Developing and teaching the virtue-ethics foundations of healthcare whistle blowing

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ABSTRACT

Healthcare whistle blowing, despite the benefits it has brought to healthcare systems in many developed countries, remains generally regarded as a pariah activity by many of the most influential healthcare professionals and regulatory institutions. Few if any medical schools or law department health law and bioethics classes, teach whistle blowing in a formal sense. Yet without exception, public inquiries initiated by healthcare whistle blowers have validated their central allegations and demonstrated that the whistle blowers themselves were sincere in their desire to implement the fundamental virtues and principles of medical ethics, bioethics and public health law. In many jurisdictions, the law, this time remarkably in advance of professional opinion, has offered legislative protection for reasonable allegations of whistleblowers made in good faith and in the public interest concerning a substantial and imminent threat to public safety.

One reason for this paradoxical position, explored here, is that healthcare whistle blowing lacks a firm virtue-based theoretical bioethical and jurisprudential foundation. The hypothesis discussed is that the lack of this bioethical and jurisprudential substrate has contributed to a situation where healthcare whistle blowing suffers in terms of institutional support due to its lack of academic legitimacy.

This article commences the process of redressing this imbalance by attempting to lay the theoretical foundations for healthcare whistle blowing. As a case study, this article concludes by discussing the Personal and Professional Development course at the ANU Medical School where healthcare whistle blowing is a formal part of a virtue-based curriculum that emphasises the foundational importance of conscience. Illustrative elements of that program are discussed.

Introduction

In the last decade, arguably it has been not bioethics, but whistle blowing, that has emerged as a significant forces for healthcare quality and safety in developed nations. In the United Kingdom, Australia and Canada, whistle blowers have forced authorities to initiate large scale public inquiries into allegations of preventable patient harm in hospital
settings. Possibly the most influential example was the Bristol Royal Infirmary Paediatric Cardiac Surgery Inquiry from the United Kingdom.¹ In Canada, the Winnipeg Paediatric Cardiac Surgery Scandal was also significant.² So too were the Australian public inquiries into Campbelltown and Camden hospitals, neurosurgical services at the Canberra Hospital and the gynaecological and obstetric services at King Edward Memorial Hospital.³ In the United States, similar findings have been made.⁴ In that country, the actions of whistle blowers under the False Claims Act 1986 (US) have become the chief means whereby the Federal Justice Department recoups more than a billion dollars each year from the healthcare sector.⁵

Large-scale, institutionally independent public investigations into the allegations of healthcare whistle blowers appear to have universally substantiated their core allegations.⁶ The law in all such jurisdictions has now sufficiently recognised the public importance of whistle blowing in all fields, including healthcare, as to accord legislative protection for such disclosures when made in good faith, in the public interest and reasonably revealing a substantial and imminent threat to public safety.⁷

Yet, healthcare whistle blowers continue to be regarded as fitting a number of largely derogatory stereotypes. Chief amongst these appears to be that which represents the healthcare whistle blower as a slightly deranged and unstable personality, constitutionally unable to function as a team player or keep the best interests of his or her colleagues and immediate institution in mind.⁸

The hypothesis explored here is that this paradoxical professional and institutional deprecation, despite manifest reliance, may derive in significant part from the lack of a firm theoretical foundation of healthcare whistle blowing in bioethics and public health law. This article attempts to develop such a foundation, through a theoretical linkage with the normative system of virtue ethics and to the practical utilitarian telos or overall regulatory goal of relief of patient suffering. The practical aspects of implementing such an approach are discussed by reference to the curriculum of the Australian National University Medical School where healthcare whistle blowing is a formal part of the curriculum.

Why are most bioethics curricula anti-whistle blowing?

The recent frequency of public inquiries initiated by the allegations of institutionally maligned healthcare whistle blowers, suggests that something must be wrong with either the way bioethics or medical ethics is taught to trainee doctors, or how it is applied by them in practice. Bioethics and medical ethics overlap, the latter being of particular concern to practising health professionals and the former involving a normative application to somewhat wider issues of science and biotechnology. In 2003, Goldie et al published data indicating that when the last and first weeks of a four year medical course were compared, the number of students making the ethically correct decision was unchanged at 40%. The percentage, however, confirming
they would actually report the unethical behaviour had declined from 13% to <5%.

In 1994, Hafferty & Franks described a ‘hidden curriculum’ in bioethics education. In 1989, Wold et al had already observed an apparent negative attitude change towards bioethical matters during medical education. Hundert and colleagues have also noted an ‘informal ethics curriculum’ acting against the principles formally taught in undergraduate medicine. The conclusion that some authors have drawn from such studies is that contemporary bioethics and medical ethics education may actually be promoting worse ethical decision making in trainees.

Perhaps an important cause for such problems may reside in an overemphasis in bioethics and medical ethics education on the system of principlism. Despite increasing academic criticism, principlism continues to dominate the core of most contemporary bioethics teaching. Central to the principlist approach is what may be termed a conceptually ‘isolationist’ approach to teaching the ‘four principles’ of Beauchamp and Childress. By ‘isolationist’ I refer to that approach which presents these principles as arriving like some deus ex machina rather than evolving, as I would argue, from foundational social and professional virtues.

Beauchamp and Childress’ seminal work Principles of Biomedical Ethics, first published in 1979, involved an academic codification of basic medical ethics into four prima facie clusters of principle: autonomy, beneficence, non-maleficence and justice. The authors claimed to have derived these not from any ideal or utopian doctor-patient relation, but from ‘considered judgments in the common morality and medical tradition.

The cluster of bioethical principle known as autonomy, for example, was defined by Beauchamp and Childress as respect for the deliberated self-rule of patients, it being linked to Kant’s ‘categorical imperative’ to treat beings capable of reason as ends complete in themselves, not as means to other goods. From the principle of autonomy, the authors claimed that more specific ethical rules could be deduced. These included those initiating a professional obligation to keep promises made to patients, to maintain confidentiality of their information, to tell them the truth about their treatment and to ensure competence and skill in communicating information and performing relevant procedures.

Beneficence and nonmaleficence were joined in an ethical duty to provide net medical benefit to patients with minimal harm. Beneficence was importantly additionally associated with the ethical duty to undertake research and participate in professional education and training. Justice in relation to health care ethics, was divided into three ethical obligations: to ensure fair distribution of scarce resources (distributive justice), to respect patients’ rights (rights-based justice) and to respect morally acceptable laws (legal justice). Technically, an act of healthcare whistle blowing could be justified by any or all of these principles. The main question for healthcare quality and safety, however, is whether learning such principles is sufficient to ensure
their constant implementation in the face of significant institutional and professional obstacles.

The importance of what came to be called ‘principlism’ in medical ethics education has been profound. Principlism was designed to be communicated through lectures or group discussions about relevant ethical theories (for instance, deontology or utilitarianism) and related principles and rules, as well as development of the cognitive skills necessary to apply them to complex clinical dilemmas. Its use of deductive logic appealed to the legalistic fascination in many doctors and principlism greatly influenced the construction of codes of ethics and guidelines. Often the four principles appeared to be discussed by doctors as if they had a type of authoritative, quasi-legislative status. One of the undoubted advantages for medical ethics education of the ‘four principles’ approach was the ease with which its components could be recalled and act as a simple mental trigger for complex duties to patients. Remembering the basic ethical principles in this mantric way has helped others emphasise their equivalence, that none was supposed to be primary.

Yet, by the 1990s the four principles approach was being challenged in medical academia. Education in medical ethics was being reconceptualised under banners such as ‘virtue ethics’ and ‘personal and professional development.’ A doctor’s capacity to parrot the principlist mantra was increasingly criticised by academics as providing insufficient proof that he or she could adequately reassure patients of being not only physically at their side, but in conscience ‘on their side,’ within the regulatory bureaucracy of an increasingly privatised developed nation healthcare system. This historical sequence was most pronounced in the US.

Sociological studies of doctor-patient interactions commenced looking for genuine outcome measures of medical ethics education, such as patient recall of and compliance with medical instructions. Also investigated were the level of return appointments kept, as well as patient satisfaction, coping ability and health outcome. Data emerging from these sources consistently declared a strong positive correlation, not with a doctor’s knowledge of the ‘four principles,’ but his or her perceived level of empathy and capacity and willingness to act competently and courageously upon it. Similar conclusions were implied by studies of the placebo effect and informed consent in doctor-patient discussions. Training in professionalism was seen to involve a variety of factors that were only at best partially assisted by a technical knowledge of ethical principles.

Instruction in the four principles, for example, was increasingly argued to be insufficient, alone, to assist doctors in developing the skills associated with explaining to patients the ramifications of complex medical technology on end-of-life decisions. Patients increasingly appeared dissatisfied with the apparently immature ‘bed-side manner’ of many academically bright and technologically competent junior doctors, for whom medical ethics appeared to ‘be’ the capacity to merely recall the four principles and to revolve around, not deliberation, but the signing and filing of pieces of paper in the clinical record. Despite such criticism, however, the ease
of instruction of principlism continues to lead to its unreconstructed dominance in the medical ethics education of developed nations. In that context it is taught is such a way that its core elements seem isolated from questions of character development or virtue in the students. Beauchamp and Childress have attempted to redress this conceptual problem in later editions of their text. Yet, they have declined to say that their four principles of medical ethics should be regarded as arising from distinct professional virtues.

**Virtue ethics: A theoretical core for healthcare whistle blowing?**

Either the principlist system of bioethics and medical ethics was flawed from the start, or what was being revealed by the previously discussed research, was an apparent decline in the ethical decision-making ability of medical students as they proceed in professional training. Leaving aside for a moment the intrinsic problems with principlism, one plausible mechanism by which a trainee's ethical behaviour and decision-making ability could be effectively undermined is by poor role models effecting a gradual erosion in the trainee's belief in the value of consistently implementing learnt ethical principles.

Yet virtue ethics is also presented by many as involving, as we shall see, a challenge to the theoretical foundations of ethical principlism. Part of the problem discussed here is that those familiar with principlism and deriving personal and career advantages from it, still frequently deride a virtue ethics approach to medical education and professional practice, as very much a 'soft' regulatory option. One of the chief reasons is its alleged lack of certainty and predictability with regard to self and external discipline.

The development of virtue ethics and its application to medical education is a relatively recent and contentious phenomenon, possibly partly a response to increasing legalism in professional regulation. Virtue ethics, until now, has not been perceived as having a norm-defining role in systems of regulation involving law and human rights. Indeed, some seem to have argued that if you made people good, you would not need rules of ethics, law or human rights at all. In simple terms, virtue ethics, for them, focuses on the agent, healthcare principlism on categorising an individual action against immutable standards, and utilitarianism on the social consequences of an act. The reality, of course, may be that these are not best conceived as exclusive, but rather as interdependent components of the professional regulatory system.

Modern virtue ethics, it is customary to say, commenced with Anscombe's work in the late 1950's, though, as we shall see, Royce had particularly relevant things to say about the virtue of loyalty as early as 1908. Anscombe argued that philosophers discussing personal ethics (or moral philosophy) should reduce their emphasis on deriving norms for conduct from a legalistically styled vocabulary of principles and rules emanating from Judeo-Christian religious theories now subject to wavering community support. Rather, she said, we should look to the
facts of what humans, such as doctors in our case, need to ‘flourish’ in the sense of leading, as Aristotle appears to have recommended, a life informed by virtue, the necessary telos for which would eventually be supplied by the research of moral psychology.\textsuperscript{38}

Philippa Foot suggested in 1978 that what Aristotle termed arete or Aquinas virtus, but she considered the four cardinal virtues (courage, temperance, wisdom and justice), are correctives, that arise from conscious and prolonged performance of duty at points of difficult temptation or deficient motivation.\textsuperscript{39} What is it, for example, but personal integrity toward development and maintenance of professional virtue, that makes a doctor agitate against significant intra-institutional obstacles and career-damaging pressure to ensure an impaired senior colleague is not allowed to operate on patients?

MacIntyre in After Virtue attempted a re-examination and refurbishment of Aristotle’s Nicomachean Ethics.\textsuperscript{40} He emphasised that a functional system of ethics, in an age of increasing moral pluralism and relativism, must revolve around efforts to achieve character development. Further and most importantly, he claimed character development arose chiefly from voluntary participation in historically variable community-oriented practices or roles.\textsuperscript{41} As well as being promoted by them, the virtues, his argument ran, help such practices resist the morally corrupting power of institutions.\textsuperscript{42} We start to see in this a more direct support for the conscience and capacity to act, to forcefully implement principle, of the healthcare whistle blower, than was ever explicit or implicit in bioethical principlism when taught as somehow isolated from any virtue-ethics base.

MacIntyre claimed his theory was teleological and posited the ultimate good or telos to be sought, as a unified ‘life narrative’ constructed from the ‘internal goods’ obtained by communal service in particular, relatively small communities.\textsuperscript{43} The usefulness of this for present purposes, of course, is that public and private hospitals, the doctor-patient relationship, the medical profession and even that vast aggregate of frayed hopes known as the public healthcare system, may be presented in medical education as such potentially virtue-inducing communities.

MacIntyre’s telos was not found in nature, but in the metaphysical biology of Aristotle.\textsuperscript{44} It involved instead an aggregate of decisions, actions and experiences consciously (and presumably unconsciously) integrated into a ‘life story’ coherent with itself and with community traditions.\textsuperscript{45} ‘The unity of human life’ he stated ‘is the unity of a narrative quest…a quest is always an education both as to the character of that which is sought and in self-knowledge.’\textsuperscript{46} A major difficulty MacIntyre skirted, of course, is that community traditions alone often promote prejudice and discrimination against those, such as whistle blowers, regarded as ‘outsiders.’

Most recent work in virtue ethics, following from this impetus, emphasises that the character of the agent, rather than principles, rules and duties, or the consequences of their performance or non-performance, is the necessary terminus of moral argument.\textsuperscript{47} Proponents of virtue ethics also commonly focus on an agent’s motive,
emotion and whole ‘plan of life,’ rather than isolated moments of choice and discrete actions. Pellegrino has been particularly prominent in championing the need to develop a sound virtue ethics foundation of doctor-patient regulation.

Consistent performance of, or a disposition to act in accordance with, relevant and authoritative principles and rules does not alone constitute virtue according to most virtue ethicists. Also crucially required are the appropriate motives and emotions. In many ways, virtue ethics aims to return normative primacy to conscience by emphasising in a very direct way that character change must come about by acts, by the implementation of learned principles. It is this connection that appears to make virtue ethics so relevant to the act of healthcare whistle blowing. According to Aristotle, accepting the mean between extremes of consequence, or between assertion of principle and compromise, not only helps a person perform functions well, but to become good, to achieve moral dignity. ‘What characterises the brave man’ he wrote ‘is his unshaken courage...he will meet the danger according to the rule or principle he has taken to guide his conduct, his object being to achieve moral dignity or beauty in what he does, for that is the end of virtue.’

Whether virtue ethics should embrace one or many professional virtues, has also been the subject of perennial debate. Some argue for equivalence, that you cannot possess one virtue, without possessing all. Others claim that, in a practical sense, they are identical. Pellegrino and Thomasma view the physician’s possession of a variety of virtues as the chief guarantee that the patient’s good, in all its senses, and with all the involved difficulties, will be fulfilled, respected and protected.

It was the American philosopher Royce, in 1908, who developed the thesis that all a person’s virtues, his or her motivation and sense of obligation to follow social and spiritual rules, could be centralised around a rational conception of loyalty. Other influential scholars such as Rawls and Finnis (both of whom explicitly acknowledge their debt to Royce’s work on loyalty) have drawn from this the important conception, that the capacity to develop a rational ‘plan of life’ is a prerequisite to the attainment of individual good. Royce’s ideas on loyalty may help us see whether loyalty to the relief of patient suffering has the ‘intellectual legs’ to withstand evaluation and assume the role of the central professional virtue in the theoretical heartland of healthcare whistle blowing.

Royce viewed loyalty as a ‘willing’ (freely chosen), ‘thoroughgoing’ (comprehensive) and ‘practical’ (not fanatical) devotion to a cause. The cause required the restraint or submission of one’s desires and impulses for personal advantage or pleasure, in order to serve a community outside the self. Virtue, said Kant, is the strength of a human being’s maxims in fulfilling his (or her) duty.

Royce metaphorically wrestled with the question of whether loyalty could be a good to the loyal individual (such as a doctor obedient to the guidelines of a hospital or to the ‘hidden culture’ of his or her colleagues), despite an apparent lack of good in his or her cause,
or presumably its outcomes. One reason it might not, Royce argued, lay in understanding that the ultimate ethical telos for mankind was loyalty to loyalty, or loyalty to the cause of promoting universal loyalty amongst human beings. Royce claimed that a wrong cause or telos (such as that promoting institutional denial of known harm to patients) is invariably characterised by the fact that it arbitrarily or selfishly limits, destroys or disregards other, normally socially valuable, forms of loyalty that disown it. For similar reasons, absolute loyalty to any specific cause (because of its inevitable and uncompromising conflict with the promotion of universal loyalty) would be unsuitable, according to Royce, to define a basic principle of morality.

Royce, in other words, felt that loyalty to another individual always involves a 'suprapersonal' loyalty to the tie that binds the two. The truly loyal person, stated Royce (perhaps a doctor with an active professional conscience) is inspired to decisive action by a 'life plan,' in which he or she is not only thereby freely loyal to self, family and social development, but is also loyal to the continued existence of an equally unique scheme of duties internationally and cosmologically. Royce’s loyalty thus involved an expansion of sympathy, a reverence for, and extension of moral principle to, all life.

Royce expressly linked loyalty with conscience and stated that, as a guide, it could take us, much as Virgil took Dante, through the worst and best in the natural world, toward fulfilment of our ethical potential. This appears to be a very Aristotelian perfectionist, metaphysical-biology teleology, though that point is not fully developed by Royce. Its preeminent emphasis on conscience does appear to resonate with the stated motivations of healthcare whistle blowers. The main problem with attempting to adapt Royce’s doctrine of loyalty for use in medical ethics education as an adjunct to principlism and as a theoretical foundation for healthcare whistle blowing, is its primary emphasis on ‘loyalty to loyalty.’ Such a notion, if it were placed at the core of medical professionalism, would appear to perpetuate the cycle of ‘virtue is what the virtuous person seeks’ that makes a non-teleological virtue ethics so difficult to utilise in a professional regulatory system alongside principles and rules. It might promote the ‘hidden culture’ or ‘closed shop’ mentality pre-eminently rewarding behaviour that facilitated income and prestige-protection amongst members of the profession. Application of this virtue-based theoretical structure to healthcare whistle blowing will now be considered. This will necessitate looking more closely at the concept of the regulatory telos.

The telos of healthcare whistle blowing

The good sought by any regulatory system may be termed a telos and philosophies providing guidance on its maximisation are known as ‘teleological.’ Many forms of utilitarianism, for example, focus on the telos of overall community welfare.

On certain interpretations Aristotle offers a non-teleological ethics, provided, that is, we regard the ‘ultimate’ good or telos as actually defined by the virtues themselves. Some contemporary virtue
ethicists accept a utilitarian telos based on a single good describable independently of virtue. Examples include the location of such a telos in a unified individual ‘life narrative’ according to MacIntyre, or scientific investigations of moral psychology according to Anscombe.  

Others propound a non-teleological theory primarily emphasising the virtues themselves, or universal principles derived from them. The latter theories are commonly subjected to objections, particularly by the principlists, concerning their circularity and failure to provide determinate guides to action. This has been perceived by some to be a major problem with using non-teleological virtue ethics in a practical regulatory system.

Teleological theories have the regulatory advantage of providing clearly determined guides to action, though often at the expense of devaluing individual human rights. It may be an important aspect of providing a firm virtue-based foundation for healthcare whistle blowing that doctor-patient regulation is able to lay claim to a unique individually-focused telos. This primary telos involves relief of individual patient suffering. Suffering, in this context refers to that understood by the health professions as capable of threatening coherence in a patient’s life narrative and not being readily amenable to self-remedy. This emphasis on the individual in the primary regulatory telos may overcome problems of possible conflict between a virtue-based system and the consequentialist communal public health good of relieving suffering in as many patients as possible. The latter might be the public health goal of a society with socialist commitment.

The primary telos may be depicted negatively (as relief of patient suffering) to more effectively arouse the conscience of health professionals toward principled action, much as emphasising injustice operates in other contexts. A crucial premise in this context, relevant most particularly to healthcare whistle blowing, is that complete instruction in and recall of the basic bioethical and legal principles comprising doctor to patient duty, will not themselves motivate action. Motivation, the generation of emotion to encourage performance of an act, also requires convictions in conscience derived from previously established virtue. One suggestion apparently confirmed by healthcare whistle blowers is that such an ‘awakened’ conscience arises most readily from direct proximity to individual patient suffering or its effective artistic representation.

For health care whistle blowing to be taught effectively, it must first be accepted that (1) professional conscience closely relates to emotions generated by perceiving and judging a specific object or belief against respected normative criteria or ethical principles, and (2) that it can be trained through a process whereby character traits known as the virtues are shaped by and encourage the implementation of ethical principles in action. Untrained conscience, when fed by emotion, can lead unpredictably to rule disobedience, or pragmatic, consequentialist reasoning that may actually be counter-productive to healthcare quality and safety. Instead of the latter, the primary telos of doctor-patient regulation should be achieved through deliberation, by all its
participants, utilising as process that which may be termed personal and professional narrative coherence.

In the process of personal and professional narrative coherence, conscience motivates action when principles intellectually assimilated into a person's life narrative, so that their breach is capable of generating emotion, are applied in a situation so as to guide decision making, once reason is satisfied of their coherence with the broader normative systems including international human rights. Conscience-based objections to, say, legal rules or an institutional culture of non-disclosure of colleagues’ impairments, have more deliberative ‘weight’ under professional narrative coherence when based on beliefs which are first, central to the coherence of the doctor's life narrative, second, accord with a recognised understanding of the ideal doctor-patient relationship, and third, do not compromise or violate recognised patient human rights. When the primary utilitarian *telos* of this virtue-based system is formulated prescriptively as the foundational doctor-patient regulatory principle, it takes on the characteristics of a master principle, intelligibly relating complementary and interstitial principles.

We may then say that a physician whose acts consistently emphasise loyalty to the relief of patient suffering, is likely to be a good role model for how conscience and knowledge of ethical principle should work together. He or she is likely to have the capacity to improve trainees’ ethical behaviour by reinforcing their respect for the legitimacy of and need to regularly apply the ethical standards they have learnt. The conclusion, that positive role models will encourage the consistent implementation of ethical principles as a guide to action and an aspect of character development, represents, I would argue, a virtue ethics approach to professional regulation that has thoroughly integrated principlism.

The model being presented here as a theoretical basis for healthcare whistle blowing is one in which effective role models of ethical behaviour are seen as not merely teaching the principles, *what* ought to be done in various problematic clinical situations, but also as setting an example of action on those principles, despite repeated, significant obstacles. Such role models typically influence a trainee’s *character* toward the consistent implementation of principle. Such doctors we can hypothesise, presumptively embody the professional virtues, such as loyalty, integrity and competence. They sufficiently *believe in* the standards and ethical principles they are teaching to consistently implement them. This practical manifestation of an approach to medical education emphasising the yoking of respect for professional virtue and principlism provides a central rationalisation for a virtue ethics foundation of healthcare whistle blowing.

**Teaching the telos of healthcare whistle blowing**

It is now necessary to consider how loyalty to relief of patient suffering might be incorporated in a modern medical curriculum to provide a practical *telos* for a virtue-based approach to healthcare whistle blowing.
At the Australian National University Medical School, the following constitute the core of the approach used to formally teach healthcare whistle blowing as part of a virtue-based bioethics curriculum. This curriculum ranges over the generally accepted topics of bioethics, medical ethics and health law, but is somewhat uniquely conceptually dominated by international human rights. Whistle-blowing is used as an example of a practical and useful activity that, when performed correctly, should involve a close integration of personal moral values and trained and awakened conscience, drawing on ethical principles and law while being calibrated against international human rights.

In the initial week, students are asked to complete a questionnaire involving various scenarios related to healthcare quality and safety. This tests the students’ baseline level of understanding about not only the conduct required by principle, but whether sufficient conscience and motivation exists to strive to implement those principles in practice in the face of obstacles.

Students are exposed to brief talks focused on personal experience based around the concept of conscience and the implementation of principle in difficult situations. These are delivered by senior members of the medical profession, or by eminent persons who wish to speak about an aspect of the doctor-patient relationship in that light. These talks occur in the first few weeks of the course at a venue that is off campus, associated with the humanities, and so is not likely to be readily identifiable with or facilitate any particular component of a ‘hidden’ institutional and professional counter-ethics agenda. Mentors, drawn from members of the local medical community believed to have the requisite ethical standards to be a satisfactory role model, are encouraged to attend these meetings. Groups or ‘nodes’ of mentors (usually about three) are then linked with groups of three students. In the following year, these students will sub-mentor an equivalent number of first year students in the same node. Mentorship involves informal meetings at mutually arranged times and locations.

Students are then asked to consider issues about whistle blowing in their problem-based learning structure and in a course of systematically developed formal lectures, as part of the Personal and Professional Development (PPD) part of the course. This differs from standard principlist teaching in that students are asked to imagine themselves in situations which demand that principles be acted upon, despite major resistance from their colleagues, institution, state or, in some instances, its ruling multinational corporations. The two-hour fortnightly PPD session opens with four closely tutored students making a group presentation on the issue. To prepare for this they have been closely tutored by the lecturer and asked to consult and use as a theme nominated works of art or literature specifically chosen for their capacity to arouse conscience and ethical reflection.

Multiple choice, mini-case and short answer questions assessing an understanding of not only bioethical principles, but the problems with implementing them in the face of such obstacles are then integrated in the assessment package along with basic sciences,
clinical skills and population health. Whistle blowing situations are one alternative appearing in such assessment options.

**Conclusion**

It has been argued here that it is possible to reverse the ‘hidden curriculum’ of medical ethics training and part of the solution involves giving a firm theoretical virtue base to healthcare whistle blowing. I have suggested that this may be achieved through an approach to medical education which links encouragement of conscience and the character disposition of loyalty to the relief of patient suffering, with implementation of related ethical principles despite significant obstacles. These decisions are calibrated against norms of international human rights, the process itself raising numerous interesting normative issues not discussed here.

Various techniques may be used to facilitate this practical approach to virtue ethics. Perhaps the most promising involves the technological imperative of having trainees regularly utilise portable digital technology programmed with ethical competencies, at the bedside.\(^7\)\(^9\) This approach would assist to transform the conscience implicit in acts of healthcare whistle blowing into an openly transparent culture of self-reporting.

It is to be hoped that as more academic work is done on the conceptual foundations of healthcare whistle blowing, these courageous professionals will begin to gain more peer respect and acknowledgement for their valuable contributions to patient safety.

**ENDNOTES**

6. Faunce and Bolsin, op. cit.
7. Ibid.
17 Beauchamp and Childress, op. cit., p. 37
19 Beauchamp and Childress, op. cit., pp. 23–24.
21 Beauchamp and Childress, op. cit., p. 25.

41 Ibid., pp. 56, 64.

42 Ibid., p. 181.

43 Ibid., pp. 183, 189.

44 Ibid., p. 181.

45 Ibid., pp. 189, 201 and 203.

46 Ibid., p. 205.


50 Beauchamp TL and Childress JF, *Principles of biomedical ethics*, op. cit., p. 64.


55 Pellegrino and Thomasma, *op. cit*.


58 Royce J, ‘The philosophy of loyalty’ in Roth (ed.), *op. cit*.


64 Royce ‘The philosophy of loyalty’ in Roth JK, *op. cit.*, p. 335.


71 Trianosky G, ‘What is virtue ethics all about?’ in Statman, *op. cit*.

72 Nussbaum M, *op. cit*.


Blowing the virtue-ethics whistle: Response to Faunce

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Tom Faunce has provided the professional and academic communities with a thoughtfully developed theoretical foundation for healthcare whistle blowing in bioethics and public health law, arguing that the lack of such a foundation is a significant reason for the absence of whistle blowing in academic curricula, and for the failure of the medical profession to support whistle blowers as the law already does. He finds fault with bioethical principlism, and develops virtue ethics-based theoretical and educational approaches to the topic of whistle blowing. He describes how the theoretical approach developed is being applied in teaching medical students in the new medical course at the Australian National University.

I suggest that the lack of a theoretical foundation for whistle blowing as the reason that it gets no attention from the medical profession, gets things somewhat the wrong way round. It is largely the familiar and persistent protectionist stance of the medical profession, as demonstrated in the recent cases which Faunce lists, which up till now has kept whistle blowing out of bounds, and led to the depreciation of the whistle blowers. The alleged connection also presupposes an inaccurate temporal relationship between bioethics teaching and professional behaviour. We should not link the recent spate of inquiries triggered by whistle blowing to a deficiency in the mode of bioethics teaching, because those who protected the profession and its institutions by closing ranks, and by ostracising the whistle blowers, were, by and large, not educated in the era of significant bioethics and medical ethics teaching in medical schools.

This does not prove, of course, that principlism is a good method of teaching bioethics and medical ethics, and Faunce has some independent reasons for both arguing the general case, and specifically questioning whether principlism, as a mode of ethics education, is sufficient to motivate potential whistle blowers to act in the face of professional and institutional opposition. These arguments, however, present problems as well.

The inference by some authors, that contemporary ethics education (which we are to assume will largely be along principlist lines), may be promoting worse ethical decision-making, on the basis of the existence of an informal or hidden curriculum acting against the principles taught in medical courses, is clearly invalid. The hidden curriculum is constituted by influences such as poor role modelling, peer influences, stress in the medical course and professional life, and it is these influences which have been argued by the investigators of
the hidden curriculum to lead to unethical practices, further poor role modelling, and so on. If these factors work against ethics teaching, and it is these factors which lead to unethical decision-making, it is not the ethics teaching which should be blamed for ‘worse ethical decision-making’.

It remains to be seen how newer models of medical education, which include but are obviously not restricted to ethics teaching, will ameliorate the negative effects of the hidden curriculum. Moreover, the prejudice against current modes of ethics teaching assumes, against common sense and the same research evidence, that the hidden curriculum mysteriously came into existence when principlist bioethics teaching commenced. I note with relief that Faunce concedes that one of the plausible mechanisms by which behaviour and decision-making can be undermined is by poor role-modelling, and it should be remembered that it was the role-modelling model of medical ethics which principlism originally challenged.

A somewhat similar objection applies to the lack of correlation between principlism and outcome measures such as patient recall, compliance, return appointments, satisfaction etc, contrasted with a strong correlation between these measures and physician empathy. This suggests that a course which happens to use a principlist approach to ethics teaching would not be capable of producing empathic physicians, whereas this outcome derives from so many other factors in addition to which approach to ethics teaching is employed. In the same way, explaining complex medical procedures to patients and deliberating effectively rather than perfunctorily with them, are the end-products of a complex combination of educational approaches and experiences, not just of a satisfactory model of medical ethics education.

Faunce provides a helpful summary of some aspects of the development of modern virtue ethics theory, and points to a number of familiar difficulties which it experiences, including the fact that community traditions, which loom large in Macintyre's virtue ethics, can include traditions like rank-closing by a professional community against activists such as whistle blowers. A further and familiar difficulty for virtue ethics is the tendency to employ some version of principlism in describing how the status of the man or woman of character and conscience is to be achieved. So, according to the author, character change is to come about by acts of implementing learned principles, and according to Aristotle, courage is shown when the brave man acts according to a principle which he has taken to guide his conduct (my emphases). Royce’s central principle of loyalty, which Faunce suggests could be adopted for healthcare in terms of loyalty to the relief of patient suffering, suffers from a related problem. Just what significant distinction can we make between loyalty to relieving the patient’s suffering and the duties/principles of beneficence and non-maleficence, directed to the same end? It cannot be that the loyal doctor will be more committed to relieving suffering than the doctor who is bound by a principle of duty, since we are told that the virtuous, loyal doctor is to restrain her personal desires, just in service to her
duty. Again, I am reassured by Faunce’s acceptance of these kinds of conceptual and practical problems in applying virtue ethics to regulatory systems.

Loyalty to relieving suffering, however, is then distinguished from a principle or a duty to the same end, on the grounds of motivation. This appears to be a mix of theoretical and empirical prediction, and while the behavioural outcomes of different methods of ethics teaching await the appropriate empirical research, the more theoretical considerations provided here also raise questions. The primary good of medicine is said to be the relief of suffering, and this, while a somewhat narrow construal, should not meet with any strong disagreement. But depicting it in this way, we are told, should arouse the conscience of the virtuous practitioner, whereas learning and recalling ethical principles will not motivate action. It would be interesting to know whether the whistle blowers involved in recent actions were educated in a virtue ethics mode; it should follow that they were, from the connected claims that whistle blowers possess awakened consciences, and that such consciences arise from established virtue. It is doubtful, however, whether this is the case. We are also told that the whistle blowers’ consciences were awakened by proximity to individual patient suffering, but if so, then all physicians, or at least most, should develop good consciences on that basis. And if professional conscience relates to emotions arising from judgments made against specific normative criteria, is this not to say that principles do play a fundamental role in motivating conscience? The distinction between the motivation resulting from virtue ethics education and that which arises from learning principles, strikes me more as an assertion in support of a theory, rather than an evidence-based or even theoretically sound claim.

The culmination of the developed model is the virtuous physician, loyal to the relief of patient suffering, who becomes a better role model than physicians presumably were in the bad old days, when they modelled, largely unconsciously, harmful practices including the ostracism of whistle blowers. But nowhere in the development of Faunce’s model do we see a good argument against the central place of principlism, nor one for its responsibility for defensive and harmful professional behaviour. Indeed, this account of virtue ethics, like others, is peppered with assumptions about regulatory principles, standards, normative criteria, master principles, and so on. Moreover, I do not believe that we get, in the virtue ethics model, an account of how virtuous physicians are to become virtuous, independently of a principlist influence, and in addition to the effect of simply being with suffering patients.

Finally, to the teaching of whistle blowing. There is no doubt that this area should figure in medical ethics curricula, and the ANU development is timely and welcome. It will be followed with interest by medical educators in Australia and abroad. I question the necessity to take the experiential talks off campus. The reason given is to avoid identification with or facilitation of a hidden or counter-ethics agenda. If the mentors are in fact satisfactory role models, however, such
identification and facilitation would not be the case. Perhaps more importantly, the way to confront hidden agendas is surely to confront them, not evade them. Moving off campus may be perceived by some in the profession (including students) as indicating that this item on the curricular agenda is less than crucial. Keeping it within the physical and cultural walls of the medical institution, on the other hand, would make it, and make it appear, an integral part of the course, and is more consistent with the espoused clinical role-model aspect of the teaching.

It is also important to note that asking students to imagine themselves in situations which demand that they act upon principles despite resistance from others, does not rule out principlist teaching and mandate virtue ethics or another non-principlist approach. The existence of resistance to the implementation of principles does not mean that the student or doctor is left floundering with nothing to which to appeal, as if such resistance could somehow snuff out a principle of action. Indeed, standard principlist teaching would be consistent with, and could well be effective in, the teaching of whistle blowing, since good quality teaching emphasises the need for careful deliberation over clashes of principles and interests, which is a highlight of the whistle blowing phenomenon. For this reason and those advanced above, the case for relegating principlism in the teaching of whistle blowing, or more generally, is far from made out.

The debates concerning principlism, virtue ethics and other ethical theories, and their application in the teaching of bioethics and medical ethics, are of crucial concern to the community and to the profession, because they involve the education of doctors who will be motivated to act ethically. We have much to do in continuing to pursue that aim, and we are indebted to Faunce for an important contribution to that work.