Whistle-blowing in the medical curriculum: A response to Faunce

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ABSTRACT

We agree with Faunce's proposal that academic legitimacy is important in ensuring that whistle-blowing is included in medical curricula. We disagree, however, with the assertion that this is best achieved by means of an over-arching theoretical foundation for health care whistle-blowing of the kind suggested by Faunce. We propose that systematic theoretical justification is neither the sole nor the main determinant of academic legitimacy when it comes to matters for inclusion in medical school curricula, and outline an alternative view, together with a practical example of a healthcare whistle-blowing topic.

Synopsis of Faunce

In his October *Monash Bioethics Review* article, Thomas Faunce makes a number of points about the role of whistle-blowing in medical ethics, health law and bioethics curricula. His main argument may be summarised in the following way. First, healthcare whistle-blowing is generally regarded as a pariah activity within healthcare institutions. This is paradoxical given the contribution that whistle-blowing makes to improving health care standards. Second, this situation derives in significant part from a lack of academic legitimacy, specifically, the lack of a firm theoretical foundation. Third, prevailing theoretical approaches employed in teaching medical ethics, especially principlism, have in general met with limited success, and fail to address the problem of a hidden curriculum in medical ethics. Faunce argues that a virtue ethics foundation for teaching whistle-blowing will confer academic legitimacy and address its supposed slow uptake in medical curricula. He claims that a virtue-based approach will address not only the pariah status of whistle-blowing in health care, but also the broader problem, as suggested by Hafferty and Franks, of a hidden curriculum in healthcare ethics education.[1]

Faunce's virtue ethics approach and problems with principlism

Faunce claims that whistle blowers are in poor professional standing; evidence for this claim lies in their poor treatment at the hands of their institutions, as described in recent public inquiries initiated by whistle blowers.[2] From this, Faunce concludes 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'.[3] There are two suggestions implicit here: the more effective the teaching of bioethics and medical ethics is, the less cause there will be for people to blow the whistle, and the less likely it is that they will experience the personal vilification Faunce notes as a consistent feature in each case. As the claims of whistle blowers in recent cases appear to have been substantiated by subsequent inquiries, and vilification of the individual has remained a feature in each case, he concludes that there is something wrong with the way medical ethics is being taught.

To suggest that effective teaching in medical ethics may help to improve standards of professional conduct in general, and the status of whistle blowers in particular, seems reasonable. It is a stretch however to suggest that because professional conduct is still not all that it could be, and whistle blowers continue to be marginalised and harassed, that poor teaching of ethics in medical schools is to blame. Faunce's argument seems to be with the status quo in health care ethics rather than one in support of addressing the status of whistle-blowing in theory and in practice. Indeed, if there is a problem with the way medical ethics is taught to trainee doctors, then this problem lies, for Faunce, in the way that principlism appears to dominate the core of contemporary bioethics teaching.[4]

Although some reports suggest otherwise, in that there appears to be a diversity of approaches at work in medical schools across Australia and New Zealand,[5] Faunce's proposal of an alternative approach against the backdrop of an 'era' of principlism is one we must take at face value. Put simply, Faunce's theoretical proposal involves the employment of a virtue ethics approach as a normative tool in pursuit of the relief of patient suffering as an overriding aim of professional practice.[6]

Faunce cites evidence in support of his case for the limited effectiveness of principlism in practice; it is difficult however to see how the sociological studies cited[7] reflect poorly on the results of principlist teaching of medical ethics, as many of them were published *prior* to the first edition of *Principles of Biomedical Ethics*.[8] Further evidence is cited which seeks to demonstrate an apparent decline in ethical decision-making during medical courses.[9] It is difficult to conclude however, just how this reflects on the effectiveness of current ethics teaching without at least some comparisons with students in medical courses that have no ethics teaching (would their ethical decision-making have declined even further?). These are of course important questions that invite further research.

The chief complaint, it seems, with regard to the principlist approach to teaching in medical ethics is that it is not virtue-based, where 'the four principles are presented as 'arriving like some *deux ex machina* rather than evolving... from foundational social and professional virtues'.[10] Even if there are serious limitations to the effectiveness of health care ethics teaching in an 'era' of principlism, it does not necessarily follow that principlism is automatically *bad* and

virtue ethics *good*. Regardless, aspects of Faunce's proposal of a virtue ethics foundation to health care whistle-blowing do have strong appeal. Focusing discussion on the role of loyalty and of conscience is certainly apposite to the topic of whistle-blowing. Loyalty is an issue central to whistle-blowing regardless of the theoretical perspective one assumes. The use of Royce[11] to put some meat on the bones of how loyalty *works* in this context seems like a worthwhile exercise, justifying further scholarship in this area. The role of conscience may be similarly important; the proposed centrality of this notion and how it operates on Faunce's account is interesting.

Faunce concludes his account with some strong conditions in order for the teaching of whistle-blowing in medicine to be considered effective. Affective involvement combined with a trained conscience seem to describe the crux of the issue for Faunce,[12] who interestingly also borrows from MacIntyre in proposing the notion of a 'personal and professional narrative coherence'.[13] It may be worthwhile to reformulate the way we discern guiding principles beyond what many may view as the constraints of principlism, and integrating this with a more prominent role for conscience and personal character as per virtue ethics are also interesting notions. But such a discussion regarding alternative theoretical approaches, we argue below, should take place in its proper context: that of approaches to moral theory and motivation, rather than as a central part of teaching ethics in a medical course.

Approaches to whistle-blowing in the medical ethics curriculum

We agree with Faunce that academic legitimacy is an important means of addressing the status of whistle-blowing in the profession. We disagree with his solution of offering an over-arching theoretical justification in pursuit of this goal. Importantly, this disagreement rests on differing notions of what constitutes academic legitimacy.

Faunce's view appears largely theoretical: a coherent and convincing normative model will provide a firm base from which to defend the merits and promote the credibility of health care whistle-blowing. Teaching virtue ethics will offer whistle blowers firmer conceptual foundations and more robust justifications for challenging the status quo, compared with those provided by current teaching based on principles. The pedagogical aims here are, presumably, better teaching and learning outcomes, improvements in professional practice, and addressing the poor regard in which whistle-blowing is held by the profession.

Coherent theoretical accounts are important, especially when dealing in matters of moral philosophy. In response to Faunce however, we believe that there are two discrete issues with regard to the academic legitimacy of whistle-blowing: the theoretical justification for taking whistle-blowing seriously, and the pedagogical aims of including whistle-blowing in the medical curriculum. It is our view that academic legitimacy is more likely to be secured by demonstrating

the value of including whistle-blowing in the medical curriculum, rather than by the persuasiveness of theoretical accounts *per se*, and that this is best pursued by means of a broader view of whistle-blowing in health care, such as the one we propose below.

The danger in Faunce's account is that normative theoretical foundations may be held to be equivalent with the academic legitimacy of health care whistle-blowing. It is our view that competing normative accounts, by their very nature, cannot adequately describe whistle-blowing as it occurs in a health care setting. The role that normative moral theory should play with regard to whistle-blowing is an important one; however, when it comes to pedagogical aims, such accounts can only describe certain aspects of the topic. Demonstrating (and having our clinical colleagues accept) the legitimacy of including whistle-blowing in the medical curriculum is important, but such legitimacy cannot rely solely upon the integrity of any single theoretical justification. In other words, we can demonstrate the importance of whistle-blowing as a topic in an ethics program and teach it in the most effective way possible, without having to justify its presence in terms of sweeping theoretical justifications, or having the teaching itself become bogged down in continued attempts to reconcile competing normative accounts.

Further, Faunce's view increases the risk of whistle-blowing being dismissed as an abstraction from the main business of teaching students what they need to know. We strongly agree with Parker's suggestion that moving the instruction for such topics off campus distinguishes them from other aspects of the medical curriculum, inviting the suggestion that they are indeed of lesser importance than the main business of the course.[14] The further we allow ethics in health care to become distinct from a 'mainstream' curriculum, the more difficult it will be to demonstrate its relevance in practice.

An alternative approach to teaching whistle-blowing: practical, professional and ethical

If the aim of teaching health care whistle-blowing were to develop students' competency in dealing with competing theoretical accounts (as is normally the purview of moral philosophy), then this aspect should take precedence over others in the curriculum. As we have argued however, it is more plausible to suggest the central aim of teaching whistle-blowing is to develop students' competency with regard to being responsible and competent practicing professionals, not unlike other areas of the medical curriculum. This being the case, we are better able to demonstrate the value of whistle-blowing in the curriculum by appealing to the need to educate students about such things as the limitations and strengths of health care governance structures, the measures available to them in preserving their sense of integrity with regard to their profession, and the possibility that any one of them may one day find themselves or their colleagues dealing with the prospect of blowing the whistle.

We believe therefore that a threefold approach to teaching whistle-blowing is more likely to provide the kind of academic legitimacy sought by Faunce than a focus solely upon offering theoretical foundations. The three components of whistle-blowing we identify describe moral, governance and professional issues respectively (see Box 1).

Box 1 What are the aims of teaching whistle-blowing in the medical ethics curriculum?

Moral issues
- evaluating the actions of others: discerning right from wrong
- assessing moral motivation: apathy, conformity and self-interest v acting on one's conscience, loyalty or in the interests of others
- balancing perceived duties or obligations: (e.g. loyalty or apathy v relief of patient suffering)
- providing support for and solidarity with whistle blowers by raising awareness of the issue

Governance issues
- the relationship between whistle-blowing and success or failure in health care governance
- whistle-blowing as a tool for patient protection and for initiating comprehensive reform to the benefit of patients, staff, and practitioners alike
- formal moves to protect whistle blowers from reprisals

Professional issues
- preparing students for situations where whistle-blowing may be an alternative, either for the students themselves as prospective practitioners, or for their peers
- empowering students with a sense of involvement in maintaining the standards and integrity of the profession

Obviously whistle-blowing entails matters of ethical concern. How can we discern situations that warrant blowing the whistle from those that do not? At what point does one defy conflicting loyalties, apathy and self-interest in the name of one's own moral conscience, or that of the greater good? How can we arrive at coherent justifications for when it may be right to blow the whistle, and when it may not? These questions are familiar matters for educators and scholars of moral philosophy and applied ethics, and normative theoretical accounts have a central role in making sense of and dealing effectively with these issues. They do not however exhaust the possible pedagogical benefits of including whistle-blowing in the medical curriculum.

Given the positive role of whistle-blowing in bringing about improvements in healthcare quality and safety, it seems obvious that whistle-blowing should also be understood as an important issue of

health care governance. The very fact that so many whistle-blowing cases in medicine are found to have been justified[15] implies that in each case institutional measures for recourse have been inaccessible or inadequate. In other words, every justifiable case of whistle-blowing represents a demonstrated failure in healthcare governance. Teaching about whistle-blowing therefore ought to address issues in healthcare governance, how they work and how they might be improved.

Finally, the inclusion of whistle-blowing in the medical ethics curriculum offers an important contribution to the development of medical students as prospective professionals in the field. This aspect is especially important if we are to address perceptions contributing to the 'pariah status' of whistle-blowing in medicine. In justifiable cases of health care whistle-blowing, it is likely that the whistle blower has acted out of a strong commitment to standards and integrity in the profession, entirely contra to the perception of whistle-blowing as un-professional behaviour. Including whistle-blowing in the medical curriculum demonstrates to students that they too have the same option open to them if they encounter threats to professional integrity and standards. Perhaps most importantly of all, we as health care educators have a duty to students to describe the concrete reality of health care whistle-blowing, for any one of them may find themselves in a situation where blowing the whistle on a colleague or an institution may be the only option left to them.

The Flinders Whistle-blowing module as part of the GEMP program

At Flinders, we are currently developing a web-based module on whistle-blowing for students in their fourth year of the Graduate Entry Medical Program (GEMP). This builds upon the ethics and health law teaching in earlier years, which currently consists of a series of lectures and seminars in years one and two (approximately 40 hours of teaching) plus tutorials in clinical ethics and individual mentoring interviews in year three. The teaching offers students a range of approaches to ethical analysis and decision-making, incorporating patients' rights, practitioners' duties, obligations and character, and consequences for health care teams, institutions and communities as well as for the individual doctor and patient. Students are introduced to common ethical principles and virtues in medical practice, but we avoid using a singular approach.

In year 4 of the GEMP, the students are widely dispersed at locations around Australia and internationally, making face-to-face teaching virtually impossible. Whistle-blowing is one of a series of ethics and health law topics that we plan to develop for web based teaching for the Year 4 students. One of the primary aims of the web-based teaching program is to provide an interactive learning tool that is accessible from remote sites. The whistle-blowing module (the pilot for the series) includes two interactive scenarios, one medical and one surgical, along with a brief introduction to whistle-blowing and links to other resources.

The scenario cases have been constructed in consultation with senior clinicians to ensure credibility and accuracy. Taking the medical case as an example, students are given a brief clinical scenario in which they are an intern on a ward where a senior clinician behaves in a way that compromises patient outcomes. They are offered three options in response to this: to do nothing, to change jobs, or to approach someone about the issue. The range of people that they can approach include the patient or their family, other staff (nurse, registrar), the doctor in question, a friend, management within the hospital, the media or a royal college. Once the student has made a decision, the next stage of the scenario appears on screen, demonstrating the consequences of their action. Students are free to cycle through the case seeking advice from all parties, or choosing the other options (of doing nothing or changing jobs). When they leave the scenario, they are returned to a resource page with links to articles about whistle-blowing[16] and to the surgical case. Finally there is an brief compulsory MCQ quiz, which tests the students on their understanding of whistle-blowing.

The teaching integrates the three aspects of whistle-blowing outlined above. The use of a scenario in which the student has an active role in making decisions that will influence, for better or worse, patient outcomes, creates a sense of moral immediacy. The advice from different parties provides examples of both self-interest and of more appropriate duty or virtue-based responses. The range of choices that students can make demonstrate common governance structures, and the contexts vary from a well-functioning system in which positive changes are implemented, through to a flawed structure that requires whistle-blowing to achieve a satisfactory resolution. Finally, the act of deliberating, implementing decisions and observing the consequences provides the students with a role-play like situation in which they can practice the decisions that they may ultimately face in their professional lives.

One of the challenges will be to evaluate the effect of this, and the rest of the ethics and health law teaching offered on the Flinders GEMP. This is part of a wider issue facing teachers of ethics in medical schools: how should we respond to research suggesting that medical students do not develop in their moral reasoning in ways that we might expect,[17] and how can we tell whether our teaching is effective? At present, explanations revolve around the power of the hidden curriculum (rather than the less palatable view that we may be ineffective as teachers). By linking ethics teaching with issues of governance and professionalism in the whistle-blowing module we aim to emphasise the practical nature of medical ethics and the very real consequences that follow from unethical behaviour, thereby providing students with good reasons to challenge the unacceptable aspects of medical culture that they will undoubtedly encounter. How we can tell whether or not we are successful in this aim is beyond the scope of this article, but warrants serious consideration by all teachers of medical ethics.

Conclusion

We propose the aims of teaching whistle-blowing in medical curricula as threefold, addressing moral, governance and professional issues. This approach is intended to be of concrete educational benefit to students, and in turn support the aim of improving the status of whistle-blowing in the profession. This approach is able to demonstrate the value of including whistle-blowing in medical curricula effectively, without recourse to a singular theoretical foundation.

With regard to the effectiveness of approaches to health care ethics more generally, it is difficult to draw any firm conclusions without further research. We believe that our teaching clearly integrates the aims outlined in our approach, but we (along with others in the field) are yet to develop formal measures to assess the effectiveness of such teaching, especially with regard to changes in supposed efficacy in the moral decision-making of students. Finally, it is not clear that either ours, Faunce's, nor anyone else's approach will be effective against the hidden curriculum largely because this remains an ill-defined and ill-identified concept requiring much in the way of further research.

ENDNOTES

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2 Faunce T, 'Developing and teaching the virtue-ethics foundation of healthcare whistle-blowing', *Monash Bioethics Review*, vol. 23, no. 4, 2004, pp. 41–55, at p. 42.

3 Ibid., p. 42.

4 Ibid., p. 43.

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6 Faunce, op cit., pp. 49–50.

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8 Beauchamp TL and Childress JF, *Principles of biomedical ethics*, 1st edition, New York: Oxford University Press, 1979.

9 Faunce, op cit., p. 43.

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12 Faunce, op cit., pp. 49–50.

13 Ibid., p. 50.

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15 Faunce TA and Bolsin SN, 'Three Australian whistle-blowing sagas: Lessons for internal and external regulation', *Medical Journal of Australia*, vol. 181, no. 1, 2004, pp. 44-7.

16 Ibid.; Coull R, 'Everything you always wanted to know about whistle-blowing but were afraid to ask', *British Medical Journal*, vol. 328, no. 7430, sections 5-6, 2004.

17 Patenaude J, Niyonsenga T and Fafard D, 'Changes in students' moral development during medical school: A cohort study', *Canadian Medical Association Journal*, vol. 168, no. 7, 2003, pp. 840-844.