011; Warnick & Silverman, 2011), and such training as there has been on this aspect has tended to be implicit and unplanned (Willemse, Lunenberg, & Korthagen 2008). Nevertheless, scholars have put forward many suggestions as to how teacher training might focus on ethical aspects in teaching and learning. Some writers have mentioned the importance of developing persons who are able to teach in a moral way and to “convey good dispositions and moral character” (Osguthorpe, 2008, p. 292). Others have argued that, among its other concerns, teacher training should prepare the trainees so that they can help their pupils to learn civic values and norms (Willemse et al., 2008). In addition, it has been suggested that teacher trainees should be taught to become skilled not only in content matter or pedagogics but also in reflecting on their own values and virtues, and on how these aspects may be manifested during their teaching (Fallona, 2000; Willemse, Lunenberg, & Korthagen, 2005; see also Liston & Zeichner, 1987). Similarly, teacher training may be expected to support trainees in discussing the questions posed by Mahony (2009) regarding moral judgments: “What ought I to do, how do I find out or know what I ought to do, and having found out, why should I do it?” (p. 983). Arguments of this kind are consistent with the view that teacher training should promote the development of the trainees’ professional identity along with the development of the general competencies regarded as important for teachers in a particular subject matter (Korthagen, 2004); clearly this will apply to teachers of health education in a school, who can be seen as having particular responsibilities in the ethical domain.

Lovett and Jordan (2010) have advocated research that would examine how people describe moral issues in everyday life (i.e. their *descriptive* conceptions of moral issues). They also point out that this should be done without weighing up how right or wrong these perceptions are, in other words, irrespective of whether the issues or situations clearly have moral characteristics or not. An examination of teacher trainees' conceptions of moral issues in teaching and learning would also respond to the points raised by Willemse et al. (2008), who noted that the education of teacher trainees in ethical issues has so far been implicit and unplanned, "due in part to the lack of a language for expressing the moral dimension in teaching" (p. 445). From a teacher trainer's point of view, the gaining of such knowledge (including how teacher trainees understand and describe the ethical aspects of a particular subject) is part of the process within which a teacher trainer achieves pedagogical content knowledge, in other words, knowledge about how a particular body of subject matter should be taught. More specifically it is a kind of content knowledge that expands "the knowledge of the subject *per se* to the dimension of subject matter knowledge *for teaching*" (Shulman, 1986, p. 9). Shulman (1986) argues that one part of such knowledge includes learners' conceptions and misconceptions about a particular topic. These conceptions can be used as examples and analogies in making the content comprehensible to the learners' (Shulman, 1986). It thus forms one dimension of the knowledge base the teacher trainer must have in order to educate trainees effectively (see Shulman, 1986, 1987), as part of a process of broadening the trainees' understanding of the object of learning. This is linked to the overall need to examine how teacher trainees understand various objects of learning within specific school subjects. In our case, we would see the ethical issues brought up in the school subject called health education as *par excellence* examples of such objects of learning.

Teacher training in the field of school health education and health promotion is a growing area of interest among academics. This may partly be explained by the general agreement that education and health are linked together (e.g. Jourdan, Pironom, Berger,

& Carvalho, 2012), and that educating teachers in health education and health promotion will have a positive influence on how health issues are put across to pupils (St Leger, 1998; Marks, 2009). It is interesting to note that arguments of this kind are by no means new; for example, Rood (1929) pondered how teacher training in health issues might influence the implementation and results of school health programs.

In Finland, health education teacher training in its present form began a decade ago, after the Finnish Government decided that the school subject called health education would be introduced as an independent subject in secondary schools, general upper secondary education, and vocational upper education. The need for a new subject was justified mainly from three varying perspectives: (i) there were alarming changes in pupils' health behavior and subjective health complaints (Government proposal, 2000); (ii) the existing school system did not offer pupils the possibilities to acquire the knowledge and skills to take care of themselves (Government proposal, 2000); and (iii) pupils' have the *right* to learn about health and related issues (Kannas, 2005). This educational reform means that in Finland pupils now learn health issues mainly through health education as a specific, independent school subject, and not merely as an officially recognized part of another subject, as was the case for almost 90 years (see Korhonen, 2007). In following this path, Finland is one of those administrations (similar to e.g. Ireland, Cyprus, and some states in the USA) which have a school subject focusing on health issues. By contrast, in many countries health is taught as part of a dual-subject entity (for example Health and Physical Education in New Zealand, see Sinkinson & Burrows, 2011) or as integrated within various subjects in the mode of a content theme (as in South Korea, see Vitikka & Hurmerinta, 2011).

The teaching of health education as a school subject in Finland is based on an understanding of health as a comprehensive and multilayered entity. The purpose of health education is to “promote pupils' competence regarding health, well-being, and safety” (Finnish National Board of Education, 2004a, p. 196). The objective is health-

literate pupils who will possess the knowledge and competencies to make the kind of sound health decisions that will benefit their own health, the health of others, and the health of the broader world they live in. Hence, Paakkari and Paakkari (2012) argue that in addition to gaining factual and practical knowledge, pupils should develop their critical thinking skills, and be able to reflect on health matters from their own personal perspective and daily lives (thus moving toward self-awareness). Important also is the ability to behave in an ethically-sensitive and responsible way, involving citizenship (Paakkari & Paakkari, 2012). What should be noted here is that the learning objectives of health education do not include pupils' health behavior (or changes in such behavior). It nevertheless has been argued that health education should set itself a more extensive *mission*, involving a genuine impact on pupils' health and that of the community (Kannas, 2005).

Health education covers content based on pupils' growth and development, their daily living, and the human lifespan (cf. Finnish National Board of Education, 2004a). Health education may thus deal with topics related, for example, to drugs, sexual health, mental and emotional health, physical activity, as well as broader public health issues, all of which may include discussions on health and ill-health. Similarly, the discourses of the topics may be built around the theme of growth as a person within a certain context (including self-awareness and empowerment), or around the theme of health risks and risky health behavior. In addition, there needs to be critical discussion on health information and "different phenomena of health culture" (Finnish National Board of Education, 2004b, p. 214). Hence, the topics also incorporate societal and cultural issues that – in the Finnish context – are connected not just to Finnish society in the abstract sense, but also to the various societal and cultural issues that pupils bring to the classroom with them. Here it should be noted that the curriculum *per se* is bound to reflect the prevailing culture of the broader context (Fien, 1997). After all, as, Fien (1997) argues, the selection of the content areas, and the learning objectives and approaches,

are based on the values and related priorities of the curriculum planners and subsequently, of the teacher.

Health education teacher training was developed to meet the demands of the new subject. However, health issues had already been taught in schools for many decades, mainly in connection with physical education; thus, courses related to health topics had formed part of the physical education teacher training program. Currently, the health education teacher training program in the University of Jyväskylä (where this study took place) is built around the competencies seen as important to qualified health education teachers. These competencies are (1) a grasp of research (Paakkari, 2012), i.e. an “investigative touch” (Rautajoki, 2009), (2) content knowledge, (3) pedagogical content knowledge and interactive skills, (4) knowledge of the pupils as learners, (5) knowledge of the school as an operational environment, (6) the teacher’s self-knowledge, and (7) ethical awareness. These seven competencies serve as themes that are seen as requiring a deliberate focus in the various courses that form the program. “Ethical awareness” as a theme has been defined in the following manner:

“The authority that the teacher possesses brings responsibilities with it. In health education these responsibility issues are important, since the topics in health education are often personal and value-laden, and require a sensitive approach from both the teacher and the pupils. Hence, a teacher should possess the ability to consider moral and ethical perspectives related to the aims, contents, and teaching methods of the subject. The aim is that the student [teacher] will understand the ethical responsibilities related to the teaching and be able to assess his or her decisions from this perspective.” (Faculty of Sport and Health Sciences, 2009, p. 202)

With these aims in mind, the courses for our teacher trainees have included some discussion on ethical matters related specifically to the assessment of pupils’ learning in schools, with mention also of various moral dilemmas that can arise in one’s teaching (see also Tirri, 1999). However, up to this point, there have been no systematic courses on the ethical issues specifically bound up with health education. Moreover, there has been a lack of research on how *health education teacher trainees* understand and

describe ethical aspects in health education (i.e. on their descriptive conceptions of the area of interest, see Lovett & Jordan, 2010). Thus, the study reported here aimed to examine in a comprehensive manner the ethical issues that health education teacher trainees considered relevant to the teaching and learning of health education.

2 METHODS

2.1 Participants and procedure

The study took in place in the University of Jyväskylä, Finland. The sample consisted of 35 (16 males, 19 females) university students of physical education who were studying health education as their second teaching subject. The students were pursuing intermediate-level studies in health education (35 credits). This means that most of them were 3rd year students (within a 5-year Master's level study program) who had already completed their basic level studies in health education (25 credits).

The data consisted of teacher trainees' essays, written during the spring of 2011. The essays were written as part of their health education teacher training, within a course entitled "Expertise in the teaching of Health Education." The trainees were asked to write about their understanding of the ethical aspects that they saw as bound up with the teaching and learning of health education as a school subject. They were given as a title "ethics in the teaching and learning of health education." Note that the essays were written as home assignments *before* a three-hour seminar that focused on this particular theme. From the perspective of the course, the aim of the essays was to support the participants in becoming aware of their preconceptions concerning ethics in health education. The essays served as a base for developing the seminar. It was emphasized to the participants that they were under no obligation to allow the use of their essays for research purposes, and they were asked to give a written statement either consenting to or refusing such use.

2.2 Data analysis

The data were analyzed anonymously using inductive qualitative content analysis. Inductive qualitative content analysis – also called conventional content analysis (Hsieh & Shannon, 2005) – was chosen according to its aim of eliciting the meanings attached to the phenomenon under study, as experienced by the participants (see Tuomi & Sarajärvi, 2002, p. 97). The further aim was to reach a “condensed and broad description of the phenomenon” (Elo & Kyngäs, 2008, p. 108). *Inductivity* in this study meant that the analytical units or wider theoretical perspectives were not decided in advance, and were instead chosen from the data in accordance with the purpose of the study (Tuomi & Sarajärvi, 2002, p. 97). Following this method, our analysis proceeded from data reduction to clustering and conceptualization. First of all, we read the essays repeatedly to gain an understanding of the whole. Then we sought to filter out the inessential material in the essays (i.e. to perform data reduction) while at the same time looking for the various meanings attached to the object of our research, namely, the ethical aspects involved in the teaching and learning of health education. This phase, too, could be called condensation, since we aimed to shorten the amount of data, while at the same time preserving what could be called the “core” from the perspective of the object of research (Graneheim & Lundman, 2004). At the same time we tried to ensure that no relevant data would be excluded (Graneheim & Lundman, 2004), an aspect that is clearly important for the trustworthiness of the research. Both words and larger parts of the texts served as analytical meaning units. Subsequently, all the reduced expressions (units) were read and re-read thoroughly and organized according to the similarities and differences in their meanings. The similar meaning units were “related to each other through their content and context” (see Graneheim & Lundman, 2004, p. 106) to form sub-categories, which were then combined to form main categories (the stage of “clustering” the data). Thereafter, the main categories were combined (again based on similarities and differences) to form uniting concepts or themes. Throughout the analytical process we often returned to the original data to ensure that the analysis was tightly anchored to the actual data (cf. Hsieh & Shannon, 2005), with the aim of

achieving good validity. Thus, we ended up by selecting representative quotations (corresponding to each sub-category); these were kept in view throughout the data analysis, and later when we reached the stage of presenting the findings. However, at the end of the analytical process, we once again read through the entire data to confirm the findings.

The validity of the findings was further promoted by the ways in which the two researchers worked with the data. The phases of “data reduction,” and of “clustering the data” to form sub-categories and main-categories, were first conducted individually; thereafter the sub- and main categories were collectively discussed and debated to reach a consensus (Bowden, 2005; Kvale, 1996, pp. 244-245). The formulation of the themes was conducted collectively. We critically tested the preliminary set of themes by debating and carefully reading the essay data and the extracts corresponding to each of the sub-categories, main-categories, and finally, themes. Thus, the analysis incorporated the notion of communicative validity – i.e. of validity in terms of a conversation – as stressed by Kvale (1996) and later by Kvale and Brinkmann (2009) (but cf. “interjudge reliability” as discussed by Kolbe & Burnett, 1991).

3 RESULTS

The qualitative analysis of the data revealed three broader themes (i.e. uniting concepts) related to ethical aspects in the teaching and learning of health education: (1) health education as an ethical subject, (2) the teacher as an ethical professional, and (3) spaces for learning. Figure 1 shows the themes, the main categories, and the sub-categories. Below, the themes will be described in more detail, with corresponding extracts exemplifying each of them.

Theme	Main category	Sub-category
Health education as an ethical subject	Complex nature of the subject	Personal Value-laden Normative
	Learning objectives	Ethical competence Critical thinking Personal meaning-making General cultural socialization
The teacher as an ethical professional	Professional expertise	Professional development Self-awareness Ethical stance towards one's well-being
	Manifesting general professional expectations	Following the general regulations for teachers Representing the general values of the teaching profession Taking on the responsibilities of teaching
	Fairness	Equality in creating learning opportunities Favor
	Pedagogical tactfulness	Protection of the pupils Respect for pupils' individuality Taking a responsible attitude towards the pupils' age and stage of development Giving due attention to the perspectives of the pupils
	Assessment practices	Focus of the assessment Equality of the assessment
	Power relations during the lessons	Power over knowledge Power over the pupils
Spaces for learning	Spaces for personal growth	Space for clarification of values Space for developing personal meanings Space for managing emotions
	General preconditions for learning	Peace to work

Figure 1 Sub-categories, main categories and themes from the qualitative content analysis

3.1 Health education as an ethical subject

The theme “health education as an ethical subject” includes two main categories: (i) the complex nature of the subject matter, and (ii) learning objectives.

(i) Ethical aspects connected to the complexity of the subject matter were related to how far topics could be seen as personal, value-laden, or normative. The teacher trainees mentioned that health topics are often related to pupils’ own personal values (such as the legitimacy or otherwise of abortion), preferences, opinions, and attitudes; hence, health education has particular ethical characteristics that need to be taken into account in teaching. As one participant wrote, *“Health education is a subject that deals with many issues related to one’s own life (m14).”* The personal nature of health issues was also related to the fact that at least some of the pupils may well have some experiences of the issues to be dealt with during the lessons, as extract 1 indicates:

Extract 1

“It is challenging to teach about the negative effects of drugs in a situation where someone’s parent is an alcoholic or for example has died from a disease caused by smoking.” (m3)

The value-laden aspect was not related to personal aspects only, but also to broader ethical issues related to health topics. The extract below indicates how discussion on the costs and responsibilities pertaining to ill-health may be problematic because it involves

relativistic evaluations – judgments whose validity depends on circumstances in a particular society in a particular era (extract 2):

Extract 2

“[...] values and attitudes are discussed. For example a question about lifestyle diseases, whether society should pay for the expenses caused by them or not. There might not be a right answer to these questions, and for that reason discussing these things can be challenging in classroom situations.” (f9)

The normative nature of the subject also raised some ethical concerns among the teacher trainees; they observed that in many issues there are perspectives (or more precisely norms) on how people should or should not behave (e.g. how to eat and how to exercise, following certain guidelines or generally accepted ways of behaving) (extract 3):

Extract 3

“In health education what bothers me is its strong prescriptiveness. You *have to* eat a certain amount and in a certain way. You *have to* exercise and feel something according to certain recommendations.” (m4)

(ii) Ethics was also related to the learning objectives of health education as a school subject. First of all, the teacher trainees mentioned that ethical competence should be learned in schools. Such competence was seen as including empathy (viewed by our respondents as a teachable *ability*, and specifically the ability to “put oneself in someone else’s position” (extract 4)). It also included general ethical thinking skills (e.g. in extract 5 the ability to reflect on one’s own values and those of others, and in extract 6 the ability to ponder the acceptability of something). In addition, there was a view that instead of transmitting one’s own opinions as the only correct knowledge, teachers should help pupils to gain the skills of critical thinking (extract 7). The teaching of critical thinking was further seen as a means to forestall the negative influence of teachers who might be over-willing to direct the pupils, or to focus only on perspectives that the teacher saw as important and “right.” This was sometimes related to the importance for pupils of being able to create their own meanings and to justify their opinions, thus

placing an emphasis on the need to support pupils' personal meaning-making during the lessons (extract 8). Finally, general cultural socialization was considered to be an ethically-laden objective for the subject, involving the transmission of generally accepted values (extract 9).

Extract 4

"Pupils' ethical skills should be developed through social skills. The ability to show empathy is an essential part of successful social behavior [...] The ability to feel empathy for others also supports behavior of an ethical nature, since in my opinion putting oneself in someone else's position leads one's behavior in a direction which is ethically more acceptable." (f20)

Extract 5

"In learning [health issues] there should be reflection on one's own values and morality in relation to the values of others, and one should possibly be able to change them." (f5)

Extract 6

"Ethics in health education learning and teaching also means that the subject [health education] makes it possible to ponder ethical issues and teaches ethical thinking. The teacher has a central role when there are discussions with the pupils concerning whether something is acceptable or not." (m7)

Extract 7

"Health education should support critical and individual thinking. Which may sometimes be challenging for a teacher, if the pupils question the teaching." (m2)

Extract 8:

"The teacher's role is not to proclaim his or her own opinions on issues, but to give the pupils the kind of competencies that would allow them to formulate personal opinions on various issues, and to give reasons for their opinions." (m7)

Extract 9

"One of the aims of health education is to transfer the values of our culture to new generations." (m8)

3.2 The teacher as an ethical professional

The theme of “the teacher as an ethical professional” was formulated in terms of five main categories: (i) professional expertise, (ii) manifesting general professional expectations, (iii) fairness, (iv) respect for the pupils, , (v) assessment practices, and (vi) power relations during the lessons.

(i) The ethical aspects of the main category called *professional expertise* were related to the requirement for professional development, that is, for teachers to develop as teachers, given that the subject matter in health education is constantly changing (extract 10). In the same context, the teacher trainees noted that teachers should ensure that the knowledge dealt with during the lessons is “*topical and valid*” (f6). In addition, they highlighted the importance of self-awareness for the teacher, a quality which will allow the teacher to become aware of his or her own values and attitudes related to a particular topic, bearing in mind that values are always present during lessons (extract 11). The teacher trainees further emphasized that teachers as professionals should be able to secure not merely the health of others but their own health – here thought of as maintaining an ethical stance toward one’s own well-being (extract 12).

Extract 10

“The work of the teacher also involves a certain kind of ethical responsibility towards one’s own expertise. For a teacher of health education it is important to keep up with current discussion and research, since the subject matter is by its very nature constantly changing, and one has to absorb new knowledge.” (f14)

Extract 11

“As a subject, health education should develop in pupils the capacity to examine values and to engage in responsible health behavior. Our wish to develop these abilities in pupils makes it necessary for teachers, too, to consider their own values, and how these values are manifested in their own teaching.” (f8)

Extract 12

“However, the health education teacher cannot take on the burden of looking after the health of all the people in the vicinity [...] The work of teachers can become overwhelming if they adopt too many expectations, unrealistic aims, or the role of being indispensable. In my opinion, one’s own well-being should be the starting point for taking care of oneself. One should be gentle with oneself, even if things don’t all go according to some ideal pedagogical model.” (f14)

(ii) Manifesting *general professional expectations* encompasses the notion that, as ethical professionals, health education teachers should follow the general regulations for teachers, which come from various quarters, including legislation, the national curriculum, and schools (extract 13). Moreover, along with their more or less personal values they should represent values that are generally related to teaching as a profession (e.g. confidentiality) (extract 14). Manifesting professional expectations relates also to the duties that health education teachers are expected to carry out. This perspective was related to not becoming overwhelmed with various tasks to the point of possible burnout (extract 15).

Extract 13

“There are requirements laid down for teaching, and the teacher has to do the job within the framework they provide. Teachers everywhere have the same kind of general rules, which come for example from the municipalities. In addition, every school has its own rules, and the teacher has to function according to them.” (f2)

Extract 14

“Teachers may have their own values. However, these values must not differ too much from the [professional] values that the teacher represents.” (m8)

Extract 15

“How far should teachers take care of the health of the pupils and their parents, and their colleagues? A teacher is not a utopian, and he or she should recognize his or her own professional boundaries [...] I think that this is why so many teachers get depressed [...]” (m7)

(iii) *Fairness* as a main category was related to point that the teacher should organize the teaching-learning sessions in such a way that everyone has equal conditions or

prerequisites for learning (extract 16); furthermore, the teacher should treat pupils equally, without favoring anyone over another (extract 17); this involves aspects such as treating all pupils in the same way, whatever the values or health behavior a pupil or his/her family may exhibit (extract 18).

Extract 16:

“The teacher has a duty to value pupils equally. This means that the teacher has to be able to give the keys of learning to every pupil. This will be possible by adopting a variety of ways of working, because the pupils learn in different ways.” (m13)

Extract 17:

“The teacher must not favor any pupil on the basis of his or her [i.e. the teacher’s] own values”. (f2)

Extract 18

“My family background is one of abstention from alcohol [...] I find it difficult to put myself in the position of pupils [whose families drink alcohol] or to see drinking families as being on the same level as sober families.” (f3)

(iv) *Respect for the pupils* as a main category includes the notion that teachers should be protective toward pupils (extract 19). In the context of health education teaching and learning it means that teachers should not discuss in public (in the classroom or elsewhere) issues which are too personal from the point of view of the pupils or which might lead to hurt or humiliation in front of fellow-learners. Moreover, the protection aspect requires that since topics may be personal, teachers should lay down certain ethical boundaries in order to prevent pupils from disclosing too much about themselves.

Extract 19

“The teacher should be careful not to inadvertently embarrass pupils or put them on the spot by raising questions during the lesson about matters that belong to a pupil’s personal affairs [...] The ethical aspect also includes the idea that if necessary the teacher should prevent a pupil from disclosing a personal

matter, even if the pupil himself/herself might wish to disclose it. The pupil doesn't necessarily understand what all should be mentioned in public." (f12)

In addition, student teachers emphasized that teachers should respect the pupils' individuality – their backgrounds, values, and differing conceptions (extract 20). Similarly, it was seen as ethical that teachers should take a responsible attitude towards the age and developmental phase of the pupils. This includes the thinking skills and teaching content (health matters) that can be taught to various age groups, and the ways in which these can be taught (extract 21), while also recognizing individual differences in their individual development (extract 22).

Extract 20

"In dealing with issues there should be respect for the principle that everyone has his or her individual background and opinion." (f1)

Extract 21

"Of course one should also pay attention to the age of the pupils, so that matters are dealt with at a level that the pupil is capable of understanding. In my opinion, one age-related responsibility involves understanding which issues can be spoken about, and how." (f1)

Extract 22:

"An additional aspect that makes the subject (sexual health) challenging is that the pupils may be at very different phases of sexual development. I as a teacher should be able to present the topic in such a way that pupils do not get the impression that they should rush ahead in their sexuality [just] because it is not in the same phase as that of others." (f21)

Respect for the pupils also included aspects such as giving attention to the perspectives of the pupils. It covered how pupils perceive the topics to be dealt with (extract 23), and how they perceive the teaching given to them (extract 24). The teacher trainees observed that the teaching should benefit the pupils, given that the teaching is organized for the sake of the pupils.

Extract 23

“In acting in a moral way, I should pay attention to the viewpoint of the pupil. Thus I should consider what the pupil thinks about the matter at hand and try to put myself in the pupil’s position.” (m12)

Extract 24

“The choice of correct ways of working means that the teacher should think of how pupils experience his or her [the teacher’s] way of doing things, and how it affects them.” (f1)

(v) *Assessment practices* as a main category includes ethical aspects related to the focus and equality of the assessment. When teacher trainees reflected on what should and should not be included in the learning assessment, they emphasized that it is unethical to consider pupils’ health behavior (e.g. smoking and drinking habits, physical inactivity, or general way of life) or their health-related values and attitudes (extract 25) as part of the assessment (for example in arriving at a grade). What matters is the pupils’ learning in terms of factual knowledge and various skills (in this case health-related skills and thinking skills). In addition, the teacher trainees stressed that teachers should organize assessment practices in which each pupil would have equal possibilities to show his or her knowledge to the best advantage (extract 26).

Extract 25

“One should not react to the pupils’ health habits in such a way that one lets these habits influence (for example) the grade given. The teacher must not evaluate the pupils’ values or attitudes.” (f9)

Extract 26

“How can one give to all pupils an equal opportunity to show what they know, for example in the lesson [relates to the comment on assessment]? (f12)

(vi) The main category called *power relations during the lessons* is constructed from two ethical aspects: power over knowledge, and power over pupils. Power over knowledge refers to the way in which a teacher may manipulate knowledge (“twist” it or “sweeten” it) based on his or her own preferences, or lead the teaching in a particular

direction based on personal opinions, values, and attitudes (extract 27). Similarly, a teacher may consider his or her own perspectives to be the only “right” knowledge (extract 27). This aspect also includes the ways in which a teacher may select and/or stress the topics to be covered during the lessons (extract 28). It is possible that teachers may cover only issues that are in line with their own personal purposes, highlight only issues that they are interested in, or avoid topics that they find emotionally difficult (extract 29).

Extract 27

“Knowledge is power [...] Within the teaching the teacher has a great deal of power in addition to his/her official position. Knowledge can be distorted or one can transmit only information that suits one’s own purpose. Especially in the case of ‘enlightening’ the pupils there is danger [...] the teacher can easily have a ‘need’ to tell pupils how things ‘really are’, even in matters of opinion.” (m2)

Extract 28

“[...] in the content of the lesson the teacher can influence what is considered good or bad. So the teacher can place an emphasis on some particular point and conversely treat something else as unimportant.” (m3)

Extract 29

“The teacher has to deal with all content areas, whether or not he/she finds them hard to discuss. For example one can’t thrust aside the subject of abortion, no matter how unpleasant it is for the teacher.” (f16)

The sub-category called *power over the pupils* includes the notion that teaching-learning situations are never balanced: a teacher has a degree of authority that the pupil does not possess (extract 30). Similarly, “*a teacher may serve as a role model for pupils [as someone] whose word is trusted and who is not questioned*” (n6). This, combined with the point that pupils are at a vulnerable age, lacking in critical thinking skills and thus easily influenced, leads to a situation in which a teacher has power over the pupils, with corresponding ethical responsibilities. In this context one participant referred to “health terrorism” (extract 31).

Extract 30

“In the work of the teacher prestige forms an important ethical tool. Because pupils do not have the same degree of prestige, the teaching situation does not comprise a balanced interactional relationship from an ethical point of view.” (f13)

Extract 31:

“[...] manipulating and molding another person in one’s own likeness is certainly a major risk for all teachers of health education. Health terrorism is not all that rare during health education lessons.” (m2)

3.3 Spaces for learning

Our theme of “spaces for learning” refers to the conditions that may support (i) personal growth or (ii) learning in general.

(i) The main category called *spaces for personal growth* covers the notion that instead of merely setting out to transmit values or perspectives teachers should *create conditions* that may support the clarification of values and the development of personal meanings (extracts 32 and 33). Moreover, it was seen as ethical on the part of the teacher if he or she allowed the expression of emotions prompted by topics raised in the classroom (extract 34).

Extract 32:

“Pupils should be given the chance to form their own values for themselves. And pupils should be able to have their own values. I think it is important for the teacher to act as an assistant for the pupil when issues are being examined. Irrespective of one’s own set of values, the teacher has to accept the pupil’s set of values.” (f12)

Extract 33

“A teacher who is ethically good will give pupils space to think or to form their opinions for themselves.” (f10)

Extract 34

“It is natural that the pupils can be perplexed or can in other ways react strongly to the matters under discussion, in which case they should be given the opportunity to express these feelings.” (f16)

(ii) The main category called *general preconditions for learning* includes the creation of a good atmosphere in the class, which is constituted by peace to work and physical and psychological safety. Specifically, it was observed that *“the teacher should ensure that each pupil feels safe in the school, that there should be peace to work in the class, and that each pupil should have the right to his or her own opinions and physical and psychological integrity.”* (f9)

DISCUSSION

The purpose of this paper was to examine the aspects that health education teacher trainees saw as ethically-related within the teaching and learning of health education. The findings showed that trainees’ conceptions could be grouped into three broad themes: (1) health as an ethical subject, (2) the teacher as an ethical professional, and (3) spaces for learning. More specifically, one can observe that ethical matters were not related merely to the teacher’s pedagogical actions, but also to how the teacher trainees viewed the subject of health education (including its knowledge and objectives), and teaching as a profession. At the same time, ethics were seen as related to what was beneficial to the individual teacher (e.g. setting limits to one’s responsibilities, for the sake of one’s own well-being) and to pupils (e.g. protection of the pupils), and further, to the kind of learning environment that should be created during the lessons (i.e. what we have called “spaces for learning”).

In the following paragraphs, rather taking up each individual finding, we shall focus on those findings that appeared to be linked to each other to form larger entities, within the health education context. In so doing, we shall highlight the connections between

the thinking of our teacher trainees and previous studies in the field. We shall also indicate issues that the teacher trainees did not deal with – aspects that they were perhaps not aware of at this stage of their studies or maturity.

Overall, the findings show that our teacher trainees related ethical aspects to issues that have previously been recognized as ethical in teaching. These included aspects such as general values related to teaching as a profession (see Campbell, 2003; Colnerud, 1997; Husu & Tirri, 2007), fairness (Campbell, 2003; Colnerud, 1997), thinking about what is best for the pupils (teaching goals and methods) (Lumkin, 2007; Mahony, 2009), respect for individuality (Lumkin, 2007), power relations in the classroom (Buzzelli & Johnston, 2001) – involving in particular the way in which a teacher emphasizes or selects the topics to be dealt with (see Campbell, 2008) – and evaluation practices (Campbell, 2008; Lumkin, 2007; Pope, Green, Johnston, & Mitchell, 2009; Räsänen, 2000). However, there were aspects which did not arise – but which have been emphasized as ethical in teaching – involving most notably the broader sociopolitical and economic context within which the teaching occurs (Benade, 2008b), pupils’ work ethics (Tirri, 1999), loyalty to colleagues (Colnerud, 1997), tensions between the school and the family (Shapira-Lishchinsky, 2009), and holding pupils to high standards and engaging them in intellectually challenging learning experiences (Lumkin, 2007). The differences may be partly explained by the fact that in our study the teacher trainees were asked to consider ethics related to health education teaching and learning rather than merely ethical situations or dilemmas in schools.

Health education was experienced by the teacher trainees as “an ethical subject.” The subject was seen as truly focusing on pupils’ daily issues and experiences, and thus the knowledge conveyed/received was seen as directly personal and value-laden. Due to the differing backgrounds, values, experiences, and conceptions of the pupils (as the trainees reflected), the “teacher as an ethical professional” has to take into account and respect pupils’ personalities and individual needs. Interestingly, some trainees

highlighted the notion that teachers should accept pupils' various values, without pondering the question of whether all values should be accepted, no matter what their possibly harmful consequences for others might be. In this connection, we would suggest that teacher training should equip teacher trainees with the skills to consider in depth and to attempt to understand the values and viewpoints pupils bring to the classroom (cf. Wong 2006, in Quintelier & Fessler, 2012). This, we would argue, should be done from the perspective of the cultural context (what is considered right or wrong in a given culture) and also that of the individual (what is right or wrong from the moral viewpoint of the individual) (Quintelier & Fessler, 2012). Here it should be borne in mind that teacher trainees may find it difficult to truly recognize, take into account, or discuss the differing values that pupils bring to the classroom, since the trainees themselves may be unaware of or uncertain about their own way of seeing the teaching content, and further, may not recognize the political, economic, cultural, and societal conditions the content is bound up with.

Nevertheless, the subject was also seen as including content matters that embody generally accepted guidelines and prescriptions on how to live in a healthy way (thus pointing to the normative nature of the subject). Interestingly, although the teacher trainees (in our study) were aware of the influence of these prescriptions and guidelines, they did not go further, to consider the precise nature or significance of that influence. Within the literature there is on-going discussion on how these prescriptions and guidelines – thought to influence people's views on how to live (Ingleby, 2012; see also Cliff, 2012) – may be influenced by medical norms and texts, which in turn reflect authority, assumptions of factual certainty, and ultimately power (Evans, 2003). Medical discussion on health issues often focuses on health risks for individuals (implying "bad" health behaviors) and further, on their effects at communal, societal, and global levels. In this context, an emphasis on pondering a particular "locus of responsibility" may, misleadingly, point to individual factors while ignoring societal and structural inequities (Rosenberg, 1997), or social and cultural factors more broadly (Cliff, 2012). The notion is

conveyed that “individuals *can* and *should* exert fundamental control over their health through careful and rational avoidance of risks” (Brandt, 1997, p. 68). However, as Brandt (1997) argues, the focus on individual behavior neglects the extent to which one’s behavior is influenced by many “external” factors and processes related to historical, cultural, and social issues. These, Brandt (1997) asserts, are not within “the scope of individual agency” (p. 68). Evans (2003, p. 94) goes even further, arguing that medical texts, speaking as “the voice of biomedical expertise” serve as a “cultural toxin” affecting not only the health promotion policies and practices of various agencies, but also the way teachers in schools think. In this context, certain overarching questions become paramount, such as how one should understand health and being healthy, or the phenomena of disease and illness, and who should have responsibility for these phenomena. One’s understanding of these issues may well impact on the health discourses that occur in the classroom.

The discussion above reflects the point that teaching can easily be a reflection of the teacher’s own values and preferences, leading to a situation in which the teacher becomes, as it were, a “guardian” of these values (cf. Ingleby, 2012). Hence, ethics is related to the position of the teacher “as an ethical professional”, and from this to the way in which a teacher possesses power: power over knowledge (by manipulating or leading knowledge in a certain direction) and power over the pupils (by being an unquestioned role model) – aspects that emerged in the writing of our health education teacher trainees. In fact, in our study, the teacher trainees did not feel comfortable with the various guidelines and prescriptions. Instead, they tended to the view that it is ethical *per se* to create and offer learning situations, or “spaces for learning”, where clarification of values, critical thinking, and personal meaning-making will emerge. From this perspective, one will be looking towards forms of education that will support the development of critical thinking among pupils, allowing them to understand not only their own personal needs, but also, as argued by Evans (2003), “the ways in which these

have been constructed, manipulated and perhaps obfuscated by the interests of the 'health industry" (p. 98).

The teaching of critical thinking and the clarification of values call for the use of non-indoctrinative and non-judgmental methods (Fallona, 2000), aspects which were also raised by the teacher trainees in our study. Thus, the findings of this paper may be related to a broader discussion of autonomy and indoctrination – bearing in mind that “indoctrination” is a process of cultivating certain beliefs and values, whether or not they are aligned with the pupils’ own interests (Hanks, 2008). In the Introduction we noted that the main objective of the school subject called health education is a health-literate pupil. In line with our data, and with previous scholars, one can argue that the promotion of health literacy and its constituent elements requires that teachers should truly support the development of a higher level of autonomy among pupils, in other words, the “inner endorsement of one’s actions, the sense that they emanate from oneself and are one’s own” (Deci & Ryan, 1987, p. 1025).

From the points raised above one can see that in supporting individual autonomy, the power-relations that exist within the classroom have a central role. As Deci and Ryan (1987) have observed, power-relations between a teacher and pupils include an autonomy-control distinction. They further argue that the teaching context may be supportive of autonomy (i.e. encouraging pupils to make their own choices) or else controlling (i.e. leading people in certain directions, toward certain outcomes). Once again, these two polarities are closely aligned with the way our teacher trainees reflected on power-relations in health education.

Although it is necessary to support the development of pupils’ skills so that they are able to identify and define their own values, it is inevitable (and a widely acknowledged fact) that “schools inculcate ideologies” (Alexander, 2005, p. 1), in other words beliefs about what is right and wrong (Alexander, 2005). It is interesting that in our study the teacher

trainees took the view that it is ethical per se to socialize pupils to the surrounding culture and society. Conversely, they did not problematize or make explicit what one's culture(s) or society might actually consist of or encompass. This aspect is highly relevant in subjects such as health education in which the topics are personal and value-laden, and in which pupils need to be supported in considering health issues not just from the perspectives of their own lives but also from a wider socio-cultural perspective. Pupils have various (sub)-cultural backgrounds; hence there is not just one culture that the individual may be socialized within, but numerous cultures or societies.

Here, what is needed – but what the teacher trainees did not explicitly ponder – is the allowance of a space for dialog (Ingleby, 2012). Dialog calls for the recognition of and respect for difference; in other words, it involves learning from others, and respecting others' views as meaningful and valuable. Here we may find similarities with what Alexander (2005) calls a pedagogy of difference. The pedagogy of difference connects ethics and education, in that it emphasizes the need to enhance pupils' capacity to become aware of the moral differences between various things, and of the probable consequences of their choices. However, it also aims "to enable youngsters to recognize and learn from mistakes by engaging with a variety of perspectives including those in conflict with their own" (Alexander 2005, p. 14). A pedagogy of difference calls for a process of coming to see and to respect differences, along with becoming aware of and respecting oneself, hence allowing oneself to be different. Such a pedagogy has implications for teaching and learning, especially in the case of school subjects that are highly personal and value-laden, such as health education. Moreover, since health as a phenomenon touches everyone, health education as a subject offers an excellent platform for a critical inquiry into multiple perspectives on health issues and their underlying political and contextual factors (see Sinkinson & Burrows, 2011). Sinkinson and Burrows (2011) have argued that if there is to be a type of health education which recognizes diversity and which includes "sensitive" topics, teachers will be called upon to move out of their own comfort zone. Teachers should not merely teach what they

feel comfortable with – hence knowledge over which they have power – and instead should actively seek to recognize difference, in order to avoid discriminating against those who are different (Sinkinson & Burrows, 2011).

The findings of this study are in part consistent with the central emphases in certain areas of health education teacher training, including assessment practices (what can be assessed), the recognition of pupils' age and development, respect for individual needs and personalities, and the teacher's awareness of his or her own values; thus one might take the view that in the present study teacher training could have influenced the trainees' thinking and hence the findings. However, there were aspects that had not been intentionally or explicitly focused on in the training, at least not at the time of the data collection, but which the trainees nevertheless seemed to be aware of: these included in particular power relations during health education lessons, the creation of learning spaces, and paying attention to the interests of the pupils. The trainees' emphasis on the creation of spaces for learning may reflect current understandings of learning and knowledge, which emphasize the importance of pupils' own thinking and of the problematizing of knowledge during learning events. Similarly, in the context of teacher training and of school curricula covering health issues in Finland, this may reflect a broader shift from privileging medico-scientific knowledge toward a more interpretative approach (cf. Cliff, 2012).

To conclude, the findings of this study may contribute to the literature on ethics in teaching and to the development of teacher training in health issues, assisting a move toward a more deliberate or explicit focus on the phenomena in question. The study gives some insights into how teacher trainees reflect on and express ethical aspects related to their future work. Bound up with these considerations is the fact that trainees' conceptions and use of language – including the conceptions and language of ethics – form an essential part of the knowledge that teacher trainers need in their work (i.e. pedagogical content knowledge; Shulman, 1986, 1987). Such pedagogical content

knowledge is also related to our findings on what the teacher trainees did not ponder – aspects that have been acknowledged elsewhere as ethical in teaching (e.g. loyalty to colleagues; see Colnerud, 1997), or that are crucial from the perspective of teaching and learning health issues in schools (e.g. spaces for dialog that will allow the acceptance of difference). Though the teacher trainees in this study showed critical insights concerning normative prescriptions and guidelines on how to live, we would suggest that health education teacher training should pay more attention to supporting trainees so that they can become aware of and critically evaluate the various moral discourses around health issues. These discourses encompass values and preferences in the health domain, people's views on the kinds of health that should be promoted and possessed, who should be seen as responsible for ill-health (cf. Rosenberg, 1997; Leahy & Harrison, 2004), and how health should be promoted. Notions of this kind are particularly important when one is teaching on health issues, since what is understood by health and ill-health, or by “good” ways of living can be seen as culturally-colored (see Ingleby, 2012), and thus always value-laden (Evans, 2003) – a point which applies also to the way in which people see good or bad health promotion practices (Bull, Riggs, & Nchogu, 2012).

Similarly, teacher trainees should be challenged to identify their own values, including how they see health and ill-health. They should become aware of how their perspectives may influence their teaching practices, since the teacher's ways of seeing something may very well have an association with the way she or he will organize classroom practices (e.g. Marton & Booth, 1997). Finally, health education teacher training should promote discussion on difference in general (Alexander, 2005) and seek to develop sensitivity to differences in pupils' backgrounds. This could enable teacher trainees truly to take into account pupils' varying backgrounds and individual needs, and to problematize the idea of socialization into “one particular” culture. In this context the teacher trainees should gain experiences in promoting dialog in the classroom in order to allow the emergence of a pedagogy of difference (see Alexander, 2005).

Fien (1997) emphasizes the notion that rather than merely pondering whether teaching attempts to indoctrinate in a certain direction or not, we should consider in depth the values and purposes that schools should or should not promote or “indoctrinate.” This argument captures the idea that health education teacher training should expand its focus further, to critically assess the overall expectations that society raises for schools and teachers. In our data, the trainees merely stated that teachers should follow the general expectations that exist for teaching as a profession. A more comprehensive focus would potentially benefit health education teaching in schools overall, and would be in line with a recognized objective of health education – namely that it should develop pupils’ critical thinking skills so that they would be able to reflect on health matters not just from their own personal perspective and daily lives, but also from wider cultural and socio-political perspectives (cf. Paakkari & Paakkari, 2012).

In this research written essays were used as a data collection method. Here, it should be borne in mind that the essays were, first and foremost, written for the purpose of the study program in health education teacher training, not just for research purposes. However, from the perspective of the validity of research it is important to select the most appropriate method to yield new knowledge (Graneheim & Lundman, 2004). The advantage of using essays is that the participants are able to focus on only the aspects they regard as important, without the influence of the researcher (Paakkari, 2012). The method appeared to work fairly well in reflecting trainees’ conceptions. However, there are limitations in using essays: the essays differed in the depth and breadth of the expressions used; some participants were extremely explicit and detailed in their expressions, while others wrote in ways that made it difficult to capture the meaning of the sentences. Thus, we may have misinterpreted what was written; moreover, essays treated as anonymous do not allow the researcher to check the meaning directly from the participants (as can be done in interviews) (see Kvale & Brinkmann, 2009). There

may also have been cases in which the expressions differed at the meaning level, despite being the same at word level, or vice versa (see Marton, 1994), and that might undoubtedly affect trustworthiness of the findings. Here we must admit that individual interviews could have provided a deeper understanding of the topic. However, as teacher educators we are also obliged to consider how well the findings serve the context from which the data were gathered, in terms of developing teacher training practices (i.e. in terms of pragmatic validity; see Kvale & Brinkmann, 2009). In fact, this has been done: we have been able to test and apply the findings when we have dealt with ethical aspects within our health education teacher training program – in other words, among the trainees from whom the data were obtained. We have noticed that the findings do indeed provide a “language” for discussion, and a starting point for broadening trainees’ understanding of ethical matters in health education.

In future it would be interesting to discover whether health education teacher trainees who are majoring in subjects other than physical education, or teacher trainees in other countries, would provide different insights from our findings. A more heterogeneous sample could contribute to richer variation in the data and lead to new findings (see Graneheim & Lundman, 2004). In addition it would be interesting to examine teacher trainees’ awareness of ethical aspects while they are teaching health issues (in their “practicum” phase), and how they may have taken these aspects into consideration during the lessons.

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