

**LEADERSHIP CHALLENGES IN CANADIAN HEALTH CARE:  
EXPLORING EXEMPLARY PROFESSIONALISM UNDER THE  
MALAISE OF MODERNITY**

by

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## **ABSTRACT**

This thesis explores the nature of leadership within the health professions and the influences upon them of the “malaise of modernity.” In order to address this question, significant aspects of the following are dealt with: moral and political philosophy, the influences of modernity, professionalism, the moral community, the communitarian ethic, leadership theories and organizational culture. Primarily a theoretical essay, this project uses a broad range of writings from classical and contemporary scholars. The objective of the thesis is to develop a model for contemporary health care leadership.

Philosophical political frameworks and sociological images are examined to understand the complex multidimensional concept of modernity as it significantly affects all areas of society, not the least of which is health care. The predicaments that arise from the “malaise,” such as bureaucratization, alienation, commodification and commercialization, provide a significant backdrop for further discussions of implications for professions and leadership.

An exploration of moral philosophy demonstrates that the work of Plato and Aristotle still informs contemporary scholarship on health care values and professional practice. Discussions of the quest for the good, virtue and ethical theories relate to views of professionalism and current challenges. A critique of

leadership theories concludes that there is a need for further development of an alternative framework to support the practice of ethical leadership within health care. Documentary cases, the Report of the Royal Commission, *Building on Values: The Future of Health Care in Canada*, and the Dr. Nancy Olivieri case illustrate these current issues of leadership, professionalism and policy development.

Throughout the thesis, the discussion of the foundations and challenges of educational leadership draws upon personal interviews with exemplary leaders. They join the dialogue with classical philosophers and such contemporary scholars as Charles Taylor, Alasdair MacIntyre and James MacGregor Burns.

The thesis concludes with a model for leadership, in response to the central inquiry of this project. The model establishes elements necessary for developing excellence in leadership in the 21<sup>st</sup> century to guide professional practice and health care reform in the midst of the malaise.

## DEDICATION

This thesis is dedicated to two health care professionals

who have exemplified mentorship and role modelling:

Doris Kirk, RN

*my mother*

and

John R. Harrigan, MD

*my husband*

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# CHAPTER ONE

## INTRODUCTION

Our health care system defines us as communities, as a society, and as a nation. What Canadians are prepared to do, and more importantly, what we are not prepared to do for each other when we are sick, vulnerable, and most in need, says a great deal about Canada, our basic values, and the values that we want to hand on to future generations of Canadians (Somerville, 1999, p. vi).

Values provide a way to interpret ourselves and our world—“the stuff out of which our very identities are made” (Elliott 1999, p. 58). The Canadian health care system exemplifies significant values, captured by and evolving within medicare. For many Canadians, health care is emblematic of a commitment to compassion, equality of opportunity, a sense of community and a common purpose (Canada, 2002; Kenny, 2002; Saul, 1999). Saul paints a picture of medicare coming into place and shaping our society: “Medicare was one of those great leaps” that forged Canada. He calls these “leaps in practical metaphysics. The application of each of these has become a central illustration of how people of that era thought their society should work” (Saul, 1999, p. 18). From these ideas, policies developed, reflecting principles and ethics of the public good. The Canadian system is characterized by a publicly administered health care service that delivers the majority of health care without cost to the person because the cost is assumed by all citizens of the country. Taylor, among others, argues that,

although the system is far from perfect, it is much superior to one that does not embrace the whole society (Taylor, 1994, p. 179; see also Somerville, 1999).

Medicare is not only a national program; it is a value-laden Canadian metaphor. However, since the “great leap” of medicare several decades ago, both Canadian society and medicine have changed significantly (Kenny, 2002, p. 64). Major forces, derived from competing and conflicting values, are influencing Canadian health care in the new millennium: reforms based on different value perspectives are proposed. We are at a crossroads (Canada, 2002). What pathway will we take? What are we moving toward? What are the leadership requirements for the future?

The type of health care system a nation selects relates in part to the “dream” of a nation. Rifkin contends that Canadians are in the midst of a trans-Atlantic debate—the “American Dream” of individual fulfilment versus the “European Dream” of community (Rifkin, 2004). The contrast between the European and the American dream is most evident in the definition of personal freedom. Freedom for Americans has been clearly associated with autonomy independent of others. In the United States, the more wealth one accumulates, the more independent and self-reliant one becomes, which also leads to exclusivity and perceived security. The American Dream depends on assimilation (2004, p. 14), whereas the new European Dream is based on assumptions about what constitutes freedom. From a European perspective, to be free is to have access to myriad interdependent relationships—access to communities and choices—for a

meaningful life. Rifkin maintains that freedom for Europeans is found in community, with a focus on quality of life, sustainable development and interdependence. The European Dream includes preserving one's cultural identity in a multicultural world (2004, pp. 12-15). Sharing a common border with the United States, Canada is vulnerable to American political and economic influence; however, Canadians' values are more attuned to the emerging European Dream (Rifkin, 2004). Adams' research leads him to conclude that Canada and European countries try to balance market forces with public policy, to "reconcile the tendency for the rich to get richer" with "a social welfare state and policies to redistribute income from the haves to the have-nots," balancing individual rights with the rights of collectives (2003, p. 116). This is exemplified in the values Canadians place on peace, order and good government. Adams claims these differences relate in part to their historical differences: an aspiration of a conservative, compromising people as opposed to the 18<sup>th</sup> century liberalism that applied to the American revolutionaries (2003, p. 117). In many ways, however, Adams contends that Canadians have become the true revolutionaries when it comes to social life, at the forefront of an important sociological experiment defining a new "postmodernity" characterized by multiple, flexible roles (2003, p. 6).

My scholarly interest stems from a passion to better understand the influences of what Taylor (1991) has termed the "malaise of modernity" on health professionals, the communitarian ethic and policy decisions. A number of related topics are relevant to this inquiry. These include the historical and current values

supporting Canadian health care, professionalism, the moral community, virtues, formal and informal leadership models, and organizational culture.

## **RESEARCH PURPOSE**

This thesis explores the nature of leadership within the health professions and the influences upon them of the “malaise of modernity.” In order to address this question, a number of significant aspects are dealt with: moral and political philosophies; the malaise of modernity; leadership theories and organizational culture; professionalism; the moral community; and the communitarian ethic (see Figure I). These aspects are closely related to each other in a manner that can be represented in a conceptual landscape. A detailed overview is discussed later in this chapter that provides the logic for the overall dissertation structure. The objective is to develop a model for leadership for health care professionals.

**Figure 1: Relevant Topics**



Understanding what others profess and transforming that knowledge into public form involves moral and political commitments. Moral issues arise because a theory of knowledge is supported by a particular view of human agency; political issues arise from their effect upon society. Grappling with the ways in which philosophies restructure efforts is to understand what it means to “do” qualitative inquiry (Lincoln & Guba, 2000, p. 174). The writings of contemporary scholars such as Taylor and MacIntyre, philosophers and ethicists, as well as classical scholars such as Plato and Aristotle, provide a significant background from which to examine these questions.

The complex nexus known as modernity has many manifestations—the unprecedented amalgam of new practices and institutional forms, new ways of living and new forms of malaise (Taylor, 2001, p. 1). Examination of the



influences of modernity is a necessary element of the research question. The influences of science and the Industrial Revolution have been pervasive on our culture, social and political resources, in both achievements and disenchantments. Loss of meaning, loss of moral horizons and other influences of the malaise of modernity have major implications for the health care professions, ethical leadership and for organizational culture that play a vital role in creating cohesion and supporting community. How is the common good constructed and influenced? What are the implications? Leaders of organizations, educational institutions and professional bodies must understand the array of influences on professional practice, and how the intricate fabric of professionalism, weakened by current societal influences, can be strengthened by intentional ethical leadership. This claim will be documented in later chapters.

The project has the following thematic structure. Chapter Two investigates the malaise of modernity through sociological and political theory, a theoretical review that explores the influences of modernity and particular predicaments that influence health care. Chapter Three examines moral foundations pertinent to health care professionals and health care policy development. It discusses foundational moral dimensions including the quest for the good, the moral community, virtue theory and contemporary views of professionalism. Chapter Four reviews past and current leadership theories and discusses ethical issues of leadership and organizational culture to provide insights into the nature of leadership within health care. Chapter Five analyses two documentary cases: the Romanow Report and the Olivieri Affair. It deals in a detailed way with the two

cases integrating previous discussions of moral and political theory. Throughout Chapters Two through Five, relevant theoretical scholarship is drawn upon. As well, the themes of the interview content are incorporated throughout, integrating classical content with interview commentary. Thus, the voices of the exemplary leaders are heard, interspersed with those of classical and contemporary philosophers and scholars. Chapter Six develops a model for health care leadership and recommendations for further research.

## **METHODOLOGY**

The project addresses the research questions using a variety of historical and current sources, consisting largely of a theoretical essay that integrates discussions from classical and contemporary scholars as well as conversations with exemplary leaders. The scope of the study incorporates three methods: conceptual analysis of relevant philosophical and political theory, content analysis of conversational interviews and content analysis of two selected documentary cases. A thematic content analysis based on Collins' intellectual network theory examines the philosophical and theoretical material. The contributions of significant scholars, philosophers and systems of ideas that have had a formative role within moral and political philosophy are integrated throughout.

Qualitative research is more appropriate than other forms for this review. As the major conceptual frameworks pertinent to this study are explored, including the

intellectual network theory from Collins (2000), moral philosophy, philosophical political theory and the hermeneutical approach, each raises pertinent perspectives and encourages reflection on the various areas of inquiry and, in doing so, addresses the research questions. Moral philosophy, in particular the quest for the good, is a theme woven through this research via exploration of the intellectual traditions. The network of ideas that bind the historical to the contemporary—appreciating the classical philosophers and how they have influenced my understanding of the ideas and work of contemporary scholars—underlies the inquiry. Another theme is that of the significance of political philosophical theory in determining policy decisions on health care systems; political frameworks are explored to situate the Canadian health care system.

Conversations are a vital thread of the thesis fabric. How are the major philosophers in conversation with each other? What concepts have been debated and sustained regarding issues of modernity, the moral community, professionalism, virtues, formal and informal leadership models, organizational culture and the historical and current values supporting Canadian health care? Conversational interviews with contemporary scholars will further guide this epistemological journey, providing valuable associations to the theoretical work of the dissertation, weaving threads from past to present, from theory to practice. A hermeneutical approach enhances and enriches the understanding.

## HERMENEUTICAL APPROACH

The problem of how human understanding occurs has long been a challenge to scholars. ...Just as Hermes, the messenger of the Greek gods, enabled humans to comprehend the words from Mount Olympus, so too hermeneutic inquiry is designed to reveal the roots of interpersonal understanding (Gergen, 1999, p. 143).

For this study, a hermeneutical perspective is pertinent for both the theoretical inquiry and the conversations with exemplary leaders while different hermeneutical approaches exist; some are more pertinent in certain situations. This section highlights the evolution of the hermeneutical approaches in order to illustrate how the historical perspective has influenced authors relevant to this inquiry and to explain why certain hermeneutical approaches rather than others are used in this study.

Hermeneutics is “the art or theory of interpretation, as well as a type of philosophy that starts with questions of interpretation” (Audi, 1999, p. 377). Initially, hermeneutics was concerned with the interpretation of texts whose meaning was confused or incomplete, and it still retains much of its early philological character. As a philosophy, however, it has broadened its interests. Its focus originally was primarily historical, tracing the connections between the Indo-European languages, especially Sanskrit, Greek and Latin. In Germany, during the nineteenth century, the prominence of studies of classical literature and philosophy, as well as biblical and Talmudic scholarship, encouraged interest in this field (Anderson, Hughes & Sharrock, 1986, p. 63). “...Making sense of the materials requires a union of philology and history. It was this that

provided hermeneutics with its central question. How could we gain an understanding of the past through its texts and other remains” (Anderson et al., 1986, p. 64)?

Important to understanding the current hermeneutical approach is the groundwork of Schleiermacher and Dilthey. Audi (1999) characterizes their work in the following ways. Schleiermacher (1768-1834) is credited as the creator of modern general hermeneutics and for his analysis of understanding and expression related to texts and speech, marking the beginning of hermeneutics in the modern sense of a scientific methodology. Schleiermacher developed the “hermeneutic circle,” a significant result of the analysis of interpretation. “The circularity of interpretation concerns the relation of parts to the whole: the interpretation of each part is dependent on the interpretation of the whole. But interpretation is circular in a stronger sense: if every interpretation is itself based on interpretation, then the circle of interpretation, even if it is not vicious, cannot be escaped” (Audi, 1999, p. 378). The concept of circularity of interpretation is relevant for this study, as a backdrop to Collins’ theory of the intellectual network. Taylor’s interpretation of Plato’s work and MacIntyre’s understanding of Aristotle are examples of this. Dilthey’s (1833-1911) main project to establish the conditions of historical knowledge is a recognized contributor to hermeneutics. In the 1800s, Dilthey’s emphasis on methodology culminated in his attempt to ground the human sciences in the theory of interpretation, focussing on the re-enactment of the subjective experiences of others. This method of interpretation exposes the “possibility of an objective knowledge of human beings not

accessible to empiricist inquiry and thus of a distinct methodology for the human sciences” (Audi, 1999, p. 377).

Thus, interpretation takes on new meaning. By the twentieth century, hermeneutics acquired a much broader significance and became a philosophical position in German philosophy. Hermeneutics radicalized the notion of the hermeneutic circle, seeing it as a feature of all knowledge and activity; the breadth of hermeneutics expanded, not only the method for human sciences but, universally to all disciplines. The concept of the hermeneutical circle is pertinent to this inquiry as it recognizes and emphasizes understanding as continuing a historical tradition, promoting a dialogical openness and broadening horizons (Audi, 1999, p. 378).

The work of Dilthey and Schleiermacher influenced Gadamer, and it is “Gadamerian” hermeneutics that is used directly in this project. Gadamer (1900-2002) focused on philosophy, rejecting the need for a special hermeneutic method to overcome historical and cultural relativism, an approach most relevant to this study. His interpretation of hermeneutics is more radical than that of Dilthey and Schleiermacher. “Tradition and language form the context for interpretation; there can be no understanding outside of language and history, and so there is nothing for our understanding of a text or artifact to be relative to” (Anderson et al., 1986, pp. 75-76). Gadamer argues against a solipsistic world that simply confirms one’s initial prejudices. Rather, he proposes that one’s horizon is expanded only by joining with the text in a *dialogic relationship*,

suspending one's own forestructure of understanding, resulting in a *fusion of horizons*. To accomplish this dialogic effort one places its meaning "in relation with the whole of one's own meanings" (Gadamer, 1975, p. 238). The dialogic relationship is thus a conversation. Further, Gergen explains that the fusion of horizons takes place in the interchange between reader and text. The result is a successful interpretation that brings forth new worlds (Gergen, 1999, pp. 144-145).

It is the close relation between questioning and understanding that gives true dimension to a hermeneutical experience. "Questioning opens up possibilities of meaning, and thus what is meaningful passes into one's own thinking on the subject. ...To understand meaning is to understand it as the answer to a question" (Gadamer, 2004a, p. 375). A key term in Gadamer's philosophy, even more so than hermeneutics or interpretation, is *phronesis*, practical "wisdom" (Gadamer, 2004b, p. 17). *Phronesis*, a primary practice that brings the moral to the clinical, will be extensively discussed in its relation to virtues and professionalism in Chapter Three.

Understanding is participative, conversational and dialogic. It is always bound up with language and is achieved through a logic of question and answer (Schwandt, 2000, p. 195). Discussing the challenges of research, and building on the hermeneutical perspective of Gadamer, Schwandt reiterates that understanding is something that is "*produced* in dialogue, not something *reproduced* by an interpreter through an analysis of that which he or she seeks to

understand” (2000, p. 195). The researcher may use a variety of different methods of reading and analyzing interviews and the resulting transcripts, including content and narrative. The current landscape of social scientific inquiry shows a “blurring genre” to the extent that even theories previously believed to be irreconcilable “may now under a different rubric inform one another’s arguments” (Lincoln & Guba, 2000, p. 174). Schwandt emphasizes the complexity of interpretation:

Knowledge of what others are doing and saying always depends upon some background or context of other meanings, beliefs, values, practices, and so forth. Hence, for virtually all postempiricist philosophies of the human sciences, understanding is interpretation all the way down (Schwandt, 2000, p. 201).

### **TRIANGULATION AND CRYSTALLIZATION**

The multi-method approach to research can be beneficial. Triangulation is the use of different research methods within the same study to collect data from alternative sources. “These data can be used to assess the validity of findings from alternative sources, and can enrich and inform findings” (Brewerton & Millward, 2001, p. 200). The triangulation process uses multiple perceptions to clarify meanings, to verify observations and interpretations, and to support the qualitative researcher’s quest for understanding. A second metaphor, crystallization, suggests a “deepened, complex, thoroughly partial understanding of the topic” as the crystal combines symmetry, substance and a variety of shapes (Richardson, 2000, p. 934). The crystallization metaphor readily



incorporates various disciplines as part of a multifaceted qualitative research design, extending discourse over several fields of study (Janesick, 2000, p. 392).

#### **METHOD I: CONCEPTUAL ANALYSIS**

This section expands upon the approach to conceptual analysis used in this project: thematic content analysis, using Collins' intellectual network theory, shows how the moral and political philosophical bodies of literature have evolved over the centuries. The network theory relates these bodies of literature to contemporary ideas, visions and values.

Whatever you have to say, leave  
the roots on, let them  
dangle  
And the dirt  
Just to make clear  
Where they come from (Olson, 1987, p. 106).

The poet's metaphor of the uprooted plant affords several reflections, including one on the significance of history and tradition represented by the sustenance of the soil and another on understanding of discourse composed of pieces removed from the intellectual and social context. Philosophical assumptions, either explicitly or implicitly, guide one's study and understanding of knowledge. "Knowledge evolves, emerges, and is inextricably tied to the context in which it is studied" (Creswell, 1998, p. 19). Theoretical frameworks situate a study within a

particular context, historical framework, the social images of modernity and the philosophical-political perspective.

Collins' (2000) examination of the history of intellectual networks is enlightening. His metaphor of the telescope, peering through a darkened lens, encourages analytical thinking about earlier realities and lineages. How has creativity through history—the ideas, energy and visions—influenced contemporary philosophy and practice, particularly regarding values? Which intellectual networks are vital to this inquiry? How are the major philosophers in conversation with each other? What ideas have been debated and sustained relevant to the historical and current values influencing Canadian health care, professionalism, the moral community, virtues, formal and informal leadership models, and organizational culture? An increased understanding of these intellectual lineages will mark this epistemological journey.

Collins' discussion of creativity within and among networks is insightful and informative at several levels. He discusses “a chain from one highly creative individual to another” (2000, p. 36). High levels of intellectual creativity are rare, according to Collins. For example, across the whole expanse of time, major philosophers appear about once or twice in a generation (2000, p. 57). Eventual conditions for creativity are those that sustain multiple bases of intellectual conflict across a main focus of attention. “Creativity comes to an end when external conditions either end the bases for multiple factions or eliminate the common centre” (Collins, 2000, p. 505).

Conflict, debate and fragmentation are essential elements of creativity. As well, there is a synthesizing element. The “grand philosophical systems” are those with a “synthesizing dynamic,” taking differences seriously. A pertinent example Collins provides is “Aristotle forging new analytical tools to reconcile the quarrels among the outpouring of schools in the post-Socratic generation. Synthesizers are necessarily dedicated to a vision of an overarching truth, and display a generosity of spirit to the intellectual community” (2000, p. 131). Understanding the construction of the common good as it relates to health care in Canada is a function of this activity and is further discussed in Chapter Three.

Several intellectual networks have notably influenced this focus of study, namely the Greek School (400-200 BC), the German Network (1738-1835), the Religious/Political Network (1835-1900) and the Existentialists (1865-1965).

The Greek school is paramount for this inquiry: the work of Plato (427 to 347 BC) and Aristotle (384 to 322 BC) forms the foundation for future development of ideas in the area of moral theory and leadership. Contemporary scholarly literature in the fields of leadership, professionalism and organizational culture is illuminated by the foundational Greek lineage. MacIntyre (1984), an example of an eminent contemporary representative of Aristotelian ethics, is an important reference for this study of virtue theory, professionalism and practice.

The German Network is relevant to the current study, particularly because of the influence of Kant’s work. Kant (1724-1804) was deeply inspired by Rousseau’s

notion of freedom as autonomy or self-legislation, the belief that human dignity requires humans to make the laws that they themselves must obey. Cahoon explains that *The Critique of Pure Reason* (1781) changed philosophy forever: “Just as Copernicus shifted the Sun to the center of our universe, displacing the Earth from its Ptolemaic, geocentric home, Kant argued that rather than our knowledge conforming to objects, experienced objects conform to our ways of knowing” (2003, p. 45). Kant’s influential *Metaphysics of Morals* (1797) consists of *The Doctrine of Justice* and *The Doctrine of Virtue*. “Although Kant’s pure practical philosophy culminates in religious hope, it is primarily a doctrine of obligation. Moral value is determined ultimately by the nature of the intention of the agent...” (Audi, 1999, p. 465). This underlying moral value is particularly significant in health care, as the fulfilment of duty (e.g., the duty not to violate the dignity of persons as rational agents) constitutes the general maxim underlying a person’s action. Kant’s ideas continue to influence modern moral theory and current health care ethics and bioethics. Professionalism in these fields is examined in Chapter Three.

The profound and diverse ideas of the philosophers in the Religious/Political Network still energize contemporary writers seeking new ways to explore organizational culture, institutional structure and authority, and policy development, all of which are pertinent elements in Canadian health care. The

major theories of Marx and Engels<sup>1</sup> are revisited by contemporary philosophers such as Giddens<sup>2</sup> (1990) as they critique elements of modernity. Intellectuals in this network also explored the concept of the loss of meaning within modernity. Kierkegaard, for instance, formulated it as “a loss of passion” (Taylor, 1989, p. 500). Understanding the influences of modernity within health care settings is vital for this inquiry and is further explored in Chapters Two and Three.

The chorus of the Existential and Phenomenological Network continues its intellectual reverberations. The voice of Weber (1881 to 1961) resonates within contemporary philosophical conversations. His prominent social theory includes a critical “diagnosis of the times,” warning of desiccating sources of value and constructing an “iron cage” of increasing bureaucratization (Weber, 2003, p. 127), raising questions as to the degree of influence on health care and educational institutions. Habermas (b. 1929), a German philosopher and social theorist, is a leading representative of the second generation of the Frankfurt School of Critical Theory. Since the 1970s, he endures as an intellectual figure in the German public sphere as a social theorist, legal theorist, social critic and

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<sup>1</sup> For example, Cahoon explains that Marx and Engels borrowed from Hegel’s work, and “formulated a comprehensive theory of human history in which capitalism is a necessary but temporary stage whose industrial development would prepare the way for the eventual communist abolition of private property. They did not object to modern industry, science, technology, and secularism, but only to the restriction of ownership and benefits to the capitalist or ‘bourgeois’ class” (2003, p. 75).

<sup>2</sup> Giddens explains that, due to the “close relation between the Enlightenment and advocacy of the claims of reason, natural science has usually been taken as the preeminent endeavour distinguishing the modern outlook from what went before. Even those who favour interpretative rather than naturalistic sociology have normally seen social science as the poor relation of the natural sciences, particularly given the scale of technological development consequent upon scientific discoveries. But the social sciences are actually more deeply implicated in modernity than is natural science, since the chronic revision of social practices in the light of knowledge about those practices is part of the very tissue of modern institutions” (1990, p. 40).

political actor<sup>3</sup> (Bowie, 2003, p. 255). Habermas, reflecting on issues of modernity, contends that “the cynical acceptance of an unjust world, the normality of repression for so many people, is evidence not of a deficit in *knowledge* but of a corruption of the *will*” (Habermas, 2003, p. 8). The images of modernity as seen by Weber, Habermas and others are discussed further in Chapter Two.

Buber (1878 to 1965), philosopher, theologian and political leader, is best known for his theological and phenomenological development of the “I-Thou” relationship (1959) that reflects the Talmudic tradition from which it emerges. The main feature is his conception of two primary relationships: I-Thou and I-It. The I-Thou relationship is distinguished by openness, reciprocity and a sense of personal involvement; agents encounter and transform each other. On the other hand, the I-It relationship is distinguished by the tendency to treat the other as an impersonal object governed by causal, social or economic forces. “We live our lives inscrutably included within the streaming mutual life of the universe” (1959, p. 29), and not as isolated, autonomous agents. Buber’s ideas are relevant to the upcoming discussions on the influences of modernity and in particular to the role of mentoring as a component of education within the health care professions discussed in Chapter Three.

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<sup>3</sup> Bowie explains that Habermas does not search for a foundation of validity for the three spheres, “of the kind logical positivism sought in empirically verifiable propositions.” Rather, “Habermas proposes a version of the consensus theory of truth, on the assumption that the best chance for objectivity arises from unfettered, non-coercive communication” (Bowie, 2003, pp. 260-261).

An examination of political philosophy is necessary to appreciate the complex relationships among health care systems and moral dimensions such as social justice as influenced by modernity. A brief exploration of the social and historical context of the evolution of political arguments surrounding the various conceptions of “freedom,” “justice” and “equality” illuminates issues in contemporary political theory (Held, 1984, p. 253) and informs our understanding of the values of Canadian health care. This discussion follows in Chapter Two, with further application in Chapter Five.

It is important though to note, as Habermas (2003) reflects, that the doctrines of the good life and of a just society—ethics and politics—make up a harmonious whole. With the increasing social change over the ages, however, models of the good life changed whether they were aimed at “the Greek polis, the estates of the medieval *societas civilis*, the well-rounded individual of the urban Renaissance or, as with Hegel, at the system of family, civil society, and constitutional monarchy” (Habermas, 2003, pp. 1-2). The relationship of the “public” and the “private” is an enduring theme that can be traced to the beginnings of civilization. From the Romans came the concept of public and private, the two realms in terms of *res publica* and *res priva*. “The Greek idea of public and private may be expressed in the terms *Koinion* (roughly, public) and *Idion* (equally roughly, private)” (Parsons, 1995, p. 3). The work of Aristotle contains the earliest attempt to find a resolution to the conflict between the public and private in the concept of the “polis” as the highest form of human association. “This search for some arrangement whereby the tension between

the public and the private may be resolved or mediated” echoes down through the history of political thought to the present day (Parsons, 1995, p. 4). Health care reform plays out on a political stage. It is questions of and tensions between these relationships that influence current Canadian health care.

## **METHOD II: ANALYSIS OF CONVERSATIONAL INTERVIEWS**

The research design includes intensive conversational-style interviews with six health care leaders. Five are educators and scholars in the field of ethics in health care (two from Canada, two from the United States, and one from New Zealand): Dr. Abbyann Lynch, Dr. Janet Storch, Dr. Albert Jonsen, Dr. Edmund Pellegrino and Dr. Grant Gillett. The sixth is a former political leader and policy consultant, Mr. Roy Romanow. Each brings academic and practical expertise, confirmed by significant honours, and each has published and lectured widely (see Appendix for a short academic biography). The study includes a review of their publications and research as it relates to the relationship among professionalism, ethics and leadership in health care. Certain literature (e.g., Odendahl & Shaw, 2002, p. 311; Wengraf, 2001, p. 11) emphasizes the advantages of the elite interviewee deemed to possess exemplary or emulatory reputation. The greater the expertise of the subject, the greater the opportunity to ask theory-related questions or, from another perspective, questioning in the language of the informant can positively influence the outcome of the interview. For this project, interviews with exemplary health care leaders provide an exceptional opportunity for dialogue and for critical analysis of the foundations of



moral philosophy, practice and contemporary approaches to leadership arising from their theoretical perspective and personal practice in the health care field.

These particular individuals were selected because of their academic and scholarly background as well as their practice experience, with the goal of integrating their voices with those of the classical and contemporary scholars studied in this research. Each of the ethicists has an academic background that is well-established, and each has achieved national and international recognition based on his or her contribution to the scholarly literature. Their various academic appointments are a reflection of their repute in academic circles. In addition, each has developed a recognized position of expertise in the practice activity of his or her own field of specialty. Their accomplishments are significant. The five ethicists have provided leadership to the field of health care ethics: Dr. Abbyann Lynch as Director of Westminster Institute, London, Ontario; Dr. Edmund Pellegrino as Director of Kennedy Institute of Ethics, Georgetown University, Washington, DC; Dr. Albert Jonsen as Professor of Ethics in Medicine, School of Medicine, University of Washington, Seattle; Dr. Grant Gillett as Professor of Medical Ethics, University of Otago, New Zealand; and Dr. Janet Storch as Chair of the Human Research Ethics Committee for the University of Victoria and Ethics Scholar in Residence, Canadian Nurses Association. Their expertise in health care ethics is established in the widespread use of their publications. The policy expert, Roy Romanow, well recognized in provincial and national politics, was the Commissioner of the Royal Commission on the Future

of Health Care in Canada, providing leadership on values and policy development.

The responsibilities of these leaders have practical breadth and depth. Their clinical consultation keeps them in tune with "issues in the trenches," for example, Dr. Gillett as a neurosurgeon, Dr. Jonsen as director of a program in medicine, Dr. Lynch as consultant to health care professional organizations, long term care facilities and ethics committees, and Dr. Storch working with nursing students and ethics committees. Their recognition is not only national, but international, many lecturing at universities throughout the world. For example, Dr. Lynch was appointed by Prime Minister Brian Mulroney in 1987 and 1989 as one of three Canadian representatives to the Summit Conferences on Bioethics. The accomplishments of these leaders have been recognized by numerous honours, as exemplified by Dr. Pellegrino's 46 honorary doctoral degrees from universities around the world. In summary, they are committed individuals, generous of spirit to colleagues and students, and are recognized scholars, educators and role models.

The interviews with these six individuals provide an opportunity for conversations in the area of moral philosophy, practice and leadership. These conversations build on the inquiry of classic philosophers (e.g., Plato, Aristotle and Kant) and contemporary philosophers and scholars such as Taylor and MacIntyre illuminating both theory and practice related to questions of leadership, professionalism, education and policy development. Through the lens of these

health care ethicists and scholars, and the Canadian policy leader, arguably one of the foremost in the policy field, further light is shed on this inquiry.

Arising from the central inquiry, particular questions are incorporated in the conversational interviews that relate to moral philosophy, education and leadership. Semi-structured but open-ended questions enable respondents to answer freely in their own terms rather than selecting from a fixed set of responses. A general interview guide (see Appendix A) outlines a set of topics to be explored with each interviewee. The topics include philosophy, theory and practice, enabling significant discussion of foundational principles that cannot be addressed well in other formats. The core questions are:

1. *What are the foundations of professionalism?*
2. *How can leaders within health care support the professional moral community?*
3. *What are the elements of leadership approaches that support value-based practice?*
4. *How do educational leaders most effectively influence decision-making in the area of health reform and social justice education?*

5. *How is the communitarian ethic (the “common good”) manifested by the moral community?*

A review of the literature on interviewing provides a number of noteworthy considerations for this project. The degree of structure, the use of language (as shared meanings) and non-verbal communication all influence the interview, as does the “reflexive, problematic, and, at times, contradictory nature of data and with the tremendous, if unspoken, influence of the researcher as author” (Fontana & Frey, 2003, p. 87). The latest trends in interviewing have reached the point of treating the interview as a negotiated text. Schwandt discusses three interrelated ways to examine the practice of interviewing within qualitative studies: as a set of techniques for generating and analyzing data from structured, group, and semi- and unstructured interviews; as the person-to-person encounter between researcher and researched that concerns ethical considerations such as confidentiality and use of information; and from the perspective of the goal—either as a means of gaining direct access to an interviewee’s experience or as a particular level of discursive or narrative unfolding a specific socio-political context (Schwandt, 2001, pp. 135-136).

Czarniawska reviews a number of authors in different disciplines who have proposed narrative study as important to modernity: Roland Barthes in social sciences, Alasdair MacIntyre and Richard Rorty in philosophy, Hayden White in history, Jean Matter Mandler and Jerone Bruner in psychology, Walter Fisher in political sciences, and Clifford Geertz in anthropology (2002, p. 733). White also

examines the extraordinary variety of scholarly traditions and approaches represented in the study of narratives—traditions that have complex histories, with Aristotle's *Poetics* (350 BC) often cited as the starting point. White reflects on narration:

So natural is the impulse to narrate, so inevitable is the form of narrative for any report of the way things really happened, that narrativity could appear problematical only in a culture in which it was absent—absent or, as in some domains of contemporary Western intellectual and artistic culture, programmatically refused. ...Far from being a problem, then, narrative might well be considered a solution to a problem of general human concern, namely, the problem of how to translate *knowing* into *telling*, the problem of fashioning human experience into a form assimilable to structures of meaning that are generally human rather than culture-specific (White, 1980, p. 5).

There are a number of advantages to conversational interviews. Mishler, in an extensive review of various perspectives on interviews, concludes that there is wide recognition of the special importance of narrative analysis that provides an alternative to the mainstream tradition of interview research. “The strength of this view of interviewing,” he contends, “lies in the diversity that it welcomes and supports among models, questions, and methods about relations between discourse and meaning” (1986, p. 142).

Significantly, the conversational interview affords an opportunity for exploration of principles and values that other formats do not. Gall, Gall and Borg emphasize the adaptability of interviews where a well-prepared interviewer is able to obtain the fullest possible response, eliciting data of greater depth than is possible with

other approaches (1999, p. 131). The questions may be further refined during the process of research to reflect an increased understanding of the problem or issue. Similarly, the less structured interview can provide a great breadth of data (Fontana & Frey, 2003, p. 74). Open-ended research questions support exploration; in-depth interviews allow greater involvement of the interviewer herself and more reflective understanding (Johnson, 2002, pp. 103-109). As the literature predicted, this conversational approach was successful for exploring the research questions with these six leaders. The quality of the narrative of these interviews enhanced the goals of this research, including relating theory to their leadership practice through a wide range of illustrations. As well, the conversational interview lends itself to several forms of metaphors (Creswell 1998, pp. 19-20) that play a part in this study.

All research is interpretive; it is guided by a set of beliefs and feelings about the world and how it should be understood and studied. ...Each interpretive paradigm makes particular demands on the researcher, including the questions he or she asks and the interpretations the researcher brings to them (Denzin & Lincoln, 2003, p. 33).

Interviewing, as with all research methods, is open to a number of biases and limitations. The interviews are not asocial, ahistorical events, nor is the analysis of the material. The researcher is “bound within a net of epistemological and ontological premises which—regardless of ultimate truth or falsity—become partially self-validating” (Bateson, 1972, p. 314). In this case, the interviewees are part of the intellectual network related to values and moral considerations of this topic.

Gall et al. suggest that a potential major disadvantage of interviews is that the direct interaction between researcher and interviewee makes it possible for subjectivity and bias to occur. Factors that may contribute to biasing of interview data are the eagerness of the interviewee to please the interviewer and the tendency of interviewers to seek out answers that support their preconceived notions. As a result, findings based on the interview method are highly contingent on the interpersonal skills of the interviewer (Gall et al., 1999, p. 131). This was not found to be a problem with this interview group. Wengraf contends that the semi-structured interview requires much more preparation than a structured one and must be fully planned and prepared. To be successful, semi-structured interviews require significant preparation before the session, more discipline and more creativity in the session, and sufficient time for analysis after the session (Wengraf, 2001, p. 5).

In addition, a number of practical considerations support the achievement of reliable and valid results. To support consistency, interview guidelines require sufficient background material, preparation and piloting in advance, establishing rapport, ensuring privacy, and obtaining the ethics consent. In the process of analyzing the interview, I followed Wengraf's suggestions to first, listen to the audiotapes, second, prepare theoretical memos while transcribing and, third, interpret the interview materials (Wengraf, 2001, p. 11). The interviews with exemplary leaders averaged one and one-half to two hours each. The sessions were audiotaped and notes were taken as well. Interpretation was an iterative process involving the personal interview, audiotape, review of memoranda and

relationship to philosophy. Each interviewee received a copy of the transcript and had an opportunity to clarify the text. A second follow-up interview occurred by telephone when necessary. The complete transcripts are contained in the Appendix.

Silverman contrasts two methodological positions taken on the validity of interviews. From the first viewpoint, the qualitative researcher aims to ensure that the interview has been accurately depicted by using measures such as intercoder agreement and computer-assisted qualitative data programs. The second approach, viewing the interview results as accessing various narratives through which people describe their works (Silverman, 2000a, p. 823 & 2000b, p. 36), was selected as more appropriate for this project. The interviews provided an opportunity for discussion of the integration of theory and practice, and personal reflection.

### **METHOD III: ANALYSIS OF DOCUMENTARY CASES**

The analysis of the Royal Commission Report, informally called the Romanow Report, begins with a review of the significant dialogue that occurred in which citizens were given the opportunity to put their voices forward, discuss the issues and deliberate difficult choices. Tens of thousands of Canadians participated. The result of the process, *Building on Values: The Future of Health Care in Canada*, contains discussion and recommendations regarding sustaining medicare in areas such as human resources, primary health care and prevention;



improving access and ensuring quality; rural and remote community services; home care and prescription drugs; a new approach to aboriginal health; and global issues. The case analysis discusses major themes, key recommendations and the critiques of the Report, and examines the relationship among values, leadership and health care policy.

The Dr. Nancy Olivieri case illustrates a number of current leadership challenges within health care including the ethics of personal responsibility, the ethics of character and virtue, and the issue of “whistle-blowing.” Olivieri, a specialist in hereditary blood diseases at the Hospital for Sick Children, a teaching hospital fully affiliated with the University of Toronto, entered into contracts in the mid-1990s with a major international pharmaceutical manufacturer, Apotex Inc. The case explores the leader-power relationship in educational settings where universities and industry partner, including the tension between industry imperatives (the duty to make profits) and the fundamental ethos of the university (the duty to seek truth). Following a recent “Olivieri Symposium,” Viens and Savulescu claim that this is “one of the most important events to occur in research ethics” (2004, p. 1). It raises questions about how theoretical commitments and norms are applied in practice at a Canadian university. The case demonstrates challenges of leadership and of the role of the health professional amidst today’s complex milieu of industrialization, commercialization and corporatism of research. These and other issues of modernity are now further discussed.

## **CHAPTER TWO**

### **THE INFLUENCES OF MODERNITY**

The major forces of modernity significantly affect all areas of society. Not the least affected has been the health care system. The health care community is influenced by the seduction of modernization that “has turned persons-in-community into individuals-in-society,” a functionalist-rationalist technical order (Beerel, 1998, p. 16) and, as some authors suggest, has imprisoned us in the “iron cage” of alienating bureaucracy predicted by Weber. The corporate model applied to health has led to the establishment of “bottom line” policies with goals of efficiency and cost savings. “Corporatism” tends to ignore the value of the leadership role of health care professionals, whose sense of vocation and ethical perspective bring vision and values to the provision of care. Questions arise about loss of ethos relating to the influences of marketplace forces, of globalization and the atomistic impact of procedural liberalism, juxtaposed with the common good for health care, values of the health care professions and the underlying communitarian ethic.

Modernity is a conceptual construction, represented by various authors through a variety of images of the legally rationalized, industrialized and bureaucratized modern world (usually within liberal democratic societies). Health care implications resulting from such imagery are ones of tension, exemplified, on one

hand, by the enormous benefits of technology and, on the other, by the loss of a sense of caring. According to Robert Orsi,<sup>4</sup> vital elements requiring exploration in the imagery of modernity include an historical awareness—the necessity to understand its history; a critical sensibility—an analytic approach; understanding the authority of science—the scientific imagination; the liberal society—the sense that all history has been tending toward the “now” and that it is better than the past; and a sense of disenchantment of the world. These elements of modernity are explored as they influence health care and education. The chapter begins with a brief historical overview of the dimensions of modernity, examines societal images relevant to health care, political philosophical perspectives and, finally, the predicaments of modernity. The chapter examines the multidimensional concept of modernity with the purpose of understanding key implications on health care professionals and on health care policy development.

## **DIMENSIONS OF MODERNITY**

The century from 1860 to 1950 brought the triumph of modernity, and simultaneously its greatest crises, both intellectual and social. It is in this period that the new science and the industrial revolution actually changed the lives of most human beings living in Europe, North America, and indirectly, much of the world. Peoples bound to a local agrarian lifestyle were thrown, either by choice or necessity, into the cities and a new industrial world market. Waves of scientific revolution, in cosmology, physics, geology, chemistry, and biology deeply altered our view of the world, unleashing new technologies of awesome power. The conditions of life changed... (Cahoone, 2003, p. 85).

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<sup>4</sup> Professor Robert Orsi, Harvard University, in a session, “Clarification of the Issues,” Friday, August 6<sup>th</sup>, 2004, 73<sup>rd</sup> Annual Couchiching Conference, August 5<sup>th</sup> to 8<sup>th</sup>, 2004, shown on CPAC Television Network, September 25, 2004.

The modern moral outlook first emerged in the culture of 17<sup>th</sup> century Europe. The rise of enlightenment gave hope for a “heightened more vibrant quality of life” (Taylor, 1989, p. 373). Prominent teaching of the Enlightenment was the autonomy of the self and a revolt against all traditions and authorities. The Stoics had urged people to “follow nature,” Descartes to follow their “own moral reason,” and Locke to pursue a rational and “scientific” knowledge (Taylor, 1989). Bowie describes a number of interrelated dimensions arising from the modern era, significant to this discussion. These can be summarized as the old social, political and economic hierarchies that are replaced by ones in which values are no longer derived from existing tradition or theology. Identity has a new focus: one is ultimately in control; one can autonomously make oneself. The knowledge of theology and established authority is replaced by knowledge that changes rapidly. Art is now seen as autonomous and also becomes a commodity. Language is seen more as what is constitutive of what there is in the world (it brings things to light by giving them a name), and less as a symbolic medium (theology related) (Bowie 2003, pp. 3-4).

With the modern era came the prospect of a limitless advance of science and technology that exercised a significant hold on Western thought. Against this “radicalized consciousness of modernity,” however, came significant doubts and concerns about the relation of “progress” to freedom and justice, happiness, and self-realization. McCarthy (1984) contends that the critiques of anti-modernism suggest an “illusion” of the Enlightenment consisting of the retreat of “dogmatism” and “superstition,” accompanied by fragmentation, discontinuity and loss of

meaning. Moreover, the abandonment of tradition resulted in anomie and alienation, unstable identities and existential insecurities. The rationalization of administration has all too often meant the end of freedom and self-determination. As well, technical progress proved to be a mixed blessing. This said, McCarthy argues for an “enlightened suspicion of enlightenment, a reasoned critique of Western rationalism, a careful reckoning of the profits and losses entailed by ‘progress’” (1984, pp. v-vi).

Thus, with the disintegration of the traditional order and liberation resulting from technology, there arose a sense of limitless possibilities. However, with the destruction of the old and the creation of the new, tensions were inevitable. These tensions are still apparent and are described in different ways. The following section examines a number of sociological images that illustrate these tensions.

## **SOCIOLOGICAL IMAGES OF MODERNITY**

The complex nexus known as modernity has many images—the unprecedented amalgam of new practices and institutional forms, new ways of living and new forms of malaise (Taylor, 2001, p. 1). As seen through different lenses, there are several sociological images that identify the influences of modernity and, in particular, the malaise it generates. This discussion begins with conceptions provided by the three prominent theoretical traditions in sociology, those of Marx, Durkheim and Weber. Each of these quintessential theorists of modernity

provides a dramatic image to interpret its nature. Each theorist helps to illuminate potential effects of modernity on health care. Further discussion then provides images from a number of contemporary scholars, the shadows of earlier ones still apparent.

For Marx (1818-1883), the major transformative force shaping the modern world is capitalism. Marx and his collaborator, Engels, devised a theory of scientific socialism in which capitalism was a temporary stage en route to the desired outcome of the abolition of private property. "Modern bourgeois society with its relations of production, of exchange and of property, a society that has conjured up such gigantic means of production and of exchange, is like the sorcerer, who is no longer able to control the powers of the nether world whom he has called up by his spells" (Marx & Engels, 2003, p. 78). Cahoone explains that Marx and Engels "did not object to modern industry, science, technology, and secularism, but only to the restriction of ownership and benefits to the capitalist or 'bourgeois' class" (Cahoone, 2003, p. 75). Claiming that the most important criticism of the dominant Western form of economic modernity is Marxism, Giddens summarizes the Marxist characterization of the emergent social order of modernity as "capitalistic in both its economic system and other institutions" (Giddens, 1990, p. 11). The restless mobile character of modernity is explained as an outcome of the investment-profit-investment cycle. Giddens further contends that the conception of modernity provided by Marx (and others influenced by him) is modernity as a monster: Marx perceived a shattering and irreversible impact of modernity and, from this perspective, capitalism as "an irrational way to run the

modern world, because it substitutes the whims of the market to the controlled fulfilment of human need” (Giddens 1990, p. 138). Marx’s theory of alienation, a critical conception of an individual’s interaction with capitalism, contributes to the negative image. In relation to health care, shadows of this “monster” can be seen as health care professionals are concerned that the whims of the market will override human needs.

The second prominent sociological image is provided by Durkheim (1858-1917) whose analysis of modernity criticized the Marxist view. Durkheim was hopeful that further expansion of industrialism would establish a harmonious and fulfilling social life, integrated through a combination of the division of labour and moral individualism. He contends that the division of labour is “characterized by a cooperation that is automatically produced through the pursuit by each individual of his own interests. It suffices that each individual consecrate himself to a special function in order, by the force of events, to make himself solidary with others” (Durkheim, 1893/1947, p. 200). Durkheim considered the process of capitalism from a much greater height of abstraction and with more detachment regarding its human consequences than did Marx and Engels (Collins, 1994, pp. 187-188). He traced the primary nature of modern institutions to the impact of industrialism and the “energizing impulse of a complex division of labour, harnessing production to human needs through the industrial exploitation of nature” (Giddens, 1990, p. 12). High social density is a significant element in Durkheim’s theory. Summarizing this theory, Collins (1994) notes that with a high

social density, “the structure changes towards a complex division of labor,”<sup>5</sup> and that “it is competition that motivates individuals to seek specialized niches when social density increases” (pp. 187-188). In relation to health care, elements of harmonious complex work can be seen in many interdisciplinary specialty teams in health care, for example, neonatal units, transplant teams, cardiac care units and rehabilitation programs. The positive aspects of technology are apparent in these specialty areas as well.

Weber (1864-1920) described a “rational capitalism” characterized by economic mechanisms (specified by Marx) including the commodification of wage labour. For Weber, rationalism was expressed in technology, the organization of human activities and the shape of bureaucracy. “The fate of our times is characterized by rationalization and intellectualization and, above all, by the ‘disenchantment of the world’” (Weber, 2003, p. 131). Increasing intellectualization—“technical means and calculations”—and rationalization “do not indicate an increased and general knowledge” (2003, p. 128). He provides medicine as an example where, on the one hand, science produces a high level of technology but, on the other, does not deal with other essential matters of the values of life (2003, pp. 128-129). Weber’s analysis led him to argue that reason and progress could turn into their opposites, a notion that greatly influenced critical theory. He warned that rationalism desiccates other sources of value resulting in a loss of meaning and

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<sup>5</sup> The division of labour was one of Adam Smith’s major concepts in formulating economics, and the competitive drive to specialization is also present in Marx who, however, interpreted it as a form of alienation (Collins, 1994, p. 188).



freedom in social life and that these basic tensions of modern rationality cannot be resolved. Weber's image of modernity is one where the bonds of rationality draw tighter and tighter, imprisoning us in a featureless bureaucratic routine. Cahoone summarizes that, for Weber, modernity comes at a price: it buys individual liberty, rational thought and material progress in exchange for "disenchantment of the world," a permanent state of dissatisfaction and an "iron cage" of bureaucratic alienation (Cahoone, 2003, p. 127). A sense of this is currently apparent in health care as expressed in criticism of undue bureaucracy. Along with this is an increase in management that focuses on control and structure (Saul, 1999, p. 11).

Moving now to images from contemporary scholars, MacIntyre, a fierce critic of modernity, provides the first contemporary perspective, attacking the failure of the "Enlightenment Project" (1984, pp. 36-50). He analyses its failures, painting an image of "catastrophe," all the more destructive because only a few are even aware of it. MacIntyre contends that the unifying frameworks that are necessary for any coherent moral discourse have been lost and what remains are fragments from discourses. Pinkard discusses how Weber and the non-Marxist socialist Polanyi influenced MacIntyre's writings. MacIntyre draws on Weber's position that, prior to the rise of capitalism, there was a conception of society as structured around common goods; however, since capitalism, the basis of legitimacy became efficiency with the basic structure of society, emphasizing economic goods. "Instead of the good and publicly fulfilling life, modernity substituted a promise only of increasing wealth and private satisfaction (provided

one has the requisite skill to prosper in the marketplace)” (Pinkard, 2003, pp. 179-180). MacIntyre argues, as does Polanyi,<sup>6</sup> that economics is not a value-free science, that modern economics is not written into the nature of rationality or into the metaphysical structure of human agency; and that there are modern alternatives to capitalism (MacIntyre, 1998, pp. 239-243).

Giddens (1990) paints a dramatic second contemporary metaphor of modernity—the juggernaut—“a runaway engine of colossal power.” He depicts this powerful runaway engine as one which, “collectively as human beings, we can drive to some extent but which also threatens to rush out of our control” (1990, p. 139). The path of the juggernaut is steady at times; at other times, it is erratic. It crushes those who resist it. Giddens contends that the ride is not completely unpleasant or unrewarding; it also may be exhilarating and charged with hopeful anticipation; however, out of control, the journey of the runaway engine is uncertain. The path and the pace of the journey cannot be regulated; the terrain is fraught with risks, as “feelings of ontological security and existential anxiety will coexist in ambivalence” (Giddens, 1990, p. 139). Within this image, four dialectically related frameworks of experience intersect in significant ways: estrangement and familiarity; intimacy and impersonality; expertise and reappropriation; and abstract systems and day-to-day knowledgeability. Thus,

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<sup>6</sup> Pinkard describes how Polanyi, in the 1940s and 1950s, challenged the conventional wisdom that economics is a value-free science and argued that modern economics only formalizes a contingent, modern form of the cash economy and modern capitalism. He contends that there are possible alternative arrangements of the economy and that past and present societies have presented such alternatives. Polanyi wanted to undermine the notion that the modern economy and its attendant conceptions of rationality, exchange, and efficiency were natural and inevitable, but notions of reciprocity were relevant (Pinkard, 2003, p. 178).

the imagery of the juggernaut of modernity is not an engine with integrated machinery, but rather one that includes tensionful and contradictory influences (Giddens, 1990, p. 139).

These tensions and influences are felt in the frequent reorganization of health care and resultant uncertainty for staff within large health authorities. The Report of the Royal Commission on the Future of Health Care in Canada acknowledges this malaise in Canada's health workforce as a result of continuing changes in how health care services are delivered combined with cost cutting measures. The toll on health care and the effects on those working within the system—professionals, paraprofessionals, workers and leaders—have been significant. Romanow notes that, while problems “differ for different health care providers, the malaise is widespread and, in some cases, it has moved from mere discontent to outright anger and frustration” (Canada, 2002, p. 91).

Further images that arise from Taylor's work enhance the understanding of modernity. He emphasizes that the theme of the disengaged instrumental mode of life has been central to most influential theories of modernity over the past two centuries. The effects of this disengaged, instrumental mode of modernity are twofold: it removes meaning from life and it “threatens public freedom, that is, the institutions and practices of self-government” (Taylor, 1989, p. 500). Thus, the

negative consequences are both experiential and public.<sup>7</sup> Taylor describes the malaise of modernity as a loss of meaning captured in images of disenchantment, fragmentation and an atomistic focus on individual goals. He reinforces a key point of Tocqueville “that the atomistic instrumental society undermines the local foci of self-rule on which freedom crucially depends” (Taylor, 1989, p. 502). Taylor describes three significant forms of self-understanding that are crucial to modernity: the economy, the public sphere, and the practices and outlooks of democratic self-rule (2004, p. 69). Further dramatic images arise. The first is a society that “has been unhooked from ‘polity’ and now floats free through a number of different applications” (2004, p. 79). Another is the modern public sphere—“a space of discussion that is self-consciously seen as being outside power” (2004, p. 89). Taylor clarifies that with the modern public sphere is the idea that “political power must be supervised and checked by something outside” (2004, p. 90). And lastly, he describes the negative image that captures “the concern about levelling, the end of heroism, of greatness,” and that carries “a fierce denunciation of the modern moral order and everything it stands for” (2004, p. 82). Health care is part of the public sphere, experiencing the influences described by Taylor. The various classical and contemporary images of modernity provide insight into the significant influences on health care, which are discussed further in Chapter Three.

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<sup>7</sup> The experiential charge presents an image where there is no room for heroism, high purposes or life or things worth dying for. Further, societal image of disengagement is also one that has dissolved traditional communities, marginalizing purposes of intrinsic value (Taylor, 1989, p. 500). In place of the community life there is often a series of mobile, changing, revocable associations (Taylor, 1989, p. 502).

## **POLITICAL PHILOSOPHICAL FRAMEWORKS**

This section examines an overview of political philosophical frameworks relevant to public policy that ultimately exemplifies the values underpinning health care. Many different perspectives have been used to clarify the field of public policy. As a field, it has been described as a patchwork of disciplines, theories and models, as through the years it has taken on a multidisciplinary character arising from historical and various contexts (Parsons, 1995, p. 29). Public policy, as Howlett and Ramesh maintain, is indeed a “complex phenomenon” (1995, p. 7). Parsons, in his comprehensive review of policy frameworks, identifies one of the most perspicacious classifications of the field, provided by Bobrow and Dryzek (1987): welfare economics, public choice, social structure, information processing and political philosophy (Parsons, 1995, p. 32). Public policy uses models and metaphors as devices to explore and develop a critical awareness of particular assumptions, origins, and significance (Parsons, 1995, p. 1). These frameworks and models are not necessarily exclusive or incommensurable. Wildavsky contends that understanding policy requires both art and craft, and that analysis involves experiments in thought and creativity (Wildavsky, 1979, pp. 16-17).

Parsons contends that the contribution of the philosophical, ethical and normative dimensions of the analysis of public policy is enormous (1995, p. 41). Guided by the work of Parsons and Held, this section explores the contributions of significant scholars, philosophers and systems of ideas that exercise a formative role within political philosophy. Communitarianism, utilitarianism, theories of

justice and market choice are major political philosophical frameworks that continue to influence public policy. The works of a number of scholars are highlighted: Bentham and Mill (the utilitarian contribution), James and Dewey (pragmatism and the development of the policy sciences), Friedman (the case for markets and individual choice), Etzioni (communitarianism), Rawls and Nozick (two theories of justice), and MacIntyre (conception of practice, and politics).

The story of political philosophy unfolds from ancient times. The questions of Socrates, the ideals of Plato and Aristotle's search for the best solution for the particular time and place, continue to influence public policy development. Other philosophers joined the conversation as the search for understanding the relationship between public and private, justice and leadership persists. Nisbet contends that the development of political and social thought since Greek and Roman times is preoccupied with the quest for community: "community: lost and community found" (1973, p. 445).

Different as are the writings and ideas of Plato, Aristotle, Augustine, More, Machiavelli, Hobbes, Rousseau, Marx, Tocqueville, and Kropotkin, all may be seen, from at least one great vantage point, as minds tormented by fear of the social void and in search of redeeming, fulfilling community (Nisbet, 1973, p. 446).

With the challenges of developing forms of governance for complex post-modern societies, policy-makers look again today at community. Thus, the idea of the community as a response to state centralism and free-market individualism is not new, nor, as Parsons suggests, is it the concept of the property of the "left" or the

“right” (1995, p. 52). He also contends that formulation of communitarianism as a framework for policy-making has widely influenced thinking in America and Europe, an approach between the excesses of state regulation and the reliance on pure market forces. The communitarian label is used rather loosely to describe the ideas of political thought that give importance to common values that foster close communal bonds (McLean, 1996, p. 91). Although MacIntyre is cautious with the terminology of communitarianism,<sup>8</sup> his discussion of community is relevant. MacIntyre describes a type of political society—that Aristotle called the polis—that requires a high degree of shared culture by those who participate in it, but it is not itself constituted by the shared culture. The polis is not possible unless the citizens share modes of deliberation, formal and informal—an active and enquiring attitude toward radically dissenting views (1998, p. 251). For MacIntyre, “practical rationality is a property of individuals-in-their-social relationships rather than individuals-as-such” (1998, p. 242). A rational argument sustains the claim that practices and institutions exhibit a connection between the goods of the individual and the common good—a common understanding of practices and institutions. Practical learning and practical inquiry are part of the reflective deliberation. Generally, the compartmentalization and fragmentation of advanced modernity are inimical to the flourishing of local community (1998, pp. 241-243).

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<sup>8</sup> MacIntyre claims that several commentators “have mistakenly assimilated my views as those of contemporary communitarianism” (1998, p. 235).

Gillett, reflecting on communitarianism, discusses two possible ways in which a group can manifest a communitarian ethic:

*One is ultimately damaging and the other is ultimately very valuable. If we were to follow our nature, we would identify the first as the herd mentality, the ideal that nobody should be allowed to stand out too much and that therefore, as a community, we must maintain our uniformity and solidarity at the expense of expressions of individuality which would, to use the colloquial expression, raise the bar.*

*To me, the right kind of communitarian ethic is a kin or family type of ethic in which we long as a community to nourish those among us who can grow and develop and explore new heights of attainment because of their nourishment. And we celebrate these achievements and we jealously preserve the valued points in their tradition which make possible those achievement. ...The value of a community is the value of the human excellences to which it can give rise, in which its own internal morals are conducive to the process of producing (G. Gillett, personal communication, May 1, 2004).*

The theme of community will be further explored following the discussion of utilitarianism, pragmatism and liberalism.

The leading exponents of early utilitarianism were Jeremy Bentham (1748-1832), a British philosopher and lawyer, and James Mill (1773-1836), a Scottish-born philosopher and social theorist. Bentham (1969; 1973) spent his life writing,



advocating changes in the legal system with a utilitarian approach—maximal happiness for everyone affected (Parsons, 1995, p. 45). According to Audi, Mill applied the utilitarianism of his contemporary, Bentham, to social matters such as systems of education, government and law (1999, p. 567). This approach emphasizes that “the principle of utility—the greatest happiness for the greatest number—should serve as the foundation of individual actions and government policies” and that “good decisions should thus lead to good consequences” (Parsons, 1995, p. 5). The utilitarianism of Mill and Bentham introduces a tool for determining public policy: the greatest happiness of the greatest number. The techniques to evaluate and select public policy options are based on the premise that the calculation of human welfare is possible and desirable. From this premise, economists claimed to devise methods of setting costs against benefits and defining levels of efficiency. As a theory, utilitarianism is criticized for ignoring moral issues and questions of equity or fairness; nevertheless, Parsons contends, “the centrality of utilitarianism to the growth of public policy and policy analysis continues despite its philosophical shortcomings” (1995, pp. 45-46).

Parsons characterizes James and Dewey as the fathers of modern pragmatism. William James (1842-1910) was a physician, psychologist and philosopher. He argued that ideas become true, or are made true, by events; ideas are essential to enable human beings to modify their environment in order to survive and develop. James also introduced the claim that theories must be found that will work. The “radical empiricism” put forward by James (1975) was a source of

inspiration to a generation that hoped to improve and adapt policies and processes in order to advance the progress of mankind (Parsons, 1995, p. 46).

For John Dewey (1859-1952), author, educator and reformer, pragmatism was a method of social experiment, a form of trial-and-error learning. Democracy was an investigative activity: ideas were exchanged, new political technologies were developed and society solved problems through learning and testing (Parsons, 1995, p. 46). This “new liberalism,” as expressed by Dewey in America, took issue with the belief that the market on its own could promote a spontaneous order. For Dewey (1916), knowledge provides the way to advance private and public spheres of interest. His ideal social order allows maximum self-development of all individuals, fosters the exchange of ideas and develops policies in a way that recognizes each person’s capacity to contribute to the direction of social life. The common welfare of all is based upon respect for the dignity of each individual (Dewey, 1916, pp. 357-358). The pragmatic inheritance of James and Dewey—a call for action and for social science to become involved in the betterment of society and government—became a central value of the policy approach developed in the post-war period in the United States and elsewhere (Parsons, 1995, p. 47).

Jonsen reflects on the influence of Dewey and James:

*Dewey and James are very significant figures, and in one sense they describe American life and they draw on American life very powerfully and yet, on the other hand, whenever their thought*

*moves to what we would think about today as communitarian, particularly in Dewey's thought—he has some very powerful expressions and very compelling arguments about the moral community—but they have not caught on (A. R. Jonsen, personal communication, April 29, 2004).*

Held contends that central questions remain within the practical philosophical dialogue. How can individuals be “free and equal” and enjoy equal opportunities to participate in the determination of the framework which governs their lives without surrendering important issues of individual liberty and distributional questions to the uncertain outcomes of the democratic process (Held, 1984, p. 180)? Further, Kingwell purports that this tension is increasing between the focus on the individual that emphasizes the uniqueness and worthiness of the individual's life, and the focus on universalism that attempts to “transcend the particularities of the individual's life in favour of some commonly held properties of humanness that demand protection and promotion” (Kingwell, 2000, p. 53). The following theories address these questions.

One theory, the “New Right” or neo-liberalism, has placed a general emphasis on individual freedom and initiative. For Held, “the New Right is concerned to advance the cause of ‘liberalism’ against ‘democracy’ by limiting the possible uses of state power” (Held, 1984, p. 175). A proponent of this approach, Friedman contends that a free-market system is the basis for a genuinely liberal order, that economic freedom is “an essential requisite of political freedom” (Friedman, 1980, p. 21). Without the direction of a central authority, the market

ensures the coordination of decisions of producers and consumers: “The pursuit by everybody of their own ends with the resources at their disposal; the development of a complex economy without an elite who claim to know how it all works” (Held, 1984, p. 176). Held explains that, according to this theory, legislation should not alter “the material position of particular people or enforce distributive or ‘social’ justice” (Held, 1984, p. 175). This view contends that distributive justice is seen as coercion, imposing on another’s conception of merit where a central authority, acting as if it knew what people should receive for their efforts, allocates resources. Rather, the value of individuals’ services can only “be determined by their fellows in and through a decision-making system which does not interfere with their knowledge, choices and decisions;” therefore, for neo-liberalism, the “one sufficiently sensitive mechanism” to decide “collective” choice on an individual basis is the free market (Held, 1984, p. 175). The American health care system exemplifies one based on individual freedom and the free market. The influence of this political approach is further examined in Chapter Three in relation to professionalism.

Another theory, the “New Left,” has developed intense claims of its own. Held emphasizes that the New Left did not develop principally as a “counter-attack” on the New Right, but rather, the contrary is true. This theory developed in the 1960s mainly as a result of political upheavals, including debates on the left, and dissatisfaction with both liberal and Marxist political theory (Held, 1984, p. 176). New Left theorists question the extent to which individuals are “free” in contemporary liberal democracies. “To enjoy liberty means not only to enjoy

equality before the law, important though this unquestionably is, but also to have the capacities (the material and cultural resources) to be able to choose between different courses of action” (Held, 1984, p. 176). The New Left argues that large numbers of individuals, lacking resources and opportunities, if systematically restricted from participating actively in political and civil life, are not “free and equal” (Held, 1984, p. 177).

As Nisbet (1973) emphasized earlier, the idea of community<sup>9</sup> as a response to state centralism and free-market individualism is not new; the development of political and social thought since Greek times may be considered as a quest for community. Where along the lexicon of the Left and Right is the contemporary communitarian concept situated? Parsons emphasizes that the concept is neither the property of the “left” nor “right.” He contends instead that, as industrialized polities aim to develop forms of governance for complex “post-modern” societies, “it is not entirely surprising that policy-makers should have recourse to the ‘new’ rhetoric of ‘community’” (1995, p. 52).

Etzioni’s<sup>10</sup> formulation of communitarianism has influenced thinking in America and Europe, signalling a middle way between state regulation and control on the

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<sup>9</sup> Parsons provides an historical perspective on community. “It has, as Plant observes, frequently been invoked as a critique of liberalism” (Plant, 1991: 325). T. H. Green, Bosanquet, Tawney and Raymond Williams, for example, have all emphasized the role of “community” in counteracting the effects of what Tawney once termed the “acquisitive society” (Parsons, 1995, p. 52).

<sup>10</sup> Parsons characterizes Etzioni’s philosophy of communitarians as the need for a scaled-back core of the welfare state where tasks currently undertaken by the state should be turned over to individuals, families and communities. The philosophical underpinning for this change applies the principle of subsidiarity that says that responsibility for any situation belongs first to those who are nearest to the problem. Only if one group cannot cope does the next group become involved (e.g., family, then community, then state) (Parsons, 1995, pp. 52-53).

one hand, and the reliance on pure market forces on the other. Etzioni provides alternatives to the rational and incrementalist approaches. He believes that personal transformation is rooted in the “joint act of the community transforming itself” (1968, p. 2). The aim of public policy is ultimately to promote a society in which people are active in their communities and in which “political action and intellectual reflection would have a higher, more public status” (1968, p. 7). Parsons explains that this is achieved by raising both individual and societal consciousness with a new emphasis on “symbolization” rather than material wealth; social science and other forms of knowledge make essential contributions to the “active society” (Parsons, 1995, p. 435).

Pellegrino continues the discussion on communitarianism:

*Communitarianism is a species of non-coercive socialism. Communitarianism emphasizes the connectedness of individuals and is opposed to the kind of atomistic individualism characteristic of John Locke and of modern-day libertarianism. For the communitarian, the way to the good life lies in communities in which collective values construct the lives of individuals and not their individualistic definitions of values.*

*While I reject atomistic or absolutized individualism, I would also reject social construction of values. Values, human rights and dignity are grounded in what it is to be human, not in the social institutions and practices in which they happen to be embedded at a particular time. Social constructionism is not self-justifying. It needs grounding in a sound philosophical anthropology. Lacking*

*this, there is no way to judge what is socially constructed as good or bad.*

*...The good for humans is the metaphysical foundation for a good society and the common good, i.e. the expression of human potentialities. The good society is one which is so structured as to achieve this end for as many of its citizens as possible. Communitarianism fosters human welfare in terms of social constructs which precede the human good, while the common good fosters human welfare in terms of what is most suitable to the nature of man qua man. The good community is shaped by what is good for humans; the good for humans is not what a society at a particular time determines it to be.*

*A more apt idea than communitarianism is the idea of solidarity and the interconnection of humans. It links them to one another because man is a social animal and needs society to flourish. But the values that connect us are grounded in our human nature, not in the nature of the societies we construct (E. D. Pellegrino, personal communication, August 4, 2004).*

Much contemporary political philosophy has focused on the communitarian-liberal debate. MacIntyre (1984) has argued that most forms of liberalism attempt to separate rules defining right action from conceptions of the human good. He contends that these forms of liberalism must fail because the rules defining right action cannot be adequately grounded apart from a conception of the good. MacIntyre also contends that, despite the clear contrasts at a theoretical level, modern states are heterogeneous with assorted values that are selected in an ad

hoc manner for particular situations or groups. A major problem is that, when commitments conflict with each other, there is no higher-order set of principles with which to refer (1998, p. 245). MacIntyre reflects on Aristotle's writings on justice:

When Aristotle praised justice as the first virtue of political life, he did so in such a way to suggest that a community that lacks practical agreement on a conception of justice must lack the necessary basis for political community (MacIntyre, 1984, p. 244).

Responding to this type of criticism, some liberals have openly conceded that their view is not grounded independently of some conception of the good. For example, Rawls (2001) has recently made clear that his liberalism requires a conception of the political good, although not a comprehensive conception of the good. Audi claims that the debate between communitarians and liberals "must turn on a comparative evaluation of their competing conceptions of the good" (1999, p. 720).

Rawls (b. 1921) and Nozick (b. 1938) became the focus of significant philosophical discussion regarding public policy since the 1970s. Rawls's theory of justice focused on the utilitarian interest in welfare, with a model of justice that involved fairness. His influential interpretation of social justice (1971 and 2001) argued that a just society must give each member the most extensive set of basic liberties that is consistent with the same liberty for everyone else. For example, social positions carrying greater advantages such as higher paying jobs must be open to everyone on the basis of equality of opportunity. Inequalities of



income and wealth are justified when they are shown to work to the benefit of the least advantaged members of society (represented by more resources channelled to the least advantaged) (Rawls, 2001, pp. 58-59). Parsons maintains that Rawls's theory of social justice explicitly makes room for a market economy and undermines claims that social justice and market freedom are conflicting goals. Advocates of Rawls's model contend that it provides a philosophical underpinning for better public policy; however, critics of the model admonish the state intervention (Parsons, 1995, p. 47).

Nozick's *Anarchy, State and Utopia* (1974) has been an influential text for the "new right" providing a powerful critique of the theory and practice of Rawlsian policy-making. Nozick argues for a state that defends rights only, "the entitlement theory," and against Rawls's redistributive justice (Nozick, 1974, p xi.). Parsons summarizes his central argument in this respect that justice relates to what people are entitled to, not what is fair: "A distribution may be just, as everyone is entitled to what they have, but it may not be fair in a distributive sense" (1995, pp. 47-48). The significant issue of distribution is further described by Stone, a contemporary American policy analyst. She explains that a major divide in the great equity debate is whether distributions should be judged by criteria of process or of recipients and items. She argues against Nozick's view that a distribution is just if it came about by a voluntary and fair process, if what people have were acquired fairly (2002, p. 53). "People who hold a process view of equity usually also see liberty as freedom to use and dispose of one's resources as one wishes, without interference" (2002, p. 57). Reverberating with echoes of

earlier scholars—Mills, Smith, Dewey—the Rawls-Nozick argument remains a significant philosophical conversation concerning public policy, influencing current theoretical conversations. McLean summarizes the debate:

The controversy between rights theorists and utilitarians continues. It is not clear that only the former have a claim to be regarded as liberals. At issue is the balance between the welfarist ambitions of utilitarianism and the protection of the individual from the effects of public power. Particular values need to be reassessed in the light of changing conditions (McLean, 1996, p. 267).

Until recently, policy analysis has been dominated by a belief in the possibilities of rationality in solving problems. The development of rational utilitarian techniques, such as cost-benefit analysis and various forms of operational research and systems analysis, exemplify this. This view of rationality, however, has been a focus of concern in the work of critical theorists such as Habermas (b. 1929) who criticize the use of rationality as forms of control and oppression. Concerned with reaching understanding within a social context, Habermas's ideas (1984) have implications for both the theory and practice of public policy and for health care because of the importance of social context. Parsons discusses the significant relevance that Habermas brings to the development: a critical policy analysis, an alternative model of "communicative rationality" to replace the instrumental rationality that is encapsulated in rational analytical techniques. At the theoretical level, this model includes the need for a greater attention to language, discourse and argument. At a practical level, Habermas's theories have prompted the search for new institutional processes to promote an

intercommunicative approach to formulating and delivering public policy (Parsons, 1995, pp. 53-54).

MacIntyre's (1984) work integrates moral theory, practice and politics. For him, practices provide a conception of a kind of good that is intrinsic and not only instrumental. Practice means:

Any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended (1984, p. 187).

MacIntyre contends that politics holds a special place in human affairs because of its role as a master practice organizing the various other practices: its good is deliberation about practices. Politics is a practice that is vital to the achievement of one's individual good. It is the practice best suited to the development of one's rational powers. The practical learning takes place through activity and reflection upon activity, in the course of "communal and individual deliberation" (1998, p. 243). Murphy, in a comprehensive review of MacIntyre's work, explains, "Engaging in politics involves deliberation about the whole range of goods available to humans, and thus is the most demanding and enriching of the various practices" (2003, p. 164). Thus, in MacIntyre's view, political deliberation should include all persons because of the relevance of the ordering of goods within a political community's life. It is crucial that governing institutions preserve

and foster an inquiry in which rational investigation into the good is pursued, where no one is excluded (Murphy, 2003, pp. 164-165).

Jonsen discusses the importance of such practical philosophy in moving from ideas to action, of relevance to public policy development:

*The idea of practical philosophy is not just to think out theoretically what ought to be done, but to take really the next step and say what are the ways in which we can draw people's affection toward this sort of endeavour, whatever it may be. And there is a movement taking place in the world that seems to be very much concerned about doing precisely that, and that's the environmental movement. People who are involved in environmental issues are not at all interested in staying in the realm of analysis of ideas. They deeply feel that things have to be done to prevent the deterioration of our environment, and then they begin to look for patterns of action. Some will take the political involvement, some will take more activist roles, and that depends on personalities. But environmental ethics is very clearly action oriented (A. R. Jonsen, personal communication, April 29, 2004).*

## **THE PREDICAMENTS**

On their way toward modern science human beings have discarded meaning (Horkheimer & Adorno, 1947/2002, p. 3).

Taylor has formulated a "diagnosis of the age," an account of the zeitgeist or the "spiritual situation of the age" to explain the pervasive sense of malaise within modern civilization. He raises a major concern: "We have read so many goods

out of our official story, we have buried their power so deep beneath layers of philosophical rationale, that they are in danger of stifling. Or rather since they are our goods, human goods, we are stifling” (1989, p. 520). Taylor contends that an instrumental society with a utilitarian value outlook “entrenched in the institution of a commercial, capitalist and bureaucratic mode of existence tends to empty life of its richness, depth or meaning.” He summarizes that the loss of meaning can be formulated in many ways. For example, Tocqueville describes this as no more room for heroism, or high purposes in life, or things worth dying for. Kierkegaard, even earlier, claims a loss of passion. Following in the existential tradition, Nietzsche depicts an extreme lack of aspiration left in life but to a “pitiable comfort,” a criticism of today’s consumer society (Taylor, 1989, p. 500). Related to this sense of a loss of meaning, Visser contends that a belief in fate is on the rise in Western societies, that popular representations of science send a message of “remorseless imprisonment” in vast, impersonalized structures beyond our control. “Transcendent hopes and moral principles are the only sources we can draw on if we are to arrest a decline into unbridled greed, ecological devastation, and short-sighted violence” (2002, p. 87).

For Borgmann, technology and its commodities gratify in only a passing and shallow way. “The promise of technology was one of liberty and prosperity. But the brilliance and joy of life that are implied in the promise have not come about in spite of two centuries of gigantic efforts” (1984, p. 246). He contends that the machinery, technology and the work from which it grew are demeaned through the consumption of commodities. Taylor emphasizes that the technological

approach in medicine has been criticized for focusing on a technical problem and not the whole patient (1991, p. 6). Society's action has been forceful—dissolving traditional communities and less instrumental ways of living with nature—exemplified in Weber's description of society as an "iron cage." The result is a further loss of meaning or fragmentation without common purpose, where the atomistic focus on individual goals dissolves and divides community (Taylor, 1989, pp. 500-501).

In the wake of the Enlightenment, MacIntyre also maintains that human beings are regarded as simply atomistic individuals. He identifies the modern denial of a human nature that provides a meaning and goal for human life, a lack of any shared substantive conception of the ethical good. MacIntyre maintains that the modern notions of utility and of rights are fictions: there is no way to argue from individual desires to an interest in making others happy or to inviolable rights of all persons, concluding that Enlightenment liberalism cannot construct a coherent ethics. He contends that, although institutions ought to be organized for the sake of practices and practices for the sake of goods of excellence, the institutions constantly threaten to corrupt practices and demoralize practitioners and subordinate the pursuit of internal goods to that of external goods. There is a current domination of practices by modern bureaucratic institutions that are organized for the sake of monopolizing and exercising coercive power, and by capitalist corporations that are organized for the sake of profit (MacIntyre, 1984, pp. 193-195).

Significantly influencing all aspects of health care are two principal kinds of institutions in our society, the market and bureaucracy; these are the powerful steering mechanisms that operate in impersonal ways and which remove responsibility for certain decisions. Taylor contends, "Though we sometimes view this situation negatively, we also play along with it because it has positive benefits for us" (1994, p. 174). In the situations of market and bureaucratic rule, impersonal forces prevail, decisions are taken away from individuals, but they are not given to others, "in a sense, in their aggregate form decided by nobody" (Taylor, 1994, p. 175). Bureaucracy is seen to be necessitated by the demand for fairness, to ensure that all voices are heard and that everyone's rights are taken into account. Within bureaucratic rule, the requirement that rules be followed precludes the possibility of eliminating the rules or finding alternative ways of making decisions. As with market rule, the decisions are removed from individuals and "repose in some impersonal institution" (Taylor, 1994, pp. 175-176). Thus, bureaucracy supports the demand for efficacy, although some applications of bureaucracy produce inefficacy. In an effort for efficiency, the influences of bureaucracies are ever increasing within the federal and provincial Ministries of Health, as well as within health care organizations that have been amalgamated into ever-larger health authorities throughout the country.

Knight, in reviewing MacIntyre's work, contends that a permeating societal ethos has developed with an emphasis on power and efficiency that incorporates and insulates efficient managers who characteristically attempt to affect the actions of others (Knight, 1998, p. 11). (Knight's view of MacIntyre is a common one in the

field and therefore representative of MacIntyre's influence, illustrative of Collins' network theory.) Saul identifies significant implications for health care: "The promotion of efficiency to the senior level of policy making has been one of the most disastrous innovations of our administratively-led medicare system" (1999, p. 10). Storch provides an example related to nursing leadership:

*...And now we have situations where there is very little clinical leadership for nurses, as often non-nurses are looking after their area and many of them do not really understand what is going on. They cannot represent the nursing voice at the senior table (J. Storch, personal communication, October 20, 2004).*

Saul reiterates that the more the focus is on efficiency, the less effective an organization will work; efficiency does not produce direction. He also purports that management is not leadership—it does not provide meaning, ideas or direction. Rather, management "only works effectively as a function or servant of policy" (1999, p. 11). There is, he contends, a growing dependency on managers, who focus on efficiency at the expense of the practical application of ideas that would result in effectiveness: the tendency to discourage integrated thinking and to create levels of distrust among citizens separated in interest groups. Related to this is the "unfortunate acceptance" of corporate structures by medical experts. Corporations must not be accepted as the determining model in society. Health professionals and other experts need to take a major role in determining the direction of health care (Saul, 1999, pp. 10-18 and 2001, p. 64).



Stein (2001), in discussing the “cult of efficiency,” claims that, as “the language of efficiency, of cost-effectiveness” infiltrates the public institutions of health care and education, physicians, nurses and teachers are expected to work towards that end. It has become an end in itself, a value more important than others. When Plato spoke of efficiency, it was as a means not an end, but was tied to values of virtue, justice and to accountability. This, claims Stein, is in sharp contrast to the contemporary meaning that is fractured and missing other value components of purpose and of effectiveness and efficacy<sup>11</sup>. Consequently, when efficiency is elevated to an end rather than a means, the discussions are misleading (2001, pp. 2-18). She contends that it is the “almost exclusive emphasis on efficiency as cost-containment that has undermined any meaningful reform of the medical-care system;” governments failed to “ask how *effective* medical care was in relation to its costs; they asked only how *much* it cost” (2001, p. 97). Efficiency cannot be measured appropriately unless it is first known what is effective (2001, p. 178).

As health care organizations in the 21<sup>st</sup> century adopt the corporate model, one is reminded of Friedman’s belief that social responsibility can be tolerated only when in the service of corporate self-interest. Bakan, in his recent review of corporations, reveals that corporations exist solely to maximize returns to the shareholder (2004, pp. 34-39). He argues that the corporation’s “legally defined

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<sup>11</sup> Efficacy: the degree to which the care/intervention for the patient has been shown to accomplish the desired outcomes. Effectiveness: the degree to which the care/intervention is provided in the correct manner, given the current state of knowledge, in order to achieve the desired outcome for the patient (Joint Commission Journal on Quality Improvement, 1995).

mandate is to pursue, relentlessly and without exception, its own self-interest, regardless of the often harmful consequences it might cause to others” (2004, p. 2). Saul discusses an increase in passivity and frustration among doctors, nurses and other health professionals that comes from “being locked up in corporations.” He suggests this occurs from a sense of not being able to influence public policy, a sense of not being able to choose directions, even when information is available. He cites the example of data that indicates that smaller hospitals are effective for many types of care; however, recent policies lead to larger hospitals as the norm. He claims this direction is a management imperative, not based on debate of available information (1999, pp. 14-15). Kingwell attests that many began the new millennium skeptical of the very idea of political change, in danger of losing the idea that a future is created from political desires and choices. He is concerned that “consensus of production and consumption goes mostly unchallenged” (2000, p. 220). Kingwell maintains that we need a positive vision to balance the current cynical ones.

Stone also contends that the market model is not a convincing description of the world and argues for a kind of analysis that begins with “a model of community, where individuals live in a web of associations, dependencies and loyalties, and where they envision and fight for a public interest as well as their individual interests” (2002, p. xi). This type of analysis takes into account people’s images of the world and how those images shape their visions, and recognizes that analytical concepts, problem statements and policy instruments are “political claims themselves, instead of granting them privileged status as universal truths”

(2002, p. xii). She claims that the struggle over ideas, the essence of policy making in political communities, is not captured in the production model (2002, p. 11).

How does one decide which concept of equity to use? One's stance on the issues of distribution is determined not so much by the specifics of any particular issue, but depends more on a general world view which includes assumptions about the meaning of community and the nature of property (Stone, 2002, p. 53).

Shared meanings motivate people to action and meld individual striving into collective action. Ideas are at the center of all political conflict. Policy making, in turn, is a constant struggle over the criteria for classification, the boundaries of categories, and the definition of ideals that guide the way people behave (Stone, 2002, p. 11).

The Report of the Commission on the Future of Health Care in Canada provides a positive vision of shared values. Lewis purports that, although the Canadian health care system needs improvement, “the critics have attacked it in the one area where we actually have it mostly right. A single-payer, state-run, tax-financed universal health insurance program is public policy at its finest” (2004, p. 600). These significant health policy questions of equity and other values addressed in the Romanow Report are discussed further in Chapter Five. A challenge continues to retain the equitable response—a deeply rooted Canadian value—to health care need and to find a way to address the challenges, including waiting lists and the ever-rising costs of health care.

Bellah (1994) relates his discussion of institutions involved with caring to the work of Habermas, where institutions are divided into two groups. On one hand, Habermas (1989) describes the “lifeworld” that includes the family, the local community, the church and the realm of non-governmental public opinion. On the other are the systems, chiefly the market economy and the administrative state. Bellah contends that institutions involved in caring, such as health care and education, would belong primarily in the lifeworld, but, like other lifeworld institutions, have become increasingly influenced or, as Habermas describes, invaded and colonized by the systems. In relation to health care issues, Bellah purports that, for the past three decades, Americans had faith in the market economy to provide freedom but, in many ways, this “seems to be slipping away from us in contemporary society” (1994, p. 25). Adam Smith’s famous defence of free market capitalism, *An Inquiry into the Nature and Cause of the Wealth of Nations* (1776), remains at the centre of a philosophical and social debate. Reflecting on this, Bellah contends that the moral consciousness of the original writings of Smith is lost, as now put forth by economists such as Milton Friedman. In the view of Friedman new influential theories see human beings exclusively as self-interest maximizers, and the primary measure of self-interest is money (Bellah, 1994, p. 26).

The American health care system, an ever-present major force influencing the current Canadian approach, provides an instructive portrait. In the United States, health care is clearly a commodity of the marketplace. American authors such as Cohen and Gabriel (2002) (see also Sullivan, 1999 and Thomasma, 1994) argue

against the idioms of commercialism, where “doctors” have become “providers,” “patients” are known as “customers,” health care “services” are now “commodities,” maintaining “values” have been replaced by improving “margins,” and instead of welfare of persons, company “profits” are paramount. The marketplace paradigm disregards many common goods such as the health care needs of those who cannot afford to pay, long-term quality improvement and medical education (Cohen & Gabriel, 2002, p. 169).

The theory of procedural liberalism, the dominant philosophy today, enshrines values of efficacy, fairness, rights and freedom; however, it does so without espousing any particular conception of the good. Taylor contends that the power of procedural liberalism is enormous; professionals battling the dominant culture of procedural liberalism in their work as nurses, doctors and educators often become discouraged—their experience of caring does not fit into the framework of cost-effectiveness and efficacy (1994, p. 181). Those concerned with the health care system know that it must be revisited, “know that the feet of procedural liberalism are made of clay. The ideals and institutions that compose it are not sufficient, even on their own terms, for human life in our society” (Taylor, 1994, pp. 177-178). Implications of procedural liberalism relate also to education as to health care service.

Blake, Smeyers, Smith and Standish claim that the malaise of modernity is also apparent in education: educational pragmatism, impelled by globalization, seems to be draining practice of normative interest and validity:

The traditions that have long mediated teaching and learning are currently under radical assault from managerialist reformers, operating within a taken-for-granted worldview of economic crisis. Globalization, it is claimed, exacts competitive supremacy in vocational achievement from populations, reductively conceived as workforces (Blake, Smeyers, Smith & Standish, 2003, p. 8).

Universities are increasingly influenced by the marketplace, and medical education and research in particular are influenced by pharmaceutical companies. The education of health care professions occurs in the midst of these strong forces. This provides a significant challenge: the pursuit of knowledge requires an ethical response—enquiry must be for the sake of truth, not profit (Pellegrino, Veatch & Langan, 1991; Freedman, 1978; Bulger & McGovern, 2001; MacIntyre, 1984).

The literature demonstrates, as a result of modernity, increased attention by scholars and professional leaders to the implications and new challenges in education for health care (Moros, 2002; Pellegrino, 2002; Coulehan, Williams, McCrary & Belling, 2003; Saul, 1999; Phillips & Benner, 1994). For example, Sulmasy, a physician and philosopher, contends:

The chief virtues of the industrial model are efficiency and productivity; those of the professional model are caring and trustworthiness. The industrial model seeks behavioral change by appealing to enlightened self-interest; the professional model cultivates the virtue of altruism. ...We need to create environments that cultivate professional virtue in our schools and in our practice settings (Sulmasy, 2000, p. 515).

Thus, new practices and institutional forms (science, technology, industrial production, urbanization), new ways of living (individualism, secularization,

instrumental rationality) and new forms of malaise (alienation, meaninglessness, a sense of impending social dissolution) provide the challenging backdrop for professional practice (Taylor, 1989; Saul, 1999; Smith, 2002; Kenny, 2002; MacIntyre, 1984). In order to support professional practice, leaders of organizations and professional bodies need to understand the range and significant influences on professional practice and the organization (Veatch, 2003; Milley, 2002). The scholarly literature identifies and analyses the complexity; however, the fields of health care and education have been distracted and influenced by the array of “soft” popular writings on leadership and cultural change, writings that minimize the issues, especially the ethical ones and those required for a construction of meaning. What are the leadership approaches that will reinforce the value-based underpinnings of health care services and counter the strong forces of the marketplace and the malaise of modernity? These are explored in the upcoming chapters.

## **CHAPTER THREE**

### **FOUNDATIONS: MORAL DIMENSIONS**

The moral philosophy of Plato (*The Republic*) and Aristotle (*Nicomachean Ethics*) informs contemporary scholarship on health care values and professional practice, inspiring scholars and philosophers like MacIntyre and Taylor. The questions of Socrates, the ideals of Plato and Aristotle's search for the best solution for the particular time and place continue to influence a contemporary understanding of "the good." Collins' theory of historical intellectual networks encourages one to think historically and analytically about earlier realities and lineages. "Intellectual creativity comes from combining elements from previous products in the field. ...Their ideas make it possible for other people to make their own statements" (Collins, 2000, p. 31). Nisbet, in his extensive social philosophical analysis, contends that, "Earlier events, acts, and ideas beget later events, acts, and ideas, quite as butterflies beget butterflies, to use Sir Isaiah Berlin's delightful phrasing" (useful in recovery and representation of moral and political history) (1973, p. 8). Similarly, Taylor emphasizes:

Our practices are shaped by formulations, and that these impart a certain direction to their development, makes it clear that self-understanding and reformulation sends us back to the past: to the paradigms that have informed development... (1984, p. 27).



This chapter examines the moral dimensions supporting Canadian health care professions, laying the groundwork for assessing the ethical aspects of professional practice. The discussion continues with philosophical reflections on the quest for the good, including virtue, the moral self and the common good, continuing with professionalism, including significant features, relationships, ethical health care theories, and concludes with current challenges. Each section illustrates the pertinence of moral foundations to health care leadership. The discussion of the vision and values underlying Canadian health care continues in Chapter Five.

### **QUEST FOR THE GOOD**

Elements of moral philosophy, an understanding of “the good” throughout the centuries, are illustrated through discussion of virtues, the moral self and the common good, examining the work of Plato, Aristotle and contemporary authors MacIntyre, Taylor and others. This section is divided into three parts. The first traces the construction of the common good, beginning with Plato, the second provides an analysis of the concept of virtue and the third relates Taylor’s discussion of the moral self and community.

Plato provides the first major work of Western political philosophy: his influence has been formidable and persistent. Nisbet claims, for instance, “that Western philosophy is little more than a series of commentaries on Plato’s fundamental ideas” (Nisbet, 1973, p. 106). For centuries, philosophers and scholars have

viewed the world through lenses crafted by Plato (Nisbet, 1973, p. 106). *The Republic* has been called a vision of many things: of justice, of true education, of beauty, of proportion and moral greatness. The quintessential rationalist, Plato finds the good, the beautiful, and the just all contained in the true, in what can be distilled from experience by pure reason (Nisbet, 1973, p.109). Plato's concept of ideas, the abstract "forms" called eidos or ideas, are eternal, changeless and incorporeal; knowledge of them is attainable only through thought (Audi, 1999, p. 710). *The Republic* also contains Plato's vision of the political community. For Nisbet, Plato's motive was to "emancipate the individual from the torments and stresses of the faction ridden, rootless, and anomic society of the time," and to give the individual a haven and moral fortress, within the political community (1973, p. 111). Taylor also emphasizes the relevance of Plato's work which:

Offers us a view of moral sources. He tells us where we can go to accede to a higher moral state. And we might say that the site he shows us is the domain of thought (1989, p. 115).

The attainment of the good society requires leadership of guardians, whose education is essential to the society. The guardians must undergo the most extensive physical and mental training to develop qualities of character that will facilitate their demanding education. The most essential field of study for them is knowledge about the good. The highest branch of education is the dialectic—the ability to systematically ask and answer questions in order to achieve understanding of the good, to reach knowledge of first principles, using reasoning to grasp the truth itself (Plato, 350 BCE/2000, 530a-545c).

Plato's metaphors and allegories still have a great deal of influence today. The allegory of the cave is a pertinent example, laden with dramatic images and moral principles. It provides Plato's insights of foundations for leadership and education, invaluable still, and illustrates the philosopher's journey from shadowy images to the true ideas behind all natural phenomena; the real world is dark, dreary, and also vague and unclear compared with the world of ideas. The setting of this narrative is a cave with "prisoners" whose only truth can be "mere shadows of manufactured objects." Only some escape the cave to experience truth, the only ones equipped to act wisely. The pedagogy requires the "turning of the soul" toward the light, which requires turning the whole body. This does not mean "better eyesight" because the eyes can "turn toward evil," although the natural inclination is to remain contemplating the divine. Those who have escaped must be compelled to return, face fierce resistance, and care for and guard principles of social community. Reluctant leaders who are committed to the truth of what is beautiful, just and good will provide the best and most stable government, since they are not driven by self-interest (Plato, 350 BCE/2000, 514a-523e).

Taylor interprets the allegory of the cave as a contemporary model where "the virtues and capacities of the body, which Plato agrees should be seen as things we acquire by habit and practice" are incorporated "in us, as it were, and put them where they didn't exist before" (1989, p. 123). The move from illusion to wisdom is similar to turning the soul's eye around to face in the right direction. The significant issue for Plato is what the soul is directed towards. The image of

the soul's eye also clarifies Plato's notion of reason that one is not able to recognize its function until "turned towards real being, illuminated by the Good" (Taylor, 1989, p. 124). Taylor contends that Plato's moral theory is familiar and understandable today: a type of self-mastery in which reason rules over desires and one is dominated by self-control rather than one's passions. One can understand and regard this moral theory as a contemporary option (Taylor, 1989, p. 124).

When Socrates asked, "What sort of a person ought one to be?" he was relating ethics to personal morality and character. Plato responded to the ethical question by stating that the good person was one who attended to and was guided by the "form" of the good. Aristotle added a pragmatic analysis of the qualities that make one human that is demonstrated in one's thinking, in one's association with others and in one's functions as a member of the natural order. Contemporary theorists interpret this to mean: "Examine what counts as human excellence or well-being in order to discover how we should act" (Campbell, Gillett & Jones, 2001, p. 3).

The concept of virtue is a significant one in the discussion of the quest for the good. Pellegrino contends that virtue is the most ancient, durable, and ubiquitous concept in the history of ethical theory "because one cannot completely separate the character of a moral agent from his or her acts, the nature of those acts, the circumstances under which they are performed, or their consequences" (Pellegrino, 2001, p. 114). In Western culture, the most enduring and enveloping

concepts of virtue are found in the thought of Plato and Aristotle, supplemented by the Stoics and Epicureans, and further developed by Thomas Aquinas. The fusion of these streams of thought—a Classical-Medieval synthesis—shaped moral philosophy in the West for 2,500 years (Pellegrino, 2001, p. 115).

Plato examines the role of values in everyday life and morality by studying the virtues of a human being. The vision of the good is central to his work on moral resources. In his view, the four classical virtues are wisdom, courage, self-discipline and justice (350 BCE/2000, 427e). For Plato, the common good was embodied as the virtue justice and, in Plato's Ideal State, justice was inseparable from the other three virtues. The lives of the guardians or "Philosopher Kings" in *The Republic* are designed to promote their allegiance to the community; in turn they draw strength from the community (Plato, 350 BCE/2000). Justice, a central value in health care, is described by Plato as so great a good that it is worth any sacrifice; "and we agreed that justice was excellence of soul" (Plato, 350 BCE/2000, 353e).

*The Nicomachean Ethics*, one of Aristotle's most heralded works, is a treatise in practical philosophy. For Aristotle the aim of ethics is pragmatic, to be good and to act well: "We are studying not to know what goodness is, but how to become good men" (350 BC/2004, 1103b.30). Aristotle defines virtue as a "disposition" or "state of character." There are two kinds of virtue. Moral virtues, like crafts, are acquired by practice and habituation. "Intellectual virtue owes both its inception and its growth chiefly to instruction, and for this very reason needs time and

experience. Moral goodness, on the other hand, is the result of habit, from which it has actually got its name, being a slight modification of the word *ethos*" (350 BC/2004, 1103a.15). "Human excellence will be the disposition that makes one a good man and causes him to perform his function well" (350 BC/2004, 1106a.20). Thus, in his definition of virtue, Aristotle emphasizes two things: the good for human beings and the good for the work we do.

"Phronesis" is the term Aristotle used for the virtue of practical wisdom, the capacity for moral insight, which discerns what moral choice or course of action is most conducive to the good of the agent or the activity in which the agent is engaged. Pellegrino and Thomasma explain the significance of phronesis and its relevance in contemporary health care: "Phronesis occupies a special place among the virtues as the link between the intellectual virtues"—those who dispose to truth (science, art, intuitive and theoretical wisdom)—and those who dispose to good character (temperance, courage, justice, and generosity) (1993, p. 84).

Remaining relatively unchanged until the thirteenth century in Western moral philosophy, the concept of phronesis was expanded by Thomas Aquinas, who used the term "prudence" or a "fundamental judgement" subsuming Aristotle's term. Prudence, for Aquinas, was a "recta ratio agibilium," a "right way of acting," and became the link between the intellectual, moral, and supernatural virtues. The "capstone virtue" known as prudence enables the agent "to discern which means are most appropriate to the good in particular circumstances" (Pellegrino

& Thomasma, 1993, pp. 84-85). Thus, argue Pellegrino and Thomasma, prudence is an indispensable virtue of the medical life, essential to the *telos* of medicine and to the *telos* (ethics) of the health professional.

Weber (1978) discusses values under the typology of social action, which includes the four main categories of instrumentally rational, value-rational, affectual, and traditional. Instrumentally rational is determined by expectations or means to a calculated end, value-rational is determined by a conscious belief in the value for its own sake of some ethical, aesthetic or religious behaviour, independent of success; affectual, especially emotional, is determined by feeling states, and traditional is determined by habituation (1978, pp. 24-25). The value-oriented action is a “clearly self-conscious foundation of the ultimate values” governing the action such as duty, honour, and the pursuit of beauty (1978, p. 25). He contends:

From a sociological point of view an “ethical” standard is one to which men attribute a certain type of value and which, by virtue of this belief, they treat as a valid norm governing their action. In this sense it can be spoken of as defining what is ethically good in the same way that action which is called beautiful is measured by aesthetic standards. It is possible for ethically normative beliefs of this kind to have a profound influence on action in the absence of any sort of external guarantee (1978, p. 36).

Greenfield (1978) furthers this discussion relating values to person, and to theory: “The personal and the academic are intimately and perhaps inextricably intertwined. Our values show in the theories we defend, and our theories shape the lives we lead and the way we lead them” (1978, p. 19).

MacIntyre contends that the exercise of the virtues is itself a crucial component of the good life for man (1981, p. 204). The distinction between internal and external means to an end is not drawn explicitly by Aristotle, but it is an essential distinction to be drawn. In his comprehensive study of virtue, MacIntyre claims, "The distinction is drawn explicitly by Aquinas in the course of his defence of St. Augustine's definition of a virtue, and it is clear that Aquinas understood that in drawing it he was maintaining an Aristotelian point of view" (1984, p. 184). Shaped by the universal moral guideline to seek good and avoid evil, prudence is a guide to the right way of acting with respect to all the virtues. It provides the capacity or disposition to select the right balance between means and good ends. Gadamer is also drawn to the ancient philosophers' contemplation of eternal truths and provides further insights on phronesis. Grondin (2003) explains how Gadamer associates the nature of this historical knowledge with the Aristotelian idea of practical wisdom or phronesis. A crucial Aristotelian distinction occurs between the practical and technical as not simply a matter of learning rules, but of achieving a wisdom in life in the form of common sense since it allows one to transcend particularity. This virtue is cultivated and non-dogmatic, "but rather consists of a capacity to adapt itself to particular situations" (Grondin, 2003, p. 27). Gadamer illustrates his understanding of phronesis, involving both thinking and acting:

As I have often reiterated, it seems that phronesis is only meant to investigate the means through which the human being is meant to effect the ideal of virtue or the virtuous human being. But it's clear that the knowledge of the means can't leave out of consideration the knowledge of the final end of every action. And this is done on a



specific basis (one to which I have always given priority)—that the meaning of every ethical action is never something specific, never a specific deed, an *ergon*; instead, it is simply pure and straightforward *euprattein*, good action. Every investigation into the means, therefore, must have this in it because the search is itself an action directed toward an end. In this sense, the search is simultaneously *logos* (thinking) and *ergon* (acting) (2004b, p. 35).

Contemporary conceptions of virtue share a common core. Zagzebski suggests that virtue is “an acquired excellence of the person in a deep and lasting sense.” Virtues and vices are the more enduring of a person’s qualities, and “come closer to defining who the person is than any other category of qualities” (1996, p. 135). Contemporary character-based theorists like Foot (1959) and Pellegrino and Thomasma (1993) argue that moral virtues, by their close relation to the nature of a human being, must be considered the most desirable virtues. MacIntyre relates the significance of virtue, practice and community. Moral characteristics are valued as inherent moral goods as they enable the individual and society to live well. Virtues can be understood as dispositions that will sustain practice and enable one to achieve the goods internal to practice, and also sustain the relevant quest for the good, increasing self-knowledge and increasing knowledge of the good. These virtues will sustain those communities in which members seek for the good together (MacIntyre, 1981, p. 204).

When character and practical reason are seen as mutually dependent, Dunne and Pendlebury suggest that much contemporary writing on practical reason falls within the category of virtue theory and that “practical reason integrates, refines, and assesses the different ends of character” (2003, p. 207). These authors note

that a number of writers (e.g., Nussbaum, 1986; Rorty, 1988; Sherman, 1989) are working to reclaim the insights of an Aristotelian conception of practical reason, *phronesis*. The virtues of intellect and character are both relevant to the exercise of practical reason. These authors have the view that quality of character is integrated with practical reason. Reflective, critical habituation has a vital role (Dunne & Pendlebury, 2003, p. 208). Gutmann (1995) uses the language of virtues in connection with practical reasons and democratic deliberation.

Virtue is a complex, historical and multi-dimensional concept. MacIntyre reformulates the Aristotelian notion of virtue, taking into account the erosion of tradition and moral consensus that has occurred. Virtue is a character trait necessary to achievement of a good—a perfected excellence, for a “significant vital aspect of the concept of a virtue is that it requires an understanding of a prior account of certain features of social and moral life” (MacIntyre, 1984, p. 186). He builds his definition of virtue from three elements—from three acquired qualities—these are: (1) necessary to achieve the good internal to practice; (2) necessary to sustain communities in which individuals can seek a higher good as the good of their own lives; and (3) necessary to sustain traditions that provide historical contexts. There is a complex relationship of virtues to practices and to institutions. The ability of a practice to retain its integrity will depend on the way in which the virtues can be and are exercised in sustaining institutions that are the social holders of the practice. “The integrity of a practice causally requires the

exercise of the virtues by at least some of the individuals who embody it in their activities” (MacIntyre, 1984, p. 195).

Another dynamic dimension of the common good is found in MacIntyre’s work (MacIntyre, 1984; MacIntyre, 1998; MacIntyre, 1999). Murphy interprets MacIntyre’s view as the notion of the common good as a central normative concept. A good that is common to a number of persons is not merely instrumental to furthering their individual ends, but “is constitutive of and partially defining of those individuals’ goods” (Murphy, 2003, p. 161). MacIntyre (1998) uses the example of a fishing crew to illustrate that the good of each member of the fishing crew cannot be characterized independently of the good common to all members of the crew. Thus, in his view, the space in which common goods are possible is the space of practices. The goods internal to the activity are relevant to answer questions about how the practices in a community’s life are to be ordered. MacIntyre promotes deliberation by everyone in the political community and the outcome is a set of common actions (1998, pp. 239-250). Knight further elucidates MacIntyre’s concept of practice and internal goods. Internal goods or “goods of excellence” of practice are goods for themselves and for the wider society, “because they comprise its moral structure and shared way of life,” they promote justice, courage and truthfulness, and they promote the common good of society (1998, p. 10).

Taylor’s discussion of the moral self illustrates another moral dimension. In his terms, humans possess a self or identity constituted by moral concerns, a

significant way of distinguishing human agency. They lead their lives and assess themselves in the light of *moral* standards. Taylor contends that to understand the struggles for democracy, freedom and justice that characterize the modern world, it is necessary to be oriented toward strong values. The unease surrounding the pursuit of “modern hypergoods” of freedom, universal benevolence and justice, according to Taylor, relates to the sources required for sustaining them. “My identity is defined by the commitments and identifications which provide the frame or horizon within which ... I can determine what is good, or valuable, or ought to be done” (1989, p. 27).

The theory of “Sources of the Self” (Taylor, 1989) combines the ideas of a constituting ground of the things strongly valued, and a moral source that is a constitutive good is a “source” and a “ground” that energizes the self into realizing the goods it strongly values. Thus, the self has an intrinsic moral dimension; a source of the self is a *moral* source. In other words, a sense of self is connected to the “stand” taken on issues that matter: lives that are fulfilling rather than empty, noble rather than base. For Taylor, frameworks of “qualitative discrimination” provide an orientation for issues of significance, for living well, for leading fully human lives—an orientation to the good, determining one’s place in relation to the good—understanding one’s quest (1989, pp. 48-52).

Taylor (1989) analyses the relationship between the rights that enshrine the freedom of the individual and the collective good of sustaining a well functioning community and concludes that the right to freedom of the individual cannot be

divorced from the “obligation to belong.” The capacity to make free choices can only develop and mature in a society with a commitment to the sustenance and protection of individual freedoms and a commitment to the sustenance and protection of society that makes them possible. Relating this discussion to a putative malaise of modernity, Taylor contends that “the exigencies of survival in a capitalistic or technical society” produce an instrumental pattern of action that results in marginalizing intrinsic value (1989, p. 500; also see Smith, 2002, p. 145).

One’s relationship to community based on moral self-construction is discussed by other contemporary scholars. Ricoeur emphasizes that, “Oneself as Another suggests from the outset that the selfhood of oneself implies otherness to such an intimate degree that one cannot be thought of without the other” (1990/1992, p. 15). Oakeshott’s answer to “the single approved condition of human circumstance” is called the “social good,” the “good of all,” the “common good.” Morality is the art in which this condition is achieved and maintained (1962, p. 304). As Milley reflects on the relevance of ethics for public policy, he contends that ethical life “consists of working out the inevitable paradoxes and tensions that exist in the relationships between private and social expressions of the good” (2002, p. 48). Magness argues that Plato, Aristotle, Thomas Aquinas and Pope John XXIII<sup>12</sup>, among others, “saw humankind as social in nature and society as

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<sup>12</sup> Pope John XXIII “defined the common good as ‘the sum total of social conditions of social living, whereby persons are enabled more fully and readily to achieve their own perfection’ (Hollenbach, 1994, p. 193)” (Magness, 1999, p. 31).

necessary for the development of the individual. The Christian influence falls more strongly on the dignity and wholeness of the individual, but nonetheless, the social dimension of the human condition is emphasized” (Magness, 1999, p. 32). Discussing the relationship between the social dimension and the individual, Smith summarizes, “The ways in which we understand ourselves as persons have a direct bearing on the ways in which we organize ourselves collectively in political communities” (1958, p. 2).

## **PROFESSIONALISM**

Few issues are more relevant to contemporary society than the nature and ethics of the professions (Pellegrino et al., 1991, p. viii).

In this section there is an exploration of the ethical threads of the fabric of the professions that make them unique, and of the challenges associated with the malaise of modernity and its implications for educational leadership. A number of related ethical questions help to frame the inquiry. What is the moral character that distinguishes a profession? What qualities actually differentiate a profession from an occupation? Are professional relationships covenantal, contractual or merely commodity transactions? What is the significance of the fiduciary relationship, a relationship long considered basic to a profession? The features of professionalism are first explored and then contemporary relationships are examined. Ethical theories that support health care decision-making are highlighted, concluding with a discussion of current challenges.

For many centuries the “learned” professions (medicine, law and the ministry) were accorded a deserved place of honour in society and its members were people of distinction. Medicine, for instance, professed an ethic arising from long standing tradition bolstered by ancient philosophies and Judeo-Christian principles. What are the ethical foundations, then, of professionalism? The voice of one of the exemplary leaders, Gillett, begins the discussion of professional foundations with historical perspectives, ethical concepts and the influence of the Hippocratic Oath:

*The foundations of professionalism for me are closely related to the Aristotelian concept, a skill informed by developed knowledge. For today this has become a range of skills informed by university-based knowledge, particularly in the biomedical sciences, but increasingly in the humanities. In fact, I think that increasing recourse to the humanities reinstates many of the values and foundations that used to be in medicine. ... Those foundations philosophically I would very much relate to Aristotelianism, an idea in which scholarship is linked to training in virtue, so that it is not at all expected that anybody would develop their intellectual life but neglect their own personal development as a virtuous and well-rounded individual. And the prominence in the Hippocratic school of the oath that was taken with its fairly unbounded commitment to human well-being and to holding sacred things that were conducive to human life endorsed that same kind of balance between the intellectual or the purely technical and the moral development of a practitioner. I think if we spring right forward into the present day, neglecting several major figures en route, it's no accident that Michel Foucault, the post-structuralist French philosopher, has used the Greek writings for inspiration in his own unfinished work*

*on ethics, and the whole idea that ethics involves far more than just rightly governing the relationships between people. It also needs essentially to involve an attention to the state of one's own soul, with it not considered in any mystical way, but merely as a kind of summary of the character, personality and conduct of the individual concerned (G. Gillett, personal communication, May 1, 2004).*

The feature of formal knowledge is foremost for Freidson (1986), who claims that the professions can be distinguished from other occupations by way of the “formal knowledge” they possess, apply, protect, and develop. Members of the professions are the “agents of formal knowledge.” The formal knowledge that is at the core of professions is specialized knowledge, different from what most people know; it requires extensive education and training. Freidson emphasizes that, in the modern West, this formal knowledge has a distinctive character, shaped into systematic theories that explain facts and justify actions, characterized by Weber’s rationalization, “the pervasive use of reason, sustained where possible by measurement, to gain the end of functional efficiency” (1986, p. 3).

Kultgen discusses another significant feature, emphasizing that “the ideal of a professional is that of a person dedicated to providing proficient service to those who need it” and, further, the dedicated professional requires both moral and intellectual virtues that can be “deliberately pursued and cultivated” (1988, p. 360). Similar themes are found in the work of Barber, who contends that a vital feature of a profession is the relation to individual and community interest.



Because of the control that generalized and systematic knowledge has over society, it is essential that such knowledge be used in the community interest, an orientation primarily to community rather than individual interest (Barber, 1988, p. 36).

Pellegrino claims that the moral and ethical foundations of professions are central:

*At its most fundamental, medicine is a profession because it “professes” to act in something other than its own self-interest—and it is expected to do so in ways “jobs” and “occupations” are not. It is this requirement for altruism that vexes many in the professions today because it is so infrequent in other occupations and simpler ways of making a living. What I have outlined for those who “profess” medicine applies analogously to the other professions like law and ministry.*

*...The vulnerability, anxiety, need for help of patients, clients, seekers of spiritual consolation, raises ethical accountability and obligation of those who promise to help. This is a degree of obligation which goes beyond the accountability of the businessman, tradesman, bureaucrat—even though we know that persons who seek their help may also be vulnerable. Unless the gap in ethical responsiveness between a profession and an occupation is sufficiently broad, a true profession does not exist (E. D. Pellegrino, personal communication, August 4, 2004).*

Originally a profession meant simply the act or fact of professing; it has developed from this base to mean “a calling requiring specialized knowledge

after long and intensive study ... committing its members to continued study to work which has for primary purpose the rendering of a public service” (Gove et al., 2002, p. 1811). Professionals continue to profess. “They profess to know better than others the nature of certain matters, and to know better than their non-professionalized clients what they need to know and in what proportions they need to know it. Professionals claim the exclusive right to practice, as a vocation, the arts which they profess to know” (Merrill, 1988, p. 40; see also Jonsen, 1990). Freedman attributes to professionals a morality of their own. They are more constrained by their professional values, which are at a higher position in the ethical hierarchy, with greater ethical importance than ordinary morality. The feature significantly impacts decision-making (1978, p. 10). One consistent theme in the literature is that “genuine professionalism” involves a sense of having a “calling” or vocation and being part of a community.

Barber summarizes significant professional attributes. The first is a high degree of generalized and systematic knowledge. The second is a primary orientation to the community interest as opposed to individual self-interest. The third is a high degree of self-control of behaviour via codes of ethics and rewards that are primarily a set of symbols of work achievement and ends in themselves (1988, p. 36). Related to this discussion, Lynch considers personal integrity vital to the foundations of professionalism:

*Personal integrity is the ultimate foundation on which any professionalism rests. The knowledge of personal values to which I*

*am committed, the knowledge of how those values must be practiced within the context of the values of my professional group, and the values of the society in which I live and work, the commitment and courage to practice such knowledge, indeed comment on personal integrity, and its fundamental importance requires a detailed essay of its own. In short form, however, professionalism cannot long be practiced in the absence of values commitment; the harm of a continuing gap here will be self-destructive, as well as seriously detrimental to those who depend on an individual's professional promises (A. Lynch, personal communication, February 13, 2004).*

Jonsen relates historical foundations of Aristotle and Hippocratic medicine to deliberation in contemporary professionalism:

*A most interesting thing about Aristotelian ethics is the concept of deliberation and the way in which practice—action results from deliberation, and that it has a great deal to do with understanding the circumstances, and that's perhaps the most Hippocratic feature of his ethics. That is, in Hippocratic medicine, it was essential that you do the right thing at the right place and the right time, and that's what the doctor's success lies in—and being able to ascertain what intervention is useful at this point in time and for this particular person. And so when you transfer that to ethics, it means that you understand ethics fundamentally, not as a structure of rules, but as a response to a situation in terms of a stable character or disposition—the virtues or the habits. And it seems to me that it runs all the way through our growing understanding of professionalism. A professional person is someone who can make those sorts of decisions in the situation with regard to the particularities that need to be dealt with at the time and they do so*

*not haphazardly, but out of a stable character that's developed. And that's what a professional is, and professionalism as we understand it even today I think is very Aristotelian* (A. R. Jonsen, personal communication, April 29, 2004).

Relationships with professionals ineradicably involve trust. Barber (1988) describes this as a “fiduciary relationship.” Similarly, Pellegrino expands, “Trust has special moral dimensions which are the foundation for professional ethics” (1991, p. 72). Trust is a permanent feature of human relating; fidelity to trust is an indispensable virtue of the good professional—lawyer, doctor, minister or teacher because, without this virtue, the relationship with a professional becomes the exploitation of vulnerability rather than a means of helping and healing. Professional ethics must revolve around the obligation of fidelity to trust (Pellegrino, 1991, p. 82).

Sociologists have defined two competing conceptual models of professions. One group of influential thinkers influenced by Durkheim sees the professions as a positive force in social development, standing against the excesses of both laissez-faire individualism and state collectiveness. For Durkheim, professions could become communities cultivating order, duty and discipline. Others, such as Kuznets and Friedman, see professionalism as a negative force, particularly due to large bureaucratized associations and monolithic practices. This view is often called the conflict model. It criticizes professions for falling short of the ideal (Kultgen, 1988, p. 62).

Organizational conditions related to professions have evolved over the centuries. According to the traditional ideology of professions, the true professional is not employed, but rather is retained, engaged, or consulted by one requiring their professional service. Hughes provides the example that, even in the early modern period:

The Freie Berufe in Germany were considered free not merely because they were worthy of free men, but because those who followed them had no employer. Even the freier Gelehrte, or independent scholar, once he had acquired the right to teach, received his income in fees from his clients, the students (Hughes, 1988, p. 34).

Professionals today, however, frequently practice within organizations and consequently particular issues of allegiance, duties and responsibilities arise. Currently, there are unique responsibilities for health professionals within organizations. They need to be involved in “the formation of the mission and values statement of the institution and commit themselves to the mission and values” (Pellegrino & Thomasma, 1993, pp. 105-106). Indeed, this is central to the “conscience” of an institution. Special roles create special moral rights and duties.

What relationships currently strengthen health care professionals: within a discipline, among disciplines, and with patients and society? Pellegrino and Thomasma describe the ideal of a moral community:

The ideal of a moral community, the idea of physicians and other health professionals bound, by their common commitment to care

for the sick, to a set of shared and collective obligations” must be cultivated. “...A moral community is one that effaces its group interests before the higher interests that give it its definitive character (1993, p. 45).

Is there a moral community today? Gillett discusses the important features of commitment, values and the role of the educator in the current climate of government restraint and technical and rational accountability influenced by the malaise of modernity:

*There is a professional moral community and it isn't inappropriate to talk about it in those relatively unified terms. And therefore, even if descriptively one would like to say that medicine and the Hippocratic professions allied to it are becoming fragmented in contemporary society, normatively in terms of what ought to be the case, one wants to reassert that there should be a community with a moral commitment to healing and caring to the love of humankind in its most practical sense.*

*And therefore, as health care educators, the role one ought to play in this community is to do whatever is required to ensure that the very real need for those underlying values be reaffirmed and implemented and borne in mind at every point in the educational context—so that it is, for instance, not acceptable for teachers to exhibit vices that are inappropriate in that community—vices of exploitation, self-aggrandisement, self-seeking, arrogance, and abuse. ...Teachers must be encouraged to share their faults, to admit their ignorance when they are ignorant, to learn from their students, to share what wisdom they have, to treat their own learning wherever it's taking them in their journey as medical educators as an adventure in which the young colleagues can be*

*caught up perhaps from time to time, involved in research projects where they do learn to function collegially with those ahead of them on the way. And then involved in clinical commitment and care, where they are drawn into a team atmosphere, where there's an unwritten assumption that the patient will be regarded as somebody to be respected and cared for and acknowledged (G. Gillett, personal communication, May 1, 2004).*

May purports that the covenant is “the most inclusive and satisfying model for framing questions of professional obligation” (1975, p. 38). Included in covenant fidelity is much more than the code obligation to be technically proficient, and the legal duty to meet minimal requirements in terms of a contract. The covenant requires a “surplus of obligation.” It is not restricted to a personal term, and reminds the professional community that it is important for whole institutions – the hospital, the clinic, the professional group – to keep covenant with those who seek their assistance and sanctuary (May, 1975, p. 36). Campbell, Gillett and Jones concur that covenant entails greater personal commitment than does the contract, for the “covenant relationship is open-ended, a promise to show active concern for the welfare of the other” (2001, pp. 22-23). Pellegrino and Thomasma claim that the profession holds medical knowledge “in trust for the good of the sick” not as a commodity, nor private property, nor intended primarily for personal gain, prestige, or power. Physicians, as stewards, are obliged to preserve, validate, teach and extend medical knowledge (1993, p. 36).

Further, character as a foundation of the moral life is being resuscitated by medical ethicists such as Pellegrino and Thomasma to enhance the rules,

principles and guidelines that have dominated biomedical ethics for the past three decades. An ethic of virtue is seen to be necessary to complement the existing ethic of principles in order “to have a comprehensive perspective on the ethical behavior of the scientist” (1993, p. 133). What are the virtues of the discipline of medicine “to act in the patient’s best interests?” Both the intellectual virtues (including theoretical wisdom, understanding and practical wisdom) and the moral virtues are vital. Pellegrino and Thomasma claim that “one of the major achievements of contemporary biomedical ethics is to lay bare the moral roots of clinical decisions and to show how inextricably intertwined they are with the scientific and technical” (1993, p. 90). Unravelling the intricacies of clinical choices in an actual case is the result of an intimate discourse between the clinical facts and moral principles, values and virtues. It is the professional’s integrity that integrates all the virtues into a whole and “can prudentially judge the relative importance in each situation of principles, rules, guidelines, precepts, and the other virtues in reaching a decision to act” (Pellegrino & Thomasma, 1993, p. 127).

Ethics—a branch of philosophy—has been used as a generic term referring to “various ways to understand and examine the moral life” (Beauchamp & Childress, 1994, p. 4). Veatch summarizes the “map of the terrain of ethics” as four levels of moral discourse: metaethics, normative ethics, rules and regulations and casuistry. Metaethics, the most basic, starts from the most abstract questions, the most basic questions of ethics—the meaning and justification of ethical judgments—where to look to find answers and how to know



when one has the right answer. Normative ethics involves three types of questions. The ethical theory of the normative address the issues of action theory, value theory, and virtue theory. Much of recent biomedical ethics has dealt with the question of what the principles of morally right action are: "What principles make action morally right" (Veatch, 2003, pp. 3-4). However, in the past two decades, there has been a resurgence of virtue ethics. Much of this interest can be traced back to the work of MacIntyre and others who rediscovered virtue theory in the early 1980s (Veatch, 2003, p. 184). Rules and rights, including codes of ethics, are the next level of moral discourse which may describe what is ethical and give direction as to what is legal. When a rule or a right is considered ethical, it is grounded in a moral system (Veatch, 2003, p. 3). Casuistry is the most specific of the four moral levels. It starts with the individual case and relies on paradigm cases.

Another way to categorize ethical theories is by the aspects of human action that are emphasized. Childress (1989) provides an overview of ethical theories from this perspective. Virtue theories emphasize the aspect of the agent: actions are right or wrong depending upon what they express about the agent. Actions are right if they express virtue. Deontological theories emphasize the aspect of acts in and of themselves, contending that there are intrinsic features of actions that make them right or wrong, not simply their ends or consequences. Teleological theories emphasize the ends of action. Consequentialist theories focus on the consequences or effects of action (1989, p. 31). Each of these broad theories influences health care ethics.

Loewy and Loewy contend that health care ethics provides a connection between individuals, institutions and society and, thus, can:

Articulate these interconnections and their ethical implications to students as well as to practitioners and the public at large. Above all, teaching health care ethics can and must awaken sensitivity and a sense of responsibility as well as provide a method for analyzing and thinking about such issues (2001, p. 468).

Since professionals face ethical dilemmas, they need guidance and approaches grounded in moral reasoning to support their decision-making. The way professionals “resolve these dilemmas determines the moral quality of their lives and the welfare of those affected by their actions” (Kultgen, 1988, p. 14). Within the past three decades, the era of formal medical ethics, there has been an extensive range of theories proposed. The different authors reflect on various strands of ethical and related theory and weave into their own argument.

...Ethical practice requires thoughtful scrutiny of the beliefs and values that underpin our adoption of ethical theories and ethical theorizing (Rodney, Burgess, McPherson & Brown, 2004, p. 56).

The application of ethics to health care has been greatly influenced by the historical evolution of philosophy and ethics (Rodney, Burgess et al., 2004, p. 58).

Principlism is the most commonly taught approach to medical ethics today. This approach attempts to find common elements at the level of principles that could be agreed to by all persons regardless of their underlying theories of ethics and regardless of radical disagreement about the nature of morality (Sulmasy, 2001, p. xx). The approach introduced by Beauchamp and Childress (1989) is

exemplified by the four principles of autonomy, beneficence, non-maleficence and justice. Their goal is to provide a moral framework in the wake of recent scientific and technological developments in health care (1989, p. 3). Sulmasy summarizes the criticism of this approach. While the use of these principles often illuminates the right course of action, in some cases it can be unhelpful, and in others it leaves the resolution of the dilemma of conflicting principles to intuition. It has also been criticized for providing only a checklist of moral concerns in specific cases, but not a guide to action (Sulmasy, 2001, p. xx; also see Childress, 1989, pp. 41-47), and can be used in a manner that is noncontextual and reductionist (Rodney, Burgess et al., 2004, p. 67).

Contractualism is the theory underlying most legal approaches to ethics and is popularized by Veatch (1989) who, in the tradition of Locke and Rousseau, avers that there is no medicine without the consent of the treated. He describes a contract that relates to society, medicine and the individual. Society has a contract with each person who is a member of that society. Thus stemming from social policy, medicine (as a profession) has a contract with all the members of society, which is grounded in health policy, and each individual patient engages in a contract for each medical encounter that is dependent upon informed consent (1989, pp. 70-71).

Pellegrino supports the covenantal relationship and discusses his differences with Veatch regarding a social contract:

*Dr. Veatch has, in his writing, denied the importance of the virtues, and, therefore, he opposes a theory that rests so heavily on them as mine does. I do not deny the existence of a social contract. Society does permit physicians a certain degree of freedom in practice and self-governance. Veatch analyses the contract as a tripartite contract. My objections to his theory are, briefly these: The most fundamental contract—that between physician and individual patients—is a misnomer. Given the inequality of existential states between doctor and patient I have already described, there is no possibility of a contract. Contracts can only be made between equals, or at least between persons with bargaining power. The patient's bargaining power is of a minimal sort when he is sick, in pain, frightened, anxious and in urgent need of the doctor's skills. (E. D. Pellegrino, personal communication, August 3, 2004).*

Casualty, Jonsen's approach to medical ethics, is a case-based approach used for clinical decision-making that relies not only on a study of principles but of circumstances and paradigms (Jonsen & Toulmin, 1988, p. 253). A strength for this approach is the appeal among physicians and nurses because clinicians deal primarily with cases<sup>13</sup> (Jonsen, Siegler & Winslade, 1992). Casualty is not connected to any particular moral theory and thus holds an attraction for a morally pluralistic society. Elements of casualty are used by ethics committees. The criticisms to this approach are that casualts rely upon the principle that "similar should be treated similarly," and so it is really not free of principles. Other concerns are that a group of cases that is not supported by firm moral

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<sup>13</sup> The four topics designating essential features of clinical care are medical indications, patient preferences, quality of life and contextual features such as social, economic, legal and administrative features (Jonsen, Siegler & Winslade, 1992, p. 2).

rules may eventually lead to ethically troubling conclusions (Sulmasy, 2001, pp. xx-xxi).

The “essentialist” approach is the theory developed by Pellegrino, who proposes that medical ethics should be part of the philosophy of medicine, not the application of moral philosophy to the problems of medicine.<sup>14</sup> Pellegrino describes his approach to a philosophy and ethic of medicine:

*My pursuit of the good in ethics is based in the first sentence of Aristotle’s Nichomachean Ethics—“Every art and every inquiry, and similarly every action and choice, is thought to aim at some good; and for this reason the good has rightly been declared to be that at which all things aim.” This I take to be a teleological ethic particularly apt for a philosophy and ethic of Medicine. The good in question is the good of the individual patient insofar as clinical ethics is concerned and the good of social or public health medicine is concerned. The virtues of the good physician, as well as the obligations and norms of medical codes and Oaths, are grounded in the degree to which they facilitate achievement of the end or the good of the patient (E. D. Pellegrino, personal communication, August 4, 2004).*

Other ethical theories and approaches include care-based ethics and narrative approaches. Veatch summarizes that care-based ethics, sometimes incorrectly

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<sup>14</sup> There are three basic assumptions of the “essentialist” approach: medicine has a fundamental, essential core; through the philosophy of medicine comes an understanding of the purposes of medicine, a set of moral expectations is derived of those who practice medicine, and define a relationship between a society and its medical professionals (Pellegrino & Thomasma, 1981; Pellegrino, 2001).

called “feminine-based,” has been espoused particularly by Gilligan. It emphasizes moral relationships of dependence and vulnerability. It concentrates more on narrative, context and relationships rather than on moral principles and rules, and calls for a need of recognition of the complementarity of the morality of care and justice (1989, p. 45). Narrative ethics approaches, based on the primacy of personal history and stories, criticizes all forms of reasoning about ethics as abstract (Rodney, Pauly & Burgess, 2004, p. 79). The terrain has been further widened by a glimpse at medical ethics in other cultures—Islamic, Chinese, Indian, Japanese and others—which are becoming increasingly significant in multicultural North America.

## **CURRENT CHALLENGES**

Health care professionals face the challenge of “negotiating between the tension by competing perspectives on ‘the good’ in general situations and applying these in particular moments of practice with particular persons” (Rodney, Burgess et al., 2004, p. 63). The kind of understanding of social life that the tradition of the virtues requires is an understanding different from those within the culture of bureaucratic instrumentalism. “*Pleonexia*, a vice in the Aristotelian scheme, is now the driving force of modern productive work. Where the notion of engagement in a practice was once socially central, the notion of aesthetic consumption now is, at least for the majority” (MacIntyre, 1984, pp. 227-228). Conceptions of the virtues become marginal and the tradition of the virtues remains central only in the lives of social groups whose existence is on the

margins of the central culture. Within the dominant culture of liberal individualism new conceptions of the virtues emerge and the concept of a virtue is itself transformed (MacIntyre, 1984, p. 225). For example, as Benner demonstrates, modern commodified health care highly values what can be made into scientific and technical procedures (Benner, 1994). Similarly, May discourages the approach of legal realists and positivists—a minimalism of contractual understanding of the professional relationship—that “produces a professional too grudging, too calculating, too lacking in spontaneity, too quickly exhausted to go the second mile with patients” (May, 1975, p. 35). Now the organization of society is not only judged instrumentally, but also “*what* this organization is instrumental to concerns the very basic conditions of existence as free agents, rather than the excellence of virtue” (Taylor, 2001, p. 7).

Pellegrino reflects on the question of the foundation of a profession and the current issues of what he calls “deprofessionalization”:

*This question has arisen in a serious way only in the last several decades. It reflects a serious identity crisis in medicine and the other traditional professions. All are asking themselves the same question—What is it to be a physician? (lawyer? minister?) What is so special about what I do that requires me to adhere to higher levels of moral obligations than other occupations?*

*The resulting identity crises are of concern to those these professions serve, to those who educate them and to legislators and policy makers as they are to the professionals themselves.*

*They are of utmost importance for all of us, inasmuch as all of us, at some time in our lives, will need the help of these professions.*

*The root causes for this state of confusion are deeply interwoven into the values of modern society. ...Among the major forces for deprofessionalization, I would list the following: Commercialism and commodification of the services the traditional professions offer, the bureaucratization and institutionalization of the ways the professions provide them, the proliferation of self-oriented life styles, and the antipathy to "elitism" in norms, traditional values and duties, especially those that limit personal satisfaction. Many of these forces represent the continuing effects of the social revolution of the sixties of the 20<sup>th</sup> century, the end of which is not yet in sight.*

*The result for the professions are several: a down drift from the more altruistic standards of a profession to the more mundane tasks of an occupation, a disaffection with the idea of a profession as a way of life in the direction of a profession as an encapsulated part of one's day leaving the rest for "having a life". Simply put, using medicine as an example, there is the growing attitude of a nine-to-five job on the one hand, as an employee. Or, on the other hand, there is the idea of the physician as entrepreneur, living by the rules of the marketplace. These tendencies and attitudes have deprofessionalized medicine (E. D. Pellegrino, personal communication, August 4, 2004).*

Sullivan, an American philosopher, is concerned that "modern American medicine has wedded scientific advance to a small business model of the individual practitioner, defining professionalism as technical understanding" (1999, p. 7). He contends that the survival of the profession depends upon



drawing on older ideals of the learned professions, reinvigorating a civic understanding of professional life. When medicine characterizes itself as a branch of applied science, it loses sight of the “complexity of healing as a human practice that requires not just expert knowledge but the context of a dedicated professional community” (Sullivan, 1999, p. 12). To safeguard patient dignity and equity, the “connecting, synthesizing link is the morality of civic equality,” a broad framework of understanding—the “body politic:” the profession-society relations are situated within the space of common citizenship (Sullivan, 1999, p. 11).

Dombeck and Olson also reflect on the affects of personhood as they analyse relationships in American health care where managed care is prevalent. Institutional contexts for care delivery involve human relationships which are being redefined in a managed care environment (values and social customs are changing); “roles and authority among professionals and patients are shifting” (2002, p. 230). Hanson claims that the moral significance of personhood and self-understanding is of such consequence that even slight degrees of intrusion are worth consideration (Hanson, 1999, p. 285). Further, he contends: “A good that becomes a commodity is also fundamentally redescribed as it is valued now in a different way: its instrumental value becomes highlighted, rather than whatever intrinsic value it may have previously been thought to possess” (Hanson, 1999, p. 268).

Frank maintains that besides the crucial tools of medical work—diagnostic techniques, surgeries and pharmaceuticals—a “generosity” is required, a

relationship of dialogue, of face-to-face encounters rather than merely an exchange of information (Frank, 2004, p. 1). Cruess and Cruess claim that neither society nor professionals have a clear understanding of the interaction of the role of the contemporary healer and professional (1999, p. 25). Individual practitioners need to redefine the social contract with society and resultant obligations. Integrity must remain central—more important than the issues of technology, bureaucratic control, or economic incentive.

How can leaders—educators and administrators—help to cultivate virtues that will enable health care professionals to consistently use their competencies in an ethical manner? From the nursing literature, Johnson responds, “Our leaders of tomorrow must be able to draw upon every tool available to them to support ethical nursing practice; one such tool is philosophy” (Johnson, 2004, p. 42). Health care professionals need to take time to understand the nature of their work, their goals and, ultimately, their vision, to consider the philosophical questions. Storch emphasizes the need for the work environment to be “a place in which the language of ethics is commonplace and in which the work environment promotes ethical discussion and action”—with a goal to operationalize ethical principles and values, a co-requisite for compassionate care (2004, p. 9).

Gillett integrates the concepts of covenant, education and overarching good to articulate the context of medical education:

*The most exhaustively outlined covenant we know about in our own traditions, we have all the elements of what medical education should be all about. It should be education and service of a good, an overarching good, a good in which we all find ourselves participating, that sometimes in powerful and effective positions and sometimes in very vulnerable and needy positions. And that participation really relies on two fundamental ethical orientations, an orientation towards the value of human life whether in oneself or another and a desire to do the very best one can to enhance human life or mitigate suffering where possible. And once that whole covenant, or ethos as it were, becomes a loving part of the spirit of medical education, then it will of course check some of our worst vices—vices of arrogance, of hierarchical vices and self-seeking vices, vices of profit, vices which would involve us in selling ourselves for currency that is not worthy of them. All the kinds of evils that one sees creep into medicine under various guises and in various kinds of background context would then be radically thrown into relief by that kind of orientation. So I see the covenant concept when pursued not in any kind of airy-fairy way, but in terms of creating a context of value within which the relationship between doctors, patients and communities ought to be understood, as being quite a valuable one, even in the 21st century medical culture (G. Gillett, personal communication, May 1, 2004).*

Recent research studies in the area of professionalism and ethics education explore the influence of environment and atmosphere on the ethical development of students. Clever, Edwards, Feudtner and Braddock (2001) advise ethics educators to investigate the ethical atmosphere of teams—to support social environments in institutions that will promote discussion of difficult issues.

Satterwhite, Satterwhite, and Enarson (2000) found that observation of, or participation in, unethical conduct may influence a student's codes of ethics currently and in the future. Sulmasy and Marx (1997), building on previous work, clearly report the benefits of an innovative curriculum that includes knowledge and attitudes. Other studies such as Savulescu, Crisp, Fulford and Hope (1999) and Malek, Geller and Sugarman (2000) focus on improving assessment tools. The extensive review of Epstein and Hundert (2002) makes a strong case for new comprehensive, multidimensional assessments of ethical learning. Their conclusions have broad implications for leadership and mentorship, reinforcing other research results that emphasize the importance of reflection, feedback and remediation.

This discussion recognizes that health care professionals must be better educated in ethics, and more informed of the responsibilities of the profession to establish its role as a moral community to provide leadership. The discussion of leaders continues in the next chapter.

## **CHAPTER FOUR LEADERSHIP**

Leadership roles are embedded in the various contexts in which health professionals exercise leadership—academic, clinical and policy development. Current societal challenges, many driven by the malaise of modernity, are compromising the integrity of Canadian health care. What leadership theory can support the practice of moral leadership within health care in the 21<sup>st</sup> century? This chapter explores this question and begins with an overview and critique of past and present leadership theories. Examination of the work of Burns and other authors in the field relating to ethical issues of leadership and organizational culture provides further insight about the nature of leadership. The chapter concludes with an overview of the roles of the educational leader in health care.

### **LEADERSHIP THEORIES: AN OVERVIEW**

McCall and Lombardo's critique of leadership theories suggests that theorists have overemphasized technique at the expense of broader perspectives, that much of the literature is fragmented and trivial, and the research findings are characterized by contradictions (1978, p. 3). Klenke also claims that a general

disenchantment with the state of leadership theories<sup>15</sup> permeates both the scientific and practitioner community. “Many of the existing leadership theories are built on two-dimensional models” such as structural-versus-functional theories, autocratic-versus-democratic and content-versus-process approaches which are oversimplified approximations of a “complex and multifaceted phenomenon which cannot be adequately captured by bi-polar dimensions” (1996, p. 56). Each theory relies on a limited set of concepts such as leadership traits, behaviours or situations that are usually applicable to only one level of analysis (Klenke, 1996, p. 84); however, the situation in which leadership occurs is a combination of at least five related areas—the leaders, the followers, the time, the place and the circumstances. For the leadership practitioner there is on one side a lack of conceptual clarity, while on the other a plethora of programs, human relations training and “One Minute Managers” to select from in the marketplace (Klenke, 1996, p. 56). Immegart emphasizes that even the latest developments do not sufficiently inform practice (1992, p. 207). There is the need for an analytic framework to develop models for leadership that support the practitioner.

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<sup>15</sup> Klenke notes that the study of leadership, found in many disciplines, has had a long and turbulent history. She points to the “efforts of Stogdill (1974) and Bass (1991) to synthesize the existing literature are based on reviews of over 5000 published works on the topic. These reviews, drawing primarily from research conducted in the social sciences, barely touched upon the study of leadership from other disciplinary perspectives like the humanities. ...Despite 100 years of analysis and research which produces mountains of work ranging from poetry to mathematical models, leadership remains a slippery concept” (Klenke, 1996, p. 12).

In the early study of leadership in the nineteenth century, it was assumed that leaders possess certain physical and psychological traits<sup>16</sup>—a mixture of hero, prince and superman—that determined their rise to power and leadership positions. Called the "great man/great woman" theory of leadership, this perspective assumed that traits associated with effective leadership were inborn qualities (Klenke, 1996, p. 57), thus the belief that "leaders are born." Watkins contends that, despite the devastating critiques of the trait approach, it has persisted in various forms. Myths were often created to provide symbolic continuity, representing "idealized characteristics with which people like to typify their imagined symbolic heroes" (Watkins, 1989, p. 13). In this theory, the implied leadership value is one of prominence, of extraordinary influence. Although it is an inadequate leadership theory for health care, lacking a framework including end-goal values, it does emphasize that individuals can make a difference. According to this view, leaders are situated in positions of power and are valued for the prominent role that they play as human agents within these significant roles.

The trait approach, notwithstanding close scrutiny, fell into disfavour and by the 1950s behavioural theories of leadership dominated. Instead of distinguishing between effective and ineffective leaders on the basis of personality traits, the focus of research shifted to the behaviour of leaders and assumed that leadership is learned by acquiring a set of behaviours necessary for effective

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16. A trait refers to a distinctive physical or psychological characteristic of an individual to which his or her behaviour can be attributed (Klenke, 1996, p. 57).

leadership (Klenke, 1996, p. 64). The leader behaviour categories generated by Ohio State and Michigan Universities identified two broad dimensions: a task-oriented axis that focused on task accomplishments and performance standards, and a relationship-oriented axis that focused on the leader's interpersonal skills, mutual trust and harmonious group interaction. Although these two dimensions are not mutually exclusive, "research has consistently failed to confirm the common sense notion that effective leaders utilize both" dimensions (Klenke, 1996, p. 65). Other researchers created similar behaviour typologies<sup>17</sup> known as leadership styles. This approach recognizes that behaviours can be learned by observing a leader in action or engaging in leadership training. However, leadership styles have been criticized in the literature for providing inadequate conceptualizations of leader behaviours, a lack of accurate measures and a failure to recognize the role of situational factors (Klenke, 1996, p. 66).

In the 1970s the situational approach, another major classification of leadership theories, became dominant. Situationists argued that leaders are constituted by events in the sociohistorical context in which they are situated. Situational variables include the characteristics of the work and the work setting. Heifetz claims that the values within situational theory are reduced to style that focuses on the task of contextual diagnosis (1994, p. 19). The situational approach

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<sup>17</sup> One typology developed by Likert distinguished between a "job-centered leadership style" and an "employee-centered leadership style" that focuses on the needs of followers by creating a supportive work environment (Klenke, 1996, pp. 64-65).



directs one toward examining how the activity of leadership differs depending on context rather than dealing with substance or end-goal values.

Leadership inquiry extended into the particular interactions between leaders and followers—the "transactions"—by which an individual gains influence and maintains it over time. The process is based on reciprocity: Heifetz, 1994, p. 17). Transactional leadership occurs when one person takes the initiative in making contact with others for the purpose of an exchange of valued things. The exchange could be economical, political or psychological in nature. Each party involved is conscious of the power resources and attitudes of the other; a leadership action occurs, but it does not unite leader and follower in a mutual pursuit of a higher purpose (Burns, 1978, p. 19).

Theorists also began to synthesize the trait approach and the situationalist view. In the contingency approach, leadership effectiveness is dependent upon social interaction between leaders' attributes and the characteristics of the situation (Heifetz, 1994, p. 17). Contingency theory<sup>18</sup> identifies factors and posits a particular style contingent upon the requirement of a specific situation. Watkins regards "the situational and contingency model approaches to leadership "[as] static, ahistorical and ideologically based. The functionalist leadership perspective operates in an authoritative way to sanitize the unequal power

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<sup>18</sup> A pertinent example, Fiedler's contingency theory, examines which decision-making style fits with situational contingencies in order for the decision-maker to maintain control of the process: a directive, task-oriented style versus a participative, relationship-oriented style (Klenke, 1996, pp. 66-71).

relations within an organization to legitimize and mystify” (1989, p. 13). Similarly, according to Heifetz, the mark of leadership with this contingency theory is influence or control (1994, p. 18).

Contemporary business and management schools commonly define the usefulness of leadership with respect to organizational effectiveness, which means leaders make decisions based on the goals of the organization. Much of this management literature is entrepreneurial in nature, focusing on the successful corporation where the ultimate desired “success” is a positive financial outcome (Kaplan & Norton, 2001). Change management has been a significant theme as well, a rather eclectic term that includes a wide range of perspectives on tasks specific to managing change. Success stories are a common way of illustrating various recommended processes (Peters & Waterman, 1982; Bennis, Spreitzer & Cummings, 2001; Kouzes & Posner, 1996; Kotter, 1996 and 1999; Clemmer, 1995; Bennis, 1989; Barker, 1992).

Leadership that currently exists in health care and educational institutions has been significantly influenced by conceptions of leadership promoted in management schools. Saul argues that the latest manifestation of the “mediocre and tired management theories of efficiency” through economies of scale promote training rather than education (2002, p. 14) and limit new approaches and creativity in health care settings. Angus argues that, although these theories of leadership have little predictive power, they are extremely influential and are essentially accepted as prevailing orthodoxy. “As such they act as ideologies,

legitimizing particular managerial concepts and forms of organization, while constraining the conceptualization of alternatives” (1989, p. 72). It is this “constraint of conceptualization of alternatives” that is a limitation for health care. These managerial models are based on economic values, and avoid incorporating ethical values in health and educational terms that are associated with personhood and community discussed in previous chapters and therefore cannot as theories provide a foundation for critical reflection and analysis. A tension is created by contrasting the values of efficiency and cost effectiveness associated with a managerial style and the values associated with community and personhood discussed in the previous chapters.

A claim of the new management literature is that of administrative expertise and effectiveness. MacIntyre argues, however, that the concept of managerial effectiveness is simply “moral fiction.” This moral fiction is embodied in the claims to effectiveness and authority by the bureaucratic manager, the central figure of the modern social drama as it affects contemporary public institutions. The manager falsely claims a “stock of knowledge by which organizations and social structures can be molded” (1984, p. 77). Mitchell and Scott also review this literature, claiming that, “Despite the current popularity ... empirical work on entrepreneurship is in utter disarray” with no evidence for the idea that certain traits “lead to either innovation or success” (1987, p. 447). Angus similarly concludes, after his review of this literature, that the new leadership models contain certain assumptions that are “flattering to the leaders and generally consistent with conservative approaches to organization” but “still assume[s] the

appropriateness of traditional bureaucratic bases of power that are thought to be apolitical.” These “functionalist assumptions” mainly ignore political and ideological influences on organizations (1989, pp. 74-75).

Educational administration occupies part of the broad spectrum of educational leadership. Reflecting on educational administration, Codd reports that the trend towards a management approach in educational leadership is part of the broader process in which economic and political concepts were initially employed to define certain forms of interaction from industrial contexts that were gradually brought into the educational cultural sphere. The lack of resistance to this trend among educators is due in part to the pervasiveness of the ideological forces and to the lack of guidance from traditional theories in their professional life as well as generally in the culture of the organization (Codd, 1989, p. 158). Bates adds to the discussion, claiming that, as a field of study, educational administration has made two fundamental errors. “The first error is to believe that the processes of abstraction and reification constitute an appropriate path toward powerful theory. The second error is the belief that the language of technique is an appropriate substitute for the discourse of ethics” (Bates, 1989, p. 131).

Codd reflects on leaders as philosophers versus leaders as managers:

The notion that leaders should be philosophers is not new. Indeed, it can be found as far back as Plato but it has never been widely accepted. As social institutions have become more bureaucratic and have acquired more specific functions, leadership has come to be identified either with managerial or interpersonal skills, or with charismatic personality. The idea that leadership could be the

natural manifestation of a philosophical disposition has been rejected as being both impractical and elitist. It is an idea that has seemed to be incompatible with the industrial imperatives of modern society. As these imperatives have embraced more and more areas of institutional life, including the institutions of education, leadership has been defined increasingly in terms of management, efficiency and productivity. But this is a view of leadership which does not value critical reflection, personal autonomy or collective deliberation. It is, therefore, a view of leadership that is particularly inappropriate to educational institutions because it negates the *educational* purposes of those institutions (1989, p. 157).

Among demands for a new leadership approach, Rost (1991) argues that present theories of leadership are centred within an industrial paradigm that limits leadership to management, whereas what is needed is a transformational leadership approach. Heifetz (1994), critical of earlier theories as well as the current corporate model of leadership, contends that it is essential to develop a definition of leadership that takes values other than economic ones into account. Building on the work of Burns, he suggests that, rather than define leadership either as a position of authority in a social structure or as a personal set of characteristics, it is more useful to define it as an activity of adaptive work, mobilizing people to learn new ways of helping to clarify values and face realities and conflicts (1994, pp. 20-22). In a similar vein, DePree (1992, 1999) emphasizes fostering people's growth processes. To deal with the demands for a new leadership approach, Klenke argues for the critical importance of context. She contends that in each context—political, intellectual, artistic, religious, scientific, social, cultural and international—leadership manifests itself differently. She suggests further that the setting in which leaders and followers interact influences leadership outcomes (1996, p. 24). The inquiry continues in the new

millennium as medical educators Parsell and Bligh ask anew, "But what are leaders, and what constitutes leadership" (2000, p. 199)? The next section discusses alternative leadership approaches based on philosophical traditions, exploring their potential to serve health care practice.

### **"NEW" LEADERSHIP ELEMENTS**

The work of scholars such as Burns (1978), Vaill (1984), Deal and Kennedy (1982), and Deal and Peterson (1999) introduces a focus on personal leadership and organizational change and renewal. This involves a "vigorous and interventionist role" for the leader "responsible for organizational change in positive, productive ways" (Angus, 1989, p. 69). A significant challenge derives from understanding the complexity of leadership and its relationship to organizational culture. The themes of their work and influence on organizational culture are explored, with a particular focus on the relevance for health care leadership.

Burns' work is important to this project because it covers a broad range of leadership elements that are consistent with health care ethics and professionalism. Plato's foundational work on leadership is acknowledged by Burns: "Like Plato we can see the role of power and values in everyday life" (1978, p. 30). Leadership is a process of morality to the degree that leaders should share with followers motives, values and goals on the basis of the "true" needs of both the followers and the leaders (Burns, 1978, p. 36). "Moral

leadership emerges from and always returns to the fundamental wants and needs, aspirations and values of the followers" (Burns, 1978, p. 4). Echoes of Plato's "Philosopher Kings" resound in Burns' work, promoting their allegiance to the community and bringing "the citizens into harmony" (Plato, 350 BCE/2000, 520a). Once again, the allegory of the cave provides insight on leadership and education. As the philosopher turns towards the light and attains understanding, he must later return to the cave and rule there (Plato, 350 BCE/2000, 518a-518e).

If there were ever a city of good men, there would probably be as much competition *not* to rule as there is among us to rule. That would be the proof that it is really not in the nature of the true ruler to think about what is good for himself, but only what is good for his subject (Plato, 350 BCE/2000, 347d).

Burns regards leadership as a special form of power. He is concerned that "viewing politics as power has blinded us to the role of power in politics and hence to the pivotal role of leadership;" he challenges one to see power—and leadership—as not things but as relationships (1978, p.11). For Burns it is ubiquitous and is composed of two necessary and interrelated elements: motive and resource. If one diminishes; so does the other (1978, p.12).

In his analysis of the challenges of past and present moral leadership, Burns summarizes the ultimate test of moral leadership. Burns emphasizes values<sup>19</sup> as the source of vital change when “mobilized and shaped by gifted leadership, sharpened and strengthened by conflict” (Burns, 1978, p. 41):

...Its capacity to transcend the claims of the multiplicity of everyday wants and needs and expectations, to respond to the higher levels of moral development, and to relate leadership behavior—its roles, choices, style, commitments—to a set of reasoned, relatively explicit, conscious values (1978, p. 46).

Burns’ work is also important for its distinction between transactional and transformative leadership. Transformative leadership, in contrast to transactional, as discussed earlier, is concerned with exploring conventional relationships and organizational understandings insofar as there is involvement between persons “in which leaders and followers raise one another to higher levels of motivation and morality” (Burns, 1978, p. 18). The essence of transformational leadership is that socially useful goals not only have to meet the needs of followers, they also should elevate followers to a higher moral level: “The genius of leadership lies in the manner in which leaders see and act on their own and their followers’ values and motivations” (Burns, 1978, p. 19). Transformational leadership defines and impacts social change; it is dynamic and engaging; it mobilizes and directs support for values such as justice and empathy (1978, p. 42). Ultimately, the

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<sup>19</sup> According to Burns, values, crucial to the concept of leadership, have a “special potency” because they embrace separate but closely related phenomena. Values indicate desirable end-states of explicit purposes, and values are standards governing which specific criteria may be established and which choices made among alternatives. He uses the term “end-values” to designate the two intertwined meanings of values: goals and standards. Values are also defined as modal values such as prudence, honour, courage, civility, honesty and fairness (1978, p. 74).



moral legitimacy of transformational leadership “is grounded in *conscious choice among real alternatives*” (1978, p. 36).

Corresponding to Burns’ transforming leadership approach, which draws upon the best of motives of organizational members who direct these towards the best interests of the organization, is Vaill’s notion of “purposing.” Through “purposing” the leader conveys a sense of mission to other members of the organization by means of a “continuous stream of actions ... which have the effect of inducing clarity, consensus, and commitment regarding the organization’s basic purposes” (1984, p. 91). Similarly, Deal and Peterson contend that people build their commitment to a vision on the foundation of values, the conscious expressions of what they stand for and deeply care about. “Values define a standard of goodness, quality, or excellence that undergirds behavior and decision making, a deep sense of what is important” (1999, p. 26). The exemplars of core values of a culture “provide the culture with an image of the best that is in us” (1999, p. 58). Handy (1997) purports that the principal goal of leadership is to find the “strange attractor,” or the “soul” of the organization, that gives meaning to movement around which a field of trust can be built and becomes the organizing focus (1997, p. 381). Core values help to focus the energy and commitment of organizational members on organizational goals (Angus, 1989, p. 70).

To inspire, strengthen and uplift, a leader must express vivid goals that in some sense people want. This conviction has permeated humankind across the centuries—paraphrasing the biblical proverb, “without vision, the people perish”

(Proverbs 29:18). A commitment to a vision is built on the foundation of values and the conscious expressions of a standard of goodness, which underlie behaviour and decision-making, "a deeper sense of what is important" (Deal & Peterson, 1999, p. 26). Vision is central to the success of the leader-follower relationship (Burns, 1978, p. 437). Further, trust, connection and knowledge of the personal resources available within the community are key to transform a collection of individuals into a community of people working toward a common vision (Axelrod, 2000).

There is a continued requirement for moral leadership within health care education, a need for leadership that brings a vision at all levels—local, provincial and national—including professional and educational institutions. Ethical leadership for the professions can be provided, supported and directed in various ways. One example is the Canadian Code of Ethics for Registered Nurses, which clarifies who the nurses serve, sets forth standards and promotes the participation of nurses in health policy process to improve ethical nursing practice for the benefit of the public. The Canadian Code of Ethics is consistent with social practice reforms.

The ability of nurses to engage in ethical practice in everyday work and to deal with ethical situations, problems and concerns can be the result of decisions made at a variety of levels—individual, organizational, regional, provincial, national and international. Differing responsibilities, capabilities and ways of working toward change also exist at these various levels. For all contexts and levels of decision-making, the code offers guidance for providing care that is congruent with the ethical practice and for actively

influencing and participating in policy development, review and revision (Canadian Nurses Association, 2002, p. 5).

Pauly, focusing on nursing issues, claims that, in the “current health care context of scarcity, corporatization and shortages,” the ability of nurses to practice ethically and safely is being jeopardized. She emphasizes that macro decisions, as a result of budget reductions, force micro-level resource allocations that result in increasing workloads for nurses at the bedside (Pauly, 2004, p. 196). This image applies as well to other members of the health care team such as social workers and rehabilitation therapists (see Canada, 2002, p. 91). It is essential that health care decision-making and health policy development have an ethical grounding to complement the entrenched economic considerations; this is not currently the norm as managerialism elevates economic values to the exclusion of moral and social values. It is the obligation of professional associations to promote the best interests of the public (Pauly, 2004, p. 197).

Heifetz (1994) emphasizes that an essential component of leadership is developing the organizational and cultural capacity to successfully meet problems according to values and purposes. Responsibilities include supporting communities to test competing values and to increase understanding of the relationships between means and ends. Within health care organizations leaders face decisions between competing claims related to patient needs and how to allocate resources fairly and compassionately. Hospitals, for example, function with several boards, committees and advisory groups that make decisions around policies and programs. The approaches to decision making are varied,

inconsistent and often opaque. Therefore, it follows that the values that underlie this decision-making process are also not immediately apparent.

The effectiveness of leaders, both formal and informal, lies in their ability to make actions meaningful to others. Storch provides an example:

*...A huge goal for nurse leaders is that they be effective in developing a moral community. But staff nurses also need to see that it takes all of us to build that kind of a community. We need it so much, to allow us to practice from an ethical, competent, perspective. ...Nurse leaders do need to step forward, they do need to take a big role in providing support to their nurses, and that their responsibility for ethical practice is a very, very big one in providing ethical leadership (J. Storch, personal communication, October 20, 2004).*

Informal leaders are seen in all disciplines of health care organizations—in advocating for improved care and in team meetings with patients, residents and families. Dependent upon particular sources of power—referent, expert, reward, coercive or legitimate—informal leaders may influence their group’s culture in many ways (French & Raven, 1968). According to Trice and Beyer (1993), informal leaders are likely to have referent power, respected for certain personal qualities, and consequently they become role models. As well, others with expertise that is highly valued by the group become informal leaders. Although they lack formal legitimate power, they also can become strong team leaders. Since the foundation for informal leaders’ influence “lies in embodying value and

norms of particular subcultures,” their influence is not equally transferable to other groups (Trice & Beyer, 1993, p. 282).

Informal leaders can play a significant role in conceptualizing the vision and values of an organization that pertain to personhood and patient-centred care. They are part of the informal cultural network that can be a crucial component of an organization expressing intangibles such as those that relate to caring, in turn giving meaning to the shared vision, shared values and shared norms that support and encourage growth that builds constancy of purpose. Mentoring and role modelling of the formal leaders will nurture and support the informal cultural network. Discussing the educational environment, Deal and Peterson claim that the cultural network provides a variety of forces that nudge an organization’s culture in a certain direction. A network of informal leaders can be “keepers of the values” (Deal & Peterson, 1999, pp. 56-57). Within health care, storytellers can be powerful and indispensable, telling stories or, in health care terms, “cases” that exemplify the values of an organization. Truly, every professional is a role model and an informal leader. Professionals and leaders are integrally related.

The challenges for the health care system of the 21<sup>st</sup> century, influenced by the malaise of modernity, are numerous. Pellegrino discusses how the major forces of commercialism and commodification that led to deprofessionalism have resulted in a focus to “re-professionalize:”

*Educators, professional associations and physicians, as a result, are seeking to “re-professionalize” their work. A variety of measures are being used: teaching “professionalism” in medical schools, issuing a new “Charter” (the American College of Physicians and the European Society of Internal Medicine) of professional commitments, or by teaching courses in medical ethics.*

*None of these efforts is likely to be wholly successful. In my view, most share the post-modern disaffection with foundations, especially moral ones. Instead, they seek solutions through new social constructions. This approach is bound to fail since the heart of professionalism, as it was conceived originally, is moral and not recoverable by social reorganization (E. D. Pellegrino, personal communication, August 4, 2004).*

Jonsen reflects upon a profession as a democratic moral community:

*If one wants to think about the profession as a moral community, one has to think about how these instances of moral communities will come into being in various settings and with various purposes and objectives and the moral community will build from the bottom up rather than from the top down (A. R. Jonsen, personal communication, April 29, 2004).*

Jonsen goes on to discuss the significance of “instances of the profession” where ideals of patient care are practised:

*I think there may be a variety of very particular ways of getting at the issues, not huge, big overall reforms that we may have to think of not of the profession as a whole but of instances of the*

*profession. That is, in particular places, particular clinics, particular hospitals, looking where the physicians can directly communicate about what makes it possible for them to serve their patients, and to formulate policies at very intimate levels of practice. That's what we hope we can do in our institution. That's why we really want to be there.*

*We want to see if our institution can become an instance of professional virtue, a place where those ideals are understood, even though they may not be built into individual habits of all parties, but that the structures, the institutional structures around the care of patients, are continually formed to assure that their care is appropriate (A. R. Jonsen, personal communication, April 29, 2004).*

Schein (1997) discusses the interactive nature of leadership and organizational change and contends that leadership is not only contingent upon the particular organizational context but, equally importantly, within a broader social, cultural and political context which influences the nature of available choices. Learning and change cannot be imposed on people but rather leaders' involvement and participation are needed to diagnose issues, determine the solutions and support implementation (Schein, 1997, p. 392). However, organizations encounter difficulty with change precisely because culture cannot easily be influenced. Creating an interactive learning environment where people transfer, share, internalize and ultimately create new knowledge is vital to meet this challenge. Accordingly, as Brailer purports, "the entire organization must build, operate, and support a mechanism by which it is able to create a learning, growing, and

teaching culture if it is to succeed in gathering and applying its collected wisdom” (1999, p. 6). The health care field has lagged behind other fields in the use of technology to support communication across programs and sectors in the support of new knowledge. The Romanow Report provides recommendations for initiatives to close this gap.

Supporting people to seek out best practices includes gathering, organizing and disseminating intangible knowledge, such as professional expertise, individual insight and experience, and creative solutions. The ability to gather and share knowledge will be particularly important as many senior physicians, nurses and other team members who currently share information informally through leadership roles will retire within the next decade. Ulrich (1997) contends that creating capabilities for change and mastering rapid learning are critical for the future. Learning environments that support communication and information systems allow everyone to be connected. This in turn supports proactive problem solvers and learners (Schein, 1997, p. 370). Duignan and Macpherson (1987) capture a vital essence of the educative leader:

An educative leader [is] one who communicates a sense of excitement, originality and freshness in an organisation ... a person who challenges others to participate in the visionary activity of defining “rightness” and preferred ways of doing and acting in education (1987, p. 51).



## **ROLE OF THE EDUCATIONAL LEADER**

Reflection on the good, vision of moral communities and policy development encourages further analysis of the roles and responsibilities of the educational leader at all levels of the health care system: micro—mentorship and role modelling, meso—within the health care organization and macro—national policy development. Bates poses valid questions:

What is the role of educational leaders to be? What sense of history might inform their understanding? What ideology might justify their actions? What vision of civilization might energize their work? What sense of motivation might shape their pedagogy (Bates, 2002, p. 139)?

Bottery (2002) contends that educational leaders need to foster a vision and transform their organizations by focusing on the following qualities: a belief in the need for a research-informed educational profession, the reassertion of the need for a centrality of debate about the values, and an ecologically driven view of the causes (2002, p. 157). Heifetz (1994) claims that a vital element of leadership is to support the development of organizational and cultural capacity to clarify values and purposes and understand the relationships between means and ends, including those found through the analysis of policies. Principal tasks for leadership are to help an organization find meaning and purpose (Handy, 1997, p. 381). Beerel (1998) claims that organizations need support to move from technical solutions to more meaning-filled solutions (1998, p. 16).

A valuable role of educational leaders is to increase capacity of citizens to “communicate their understandings to other people, and engage in the give-and-take of moral argument with a view to making mutually acceptable decisions” (Gutmann & Thompson, 1996, p. 359). Communities in general must continue to build and support this approach. Educational leaders can support society to widen the circle of involvement to include new and different voices (Axelrod, 2000; Deal & Peterson, 1999).

Building community involves creating a vision for the future and creating partnerships. It includes analyzing organizational processes and designing new organizational structures and processes (Axelrod, 2000). The model for change discussed by Axelrod is the “engagement paradigm” where issues are grasped; urgency and energy are profound; free-flowing information and cooperation emerge; broad participation develops; creativity is sparked; and capacity for future changes increases. “Successful strategy implementation requires people at all levels of the organization who care about the outcome, people who have the necessary ownership, commitment, and will to implement them” (Axelrod, 2000, p. 2).

The roles of the leader as both mentor and role model with teams are pertinent within various interdisciplinary health care settings:

The combination of qualities acquired for leadership in an interprofessional educational context must be similar to those needed in many others, but not in all. They would not all serve well in a surgical theatre. The most essential are, first, a clear

purpose—a vision—which can attract allegiance and be shared, because its meaning can be understood by all involved, despite different backgrounds. In the context of health and social care, the purpose must focus continually on the needs of vulnerable people, groups or populations and on the tasks of responding to or pre-empting them. Second, enthusiasm and commitment, which stimulates, without dominating, the contributions of others. Thirdly, open and consistent behaviour which creates trust. Lastly, energy, giving time and planning ahead (Horder, 2000, p. 205).

Educational leaders, formal and informal, need to recognize their responsibility to moral leadership. Professions require a self-critical examination motivated by ethical considerations. Uncritical acceptance of social mores has resulted in some of the horrors of history. Virtues demand a standing within the moral community. Aristotle, in his definition of virtue, focuses on two things: the good for human beings and the good of the work we do. Centuries later, many philosophers concur that “the excellence of human beings will also be the state of character which makes a person good and which makes that person do his or her work well” (Pellegrino & Thomasma, 1993, p. 85). Professional virtues entail a commitment to practice in an exemplary way. These include understanding new practices, researching and accepting responsibility for one’s own development. The professional virtues enable the development of professional community and help to counter bureaucratic and market change forces. Virtues are interrelated with principles and moral rules within a profession and the wider society in which the profession practices. While society is constantly evolving, some changes in the internal morality of a profession may occur. These may be required by public expectations; however, the profession should not be subject to the whims of society or by an uncritical acceptance of any societal change

(Pellegrino & Thomasma, 1993, p. 51). Professional health associations provide an avenue for the voices of health professionals to be heard at the macro level within the national and provincial policy arenas.

Pellegrino discusses the influence of the teacher:

*Clearly, the role of educators is to educate. In the influencing of decision making, they do this best by their personal example, by their activity within the institutions wherein they teach and, of course, by influencing future practitioners and leaders. This means authenticity within their own institutions, solid research and clear argumentation.*

*...If, as the 9-11 Commission put it—the character of the person is more important than the wiring of the institution—then we teachers must concentrate on making a good case for our students. They can change the culture of the institutions within which they work. To do this, they need secure knowledge of the directions these institutions should take and the character to learn wisely and well in the right directions (E. D. Pellegrino, personal communication, August 4, 2004).*

Educational leaders play significant roles in shaping the future to the advantage of groups with which they identify, an advantage they define in terms of the highest possible levels of morality and the broadest possible goals. Leaders and their followers share a particular set of motivations and values. To improve the larger social situation for which they have responsibility and over which they have influence, educators, as leaders, must extend awareness of human needs, help

define moral values, pose hard moral choices and encourage conflict and debate (Burns, 1978, p. 449). "Ultimately," Burns contends, "education and leadership shade into each other to become almost inseparable, but only when both are defined as the reciprocal raising of levels of motivation rather than indoctrination or coercion" (1978, p. 448). Leaders, facilitating learning, influence *ethos*, "the tone, character and quality of life, its moral and aesthetic style and mood... [as] the underlying attitude towards themselves and their world that life reflects" (Geertz, 1973, p. 127). Gillett emphasizes that the expectations of health care educators and leaders:

*Can help to create this atmosphere by exercising upon themselves those very techniques of care of the self and self-development that they are entrusted with imparting to their students (G. Gillett, personal communication, May 1, 2004).*

The responsibilities of the educational leader are paramount in building the moral community, essential to the good of health care. Storch illustrates this basic principle:

*...I like the term moral community because it is about "me" if you will. It is about how I participate in creating a community that is a virtuous community, one that supports people who are whistle blowers, who raise questions, who want to get us to think more widely than we do about ethical responsibilities. This involves extending those responsibilities in our minds and our practice, to the whole range of people we deal with (J. Storch, personal communication, October 20, 2004).*

Educational leaders, from professors to informal mentors, can promote a learning culture: understanding perspectives on learning (Jarvis, 1995, Kolb, 1984), supporting a range of adult learning approaches (Knowles, 1990) and fostering an ethos of life-long learning (Houle, 1980, 1984; Handy, 1994).

Mentorship continues to be a significant element of health care leadership. The history of the word “mentor” is instructive for several reasons as it underscores the legacy nature of mentoring.<sup>20</sup> The symbolism contained in this relationship is apropos to contemporary mentors. Effectual mentors are similar to friends in that their goal is to create a safe context for growth. They resemble family in that their focus is to offer an unconditional acceptance of the protégé. Superior mentors understand how adults learn. Like the first practitioner of their craft, mentors love learning (Bell, 2002, p. 6). Samier clarifies one role of mentorship as countering depersonalized elements of society:

Mentorship, as a formal educational instrument, has received increasing academic and professional interest since the mid-1970s. Its value varies and is interpreted differently according to one's disposition in either humanistic or positivistic directions. ...Promoting mentorship can be seen as a reaction to the negative effects of modernization produced by the alienating rationalization of social relations, and a challenge to the continued dominance of depersonalized structural, functional, and systems approaches to administration. Mentoring is thereby reflective of more humanistic approaches focussed on valuational, political, and cultural analyses, many of which are part of the post-modern critique. As a strong interpersonal relationship in professional development, it

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<sup>20</sup> “Mentor” comes from Homer's *The Odyssey*. As Odysseus is preparing to go off to the Trojan Wars, he realizes he is leaving behind his one and only heir, Telemachus. He hires a trusted elderly family friend named Mentor, who is both wise and sensitive, to be his tutor. Reminiscent of Odysseus, great leaders strive to leave behind value. Homer characterizes Mentor as a family friend who combined wisdom and sensitivity to convey knowledge and skills (Bell, 2002, p. 6).

lends itself to detailed study of subjective, symbolic, and context-dependent experiences from phenomenological and hermeneutic perspectives (2000, p. 97).

Although mentoring may be seen in a variety of different ways, it is always a one-to-one relationship, where the mentor seeks to assist the learner to reflect upon practice, learn from experience and improve (Jarvis, 1995; Knowles, 1990). Daloz (1986) believes that the significant role of mentors is to support, challenge and provide a vision. Heifetz (1994), similarly, contends that informal leaders with knowledge and skills are able to take personal responsibility for framing hard questions about purposes, possibilities and ethical decision-making. The mentor achieves this through an in-depth relationship—a primary experience—that makes mentorship important to professional practice and to life itself. Both mentor and mentee can gain from the relationship (Jarvis, 1995, p. 120).

Buber also emphasizes that it is the relationship that is important in mentoring. In his words, it is an “I-Thou relationship:”

I have characterized the relationship of the genuine educator to his pupil as being a relationship of this kind. In order to help the realization of the best potentialities in the pupil's life, the teacher must really *mean* him as the definite person he is in his potentiality and his actuality; more precisely, he must not know him as the mere sum of qualities, strivings and inhibitions, he must be aware of him as a whole being and affirm him in his wholeness. But he can only do this if he meets him again and again as his partner in a bipolar situation (1959, pp. 131-132).

From medieval guilds to the current professional bodies, role modelling as well as mentorship have influenced professional education. Within health care

education, a role model is “a person whose behavior in a particular role is imitated by others” (Merriam-Webster, 1989, p. 1021). Like the more formal role of mentoring, role models inspire support and influence the development of character as well as facilitate discussions of ethics. Klinge contends that “everyone involved in health care education should not only lead, but also serve as role models for their respective areas of interest and expertise (2000, p. 201). Role modelling is vital to the development of attitudes and ethos within a profession.

Like all professional education, medical training is more than just the passing on of knowledge and the teaching of skills. It is also the transmission of a whole set of attitudes that the profession has acquired over many years, attitudes passed on in many subtle ways by more experienced practitioners as they instruct the novice doctors under their tutelage. This set of attitudes may be described as the *ethos* of medicine. ...Ethos and ethics are not always the same thing and what has become accepted practice must be open to continual ethical scrutiny to ensure that the needs of the patient are truly served (Campbell, Charlesworth, Gillett & Jones, 1997, p. 17).

Lynch adds to the discussion of mentorship and role modelling:

*It seems obvious that tomorrow's leaders in practice must also have some kind of continuing encouragement to be as good as you can be in professional practice; these people should be challenged in some way to set high goals for themselves, even as they are given the support they require to begin to achieve those goals.*

*Even though there will be just a few individuals who can take on leadership roles in health care professional practice, these few individuals must remain close enough to their other peers so that*



*the leaders-to-be still have a good sense of what the group requires, and so that they will always have a sense of continuity with others in the goals they are trying to reach. Again, this will require guidance and assistance from current professional leaders* (A. Lynch, personal communication, February 13, 2004).

Stewart et al. describe the learner-centred method as a way to support mentorship within the health professions. This consists of six interactive components: exploring learning needs and aspirations; understanding the whole person; finding a common ground; incorporating prior knowledge; enhancing the teacher-learner relationship; and being realistic (1995, p. 144). They emphasize the *metaphor of dialogue or conversation* with roots in the Socratic method and the humanist tradition. In this metaphor, students and teachers are inquirers, assisting one another in the pursuit of truth, engaged in a joint enterprise of acquiring knowledge (1995, p. 119). Education is something we neither “give” nor “do” to our students. Rather, “it is a way we stand in relation to them” (Daloz, 1986, p. xv).

Educational leaders are able to influence students, colleagues and communities to ‘higher’ values, whether in universities or the informal continuing learning environment. The influence of experts, those prominent individuals by virtue of their expertise, must be significant—seed carriers of new ideas, new paradigms—to counter the momentous challenges due to corporatization of the education system and increasing bureaucratization; to encourage language that will serve as a vehicle for ethical reflection and give voice to ethical concerns.

Jonsen suggests that people working in ethics can make a significant contribution to provide a language and a setting for working on ethical problems:

*...Parties struggling to find a way of saying what they knew to be true were helped when language was given to them, when we pulled out of the philosophical discourse language like respect for persons and made that a key element, when we were able to criticize the inadequacy of utilitarian approaches which of course can lead to a lot of abuse (A. R. Jonsen, personal communication, April 29, 2004).*

The notion of organizational ethics is a relatively new field of study that is pertinent to this work from several perspectives. One issue concerns the ethical environment of education and training of students in Canadian educational centres. Other issues are the relationship among core values, policies and practices in the health field. Current research emphasizes interdisciplinary and inter-professional work in effective organizational ethics (Kenny, Downie, Ells & MacDonald, 2000, p. 141). There is a “need for research and reflection on the identification of ‘core values’ and methodologies to facilitate and promote the incorporation of these values in policy development at all levels of healthcare decision-making” (Kenny et al., 2000, p. 144).

Leadership in health care has a critical role to play in policy development. In policy making, many different cultural communities come together as political communities of citizens. Because “policy can happen only in communities, community must be the starting point as polis. Public policy is about communities

trying to achieve something as community” (Stone 1993, p. 18). According to many commentators, without a background of commonality and without some form of civic responsibility, autonomy degenerates into mere special insistence, and loses its deeper significance (Kingwell, 2000; Pellegrino & Thomasma, 1993; Taylor, 1991; MacIntyre, 1998). A strong notion of commitment to other people and shared undertakings is vital, “a sense that we are together creating a just world,” a world not ruled by acceptance of inevitability or superiority of wealth (Kingwell, 2000, p. 15). This thesis argues that the Canadian health care system is threatened with losing its sense of moral community and ethical commitment. Through the pervasiveness of bureaucratic and economic values of modernity, a unique challenge affords itself in public policy, where differences must be taken into account, where sufficient agreement must be achieved to allow public policy to be formulated for everyone. “Inevitably and inextricably, policy is about shared values just as policy is about value conflicts” (Kenny, 2002, p. 205). In Canada, health care policy has been a priority since the establishment of medicare. These issues are further discussed in Chapter Five.

## **CHAPTER FIVE ILLUSTRATIVE CASES**

Public policy in health care is a vital dimension of this thesis, since it is a primary avenue through which leadership expresses itself. This chapter opens with reflections on essential components of policy development and new perspectives on ethical frameworks for development and analysis that provide contextual background for two illustrative cases. The recent *Commission on the Future of Health Care in Canada* is analysed for purpose, process and outcomes. The Dr. Nancy Olivieri case examines the challenges of professional and organizational leadership within a university environment. Both cases demonstrate the continued “quest for the good” in conflict with the malaise of modernity.

### **REFLECTIONS ON POLICY DEVELOPMENT**

Policy development is a multidimensional, dynamic and incremental process embedded within social contexts and institutional traditions (Howlett & Ramesh 1995; Parsons, 1995). Excerpts from an interview of Dr. Abbyann Lynch, a Canadian health care ethicist, exemplify significant aspects present in political philosophical frameworks—language, discourse, expanding conversations and new understanding. Echoes of conversations of past scholars are heard in the reflections of Lynch as she discusses issues, challenges and approaches to

health policy development. The significant themes arising from her reflections on the topic of health care policy development include leadership, continuing education, directed focus to build expertise, teams and dialogue. These essential elements for successful policy development are pertinent whether considering an organizational policy for a local health care facility, a national policy or an international code of ethics (see UNESCO<sup>21</sup>). They include philosophical and practical aspects.

Lynch identifies several requirements for leaders involved with policy development. These include understanding the related role of ethics within the care team, the mission of the organization, the professionals involved, related science, legal issues, as well as the relevant ethical theory of practice. Attention to and integration of these elements supports successful policy development:

*First is the matter of knowledge. So as to be involved effectively in the matter of policy formulation, review, enforcement, etc., leaders must know the science in question well, as well as the focus for the professional group in this area. They must know the institutions involved well (for example, health care at the national or provincial or agency or professional level). There must be some acquaintance with the law guiding this area, or at least access to direction in this matter. This all implies a good grasp of what is possible/probable in the area of action under consideration. Most importantly here, when setting policy, or attempting to ensure its observance, one must know the mission and values of the constituency involved as well*

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<sup>21</sup> See the following Web site, as Canada is a signatory: UNESCO Ethics Home Page:  
[http://portal.unesco.org/shs/en/ev.php-URL\\_ID=1837&URL\\_DO=DO\\_TOPIC&URL\\_SECTION=201.html](http://portal.unesco.org/shs/en/ev.php-URL_ID=1837&URL_DO=DO_TOPIC&URL_SECTION=201.html)

*as the values and goals of those directly involved in the policies' implementation. Second, with attention to the area of health care ethics, and the questions of health (care) reform and social justice issues more particularly, leaders must have an adequate acquaintance with relevant ethical theory, as well as some experience in the matter of health care ethics in practice. Needed, too, is a certain sense of the general areas of ethical concern here, and the ability to foresee how these might play out in the matter of practice. ...Attention to all these matters helps to make the resulting policy-document well-grounded, ethically speaking; even as it helps ensure relevance and completeness regarding practice (A. Lynch, personal communication, February 13, 2004).*

The discussion continues with a review of policy within an organization:

*In ethical terms, policy is concerned with the application of principles to practice in a very individual milieu. Policy directs specific actions in a specific way for a particular place. Guidelines, in contrast to policy, direct action within a set range of options, so as to meet a stated goal. Guidelines thus may have a wider sphere of influence than policies.*

*A first consideration here: policy in one place, hospital "X," for example, may not be identical to policy in hospital "Y:" similar, perhaps, but not identical. Why? Patients are of a different kind (children, not adults); mission may be different (a religiously-based practice in one case, not the other); staffing may differ by culture (for example, language and experience differ). Thus, while the policy regarding action in a fire emergency may have a similar goal (safety first) everywhere, the way in which this is to be carried out in "X" and "Y" differ. A more general difference here: policy will also*

*be coordinated with the legal requirements of the area, for example, the policy regarding consent for medical intervention in the care of cognitively-impaired persons may differ between hospitals “X” and “Y” because these hospitals are in different provinces and provincial laws may differ regarding consent for intervention (A. Lynch, personal communication, February 13, 2004).*

Essential ingredients for successful policy development within organizations are commitment and varied expertise that culminates in collaboration. Lynch describes how a team approach supports the writing of policy. The range of dialogue involved in learning the new language of other disciplines is central to understanding and bringing together a variety of expertise. At the outset, each discipline needs to learn something of the other’s discipline and understand the language of the others. Thus, the process may involve learning a new “language” and sharing knowledge in order to collaborate. She clarifies the need for collaboration with those directly involved in the disciplines concerned, as well as those affected by their practice:

*Policy requires input from many resource persons, and the better they understand each other and work together, the more helpful their endeavours will be. This means that ethicists never work alone, and that professional practitioners do not, either. The resulting policy will be the better for the effort this collaboration demands (A. Lynch, personal communication, February 13, 2004).*

Lynch’s overview of the contextual features and leadership requirements for policy development demonstrate many of the concepts and values discussed in

earlier chapters. These include understanding the role of ethics in policy development and that policies involve a social contract. Also central to successful policy development is the need for dialogue, collaboration and understanding. Former Commissioner Romanow furthers the discussion by expanding on the challenges for policy development due to the various health care disciplines:

*In the health care field, the disciplines are so many and varied and so technical and scientifically oriented that the disciplines tend to be focused very much within a very narrow band of interest. That band of interest, of course being the particular field of expertise. ...It's still at the end of the day a part of a larger role that they have as citizens in a civil and hopefully compassionate society. It is the latter part that they must concentrate as much as they do on their specific discipline ... there needs to be a greater awareness of the civil responsibility.*

*... I see before us a larger fundamental debate about the nature of Canadian society surrounding the issue of whether or not health care is viewed as a public good and therefore the responsibility of all of us or whether it is viewed as a commodity and something that is bought and sold like a car. I have found that to be one of the biggest challenges of the whole business of trying to get the large elements, the larger elements, as I would see them in any event for reform, implemented, and the vision implemented (R. Romanow, personal communication, May 19, 2004).*

Kenny et al. reiterate the theme that it is essential to ground policy in clear and consistent values, and also focus on the interplay among the various levels—



federal, provincial and local—of health care policy-making. “In Canada, the general principles of the *Canada Health Act* help to shape the particular policies and practices of institutions, which, in turn, influence bedside decisions” (2000, p. 141). These authors note that every level of health care addresses fundamental questions such as accessibility that involve “fundamental conceptual issues that require reflection and in-depth analysis” (Kenny et al., 2000, p. 143).

Recent policy research in North America and Europe includes a “view on the values and ethical issues that are at stake in efforts to rationalize<sup>22</sup> health policy on the basis of economic evaluations (like cost-effectiveness analysis) and randomly controlled clinical trials” (Biller-Andorno, Lie & ter Meulen, 2003, p. 261). Hoedemaekers claims that, during the last decade, health technology assessments have influenced choices made. These were based on “hard evidence,” “technical” criteria like effectiveness and cost-effectiveness of health care services (2003, p. 275). Although the prominent discourses are predominantly “technical” and “procedural,” ethical factors such as access and equity often operate at the level of a “hidden curriculum” (2003, p. 277). Research exposes the “hidden curriculum” of normative judgements in order for these judgements to be discussed as an explicit part of priority setting (Hoedemaekers, 2003, p. 278). Other authors also use the “hidden curriculum” notion to discuss the nature of resource allocation processes and the role of

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<sup>22</sup> “Though such rationalization was generally seen as an objective and ‘value free’ process, moral values often play a hidden role, not only in the production of ‘evidence’, but also in the way this evidence is used in policy making” (Biller-Andorno, Lie & ter Meulen, 2003, p. 261).

hidden political factors in play in shaping resource allocation policies (Wirtz, Cribb & Barber, 2003, p. 295). This discussion supports earlier ones of clarity, transparency and an ethical framework for policy development.

Malone considers what it means to talk about health policy as a “product” and what kinds of ethics and policies emerge from such a conceptualization of policymaking. She asks, “What is left out? What is left in? Who is best served? What is rendered invisible” (1999, p. 16)? Her response is that the major deficiency in the product-market metaphor rests in the moral dimension. The market appears to have no concept that corresponds to policy’s moral mandate to appreciate problems from the perspective of those affected (Malone, 1999, p. 20).

The market metaphor constrains in various ways our vision of the goals we pursue in making health policy, of the options available to us in pursuing them, indeed—because policy implies a certain view of moral agency—of the way we relate to each other (Malone, 1999, p. 16).

The exploration of underlying values of policies is increasing as “policy researchers more often recognize that ideologies and values are embedded in the evidence that informs causal arguments and policy choices” (Kenny & Giacomini, in press, p. 3). Related to this discussion is the role of bioethics. While policy analysis is expanding its instrumental view to include ethics and values (Kenny, 2002; Malone, 1999), so too has bioethics expanded its view to include research on public policy, recognizing that clinical bedside ethical issues and

dilemmas are inherent within institutions and systems of care (Kenny & Giacomini, in press).

Canadian patients, families, health professionals and public officials bring passion to the issue of health care and its reform. “It makes eminent sense that a key public policy such as medicare resonates with society’s sense of the right thing to do and the right way to be as Canadians” (Kenny, 2002, p. 45). The underlying vision and values of Canadian health care were discussed at the national level in the work of the Royal Commission on the Future of Health Care in Canada. The process—a variety of methods—used by this commission to investigate health issues, a “collective authority,” asked Canadians to propose solutions to the challenges facing our health care system.

### **THE ROYAL COMMISSION ON THE FUTURE OF HEALTH CARE IN CANADA**

Both the “quest for the good” in Canadian health care and aspects of the malaise of modernity are illustrated in the review of the Royal Commission on the Future of Health Care in Canada. This section commences with a brief historical overview of medicare, epitomizing a leadership that brings forward the best in people that Burns describes as “the genius of leadership” (1978, p. 19). The Commission, in its working report, particularly tackled the malaise problem as it compromises this heritage.

## **CANADIAN HEALTH CARE: HISTORICAL HIGHLIGHTS**

Understanding the historical development of medicare and the values and interests, which dominated that development, is essential for our current reflection (Kenny, 2002, p. 46).

The history of Canadian medicare (Badgley & Wolfe, 1967; Shillington, 1972; Taylor, 1978) provides insight into why the system developed as it did and some of the underlying social, moral, scientific and medical values. The following brief review outlines the critical context in which the fundamental values, corresponding to the above discussion of moral elements of the good and the common good evolved, embodied in the health care system. The type of leadership necessary for bringing this public policy to fruition is apparent in many significant historical changes; the leadership of a few individuals—from Tommy Douglas to Emmett Hall—was paramount to bring forward the desired change.

The story of Canadian medicare begins in the difficult times following World War I, when “there was considerable concern that the poor health of soldier-conscripts was directly related to poor health care” (Kenny, 2002, p. 47). In 1919, Mackenzie King advocated “health insurance” as federal Liberal Party policy; however, it took several decades for it to become a reality. A general economic depression “fundamentally altered both the state’s and the medical profession’s perspective on health insurance” (Bothwell & English, 1981, p. 482). During the 1930’s, when an economic depression settled over the country, a common conviction developed that extensive social services should be the right of citizens without the indignity of welfare and means testing. For example, “because of the

harsh climate, rural isolation, and mixed population, the people of Saskatchewan—the settlers of the ‘last best west’—from early on became used to helping each other through collective and co-operative action” (Badgley & Wolfe, 1967, p. 3). The Conservative party in 1934 also advocated a federal role in establishing health services; however, the proposed reforms did not come to completion (Leatt & Williams, 1997, p. 3). During the major depression of the 1930s, the Canadian Medical Association began to perceive health insurance as an antidote for difficult economic situations (Bothwell & English, 1981, p. 482).

After World War II, the health of Canadians emerged yet again as a public issue, taking its “place on the national political agenda,” solidifying a common belief that government “should act to prevent the catastrophic consequences to individuals of accidents, disease and disability” (Leatt & Williams, 1997, p. 3). The stage was now set for major reform of health care. It is significant to note that there was a developing consensus that state intervention was more efficient than the market for delivering public goods. The market’s “slow, haphazard process ... had been exposed in the inter-war period” (Panic, 1995, p. 38).

On to the stage strode a central character, Tommy Douglas, Premier of Saskatchewan from 1944 to 1961, one of the individuals with a vision and courageous initiative that “changed us as a nation and cemented our role as one of the world’s compassionate societies” (Canada, 2002, p. xxi). Douglas’s commitment to a universal public health care system rose from his philosophy as a social democrat, and from his personal experience related to childhood illness.

Douglas believed that every civilized society owed its citizens health care and introduced universal hospital insurance in Saskatchewan in 1947 with a prime goal to eliminate the financial barrier between those providing, and those receiving, the service. The first element to be covered was hospital care, because of the need to develop physical facilities with sophisticated technology. He requested federal financial assistance from Prime Minister Louis St. Laurent. In 1957, "the federal fifty-percent contribution to hospital care provided a windfall that allowed Douglas to proceed with his dream of a more comprehensive system" (Kenny, 2002, pp. 49-51). Douglas then attempted to introduce government management and government payment of medical services. The medical profession, through the Canadian Medical Association, demanded input that the government refused and, in 1962, the doctors went on "strike." The issue was eventually resolved with the expansion of medical coverage. Finally, a new system of health care delivery developed with universal coverage by the state but with patients free to choose their own doctors (Tuohy, 1999, pp. 203-204).

During this period, an increasing number of Canadians across Canada received some coverage for medical care through insurance plans, some initiated by physicians, others by unions, and at times by both, especially in the industrial areas of the country. Nonetheless, small organizations and the self-employed still lacked coverage. By the early 1960s, health care management had become an increasing political issue. Conservative Prime Minister John Diefenbaker appointed Emmett Hall, a Justice of the Supreme Court of Canada and his personal friend, who had been involved in medical and hospital matters most of

his life in Saskatchewan, to be a sole Royal Commissioner on Health (Taylor, 1978, p. 342). The Report of The Royal Commission on Health in June 1964 recommended a universal, compulsory, tax-supported health plan. The “five pillars” enunciated by Emmett Hall—portability, public administration, universality, accessibility and comprehensiveness—remain the basic principles that underlie Canadian medicare. The primary goal of medicare for the Canadian “community” was clearly stated in the Report:

The field of health services illustrates, perhaps better than any other, the paradox of our age, which is, of course, the enormous gap between our scientific knowledge and skills on the one hand, and our organizational and financial arrangements to apply them to the needs of men, on the other. What the Commission recommends is that in Canada this gap be closed, that as a nation, we now take the necessary legislative, organizational and financial decisions to make all the fruits of the health sciences available to all our residents without hindrance of any kind (in Taylor, 1978, p. 342).

The government under Prime Minister Lester Pearson passed the *Medical Care Insurance Act* (medicare) in 1966 embodying the principles of the Hall report. Part of the arrangement had the federal government agreeing to fund half the cost of physician services in provinces with a universal health care plan (Kenny, 2002, p. 55). A few provinces demurred, citing provincial autonomy, but by 1972 all the provinces had accepted the arrangements and Canadian medicare was fully functioning.

In 1977, motivated by the rapidly expanding rate of health costs, Pierre Trudeau’s Liberal government changed the funding policy from a 50:50 percent

cost-sharing formula, which had initially enticed provinces to join the medicare scheme, to block funding by which provinces received a fixed sum annually through the *Established Program Financing Act* (EPF) for both health and postsecondary education. Canadian health care was thereby “drastically altered” (Taylor, 1978, p. 415). The provinces were no longer required to allocate a specific amount to health care as they were with the cost-sharing formula. The cost of medical care increased dramatically over the next twenty years, due in large part to advances in medical care, technology and inflation. The issue of funding and adequate services for health care arose: the provinces complaining that federal contributions to health care were steadily decreasing; the federal government claiming that their contributions were not fully used by the provinces for health.

Reports such as the Sinclair Commission in Ontario (Sinclair, 1999), the Clair Commission in Quebec (Québec, 2001), the Fyke Commission in Saskatchewan (Saskatchewan Commission on Medicare, 2001), and the Kirby Senate Report (Canada, Senate, 2001), clearly stated the need to find alternatives to providing health care services differently. In addition to the significant financial concerns, these reports and others have cited a range of issues such as the aging population, spiralling drug costs, the need to reduce unintentional error and waste, more collaboration with other policy decision areas, and improved sharing of information. Other themes include the need for a health system infused with a quality culture and the continuous pursuit of quality as the basis for innovation and excellence (Harrigan, 2000). The original underlying values of Canadian



medicare were voiced across all reports; however, recommendations for change were case-specific. “Only the Mazankowski Commission’s proposals constitute a real (if veiled) effort to transform the values on which Medicare operates” (Marmor, Okma & Latham, 2002, p. 7). Recommendations of this Report include exploring choice and competition between providers, new methods of payment and of revenues, blends of public and private facilities for delivery of service, and more options to contract with a variety of providers and organizations. Many of these recommendations are in keeping with a libertarian and individualism framework that focuses on the benefits of the marketplace. The Mazankowski Report concludes: “...If actions are not taken to make changes in critical areas ... pressures will mount to look for new options outside the limitations of the Canada Health Act (Alberta, 2001, p. 72).

From the “great leap” of medicare several decades ago, there have been profound changes in both Canadian society and medicine. These changes are interrelated—an increase in urbanization and globalization, as well as “individualism,” a more powerful and pervasive medical science and technology—major forces which influence health care in the 21<sup>st</sup> century (see Kenny, 2002, p. 64; Somerville, 1999). The communitarian-libertarian political philosophical debate becomes central once again. As discussed in Chapter Two, there are a number of predicaments that arise from the libertarian framework.

Marmor et al. claim that the “public devotion to medicare values has grown over the life of the program,” and that these values have been critical in shaping the

program (2002, p. vi). This relates to the notion discussed earlier in Chapter One that the type of health care system a nation selects relates in part to the “dream” of a nation, and that Canadians are in the midst of a trans-Atlantic debate—the “American dream” of individual fulfilment versus the “European dream” of community (Rifkin, 2004). Lewis passionately recounts the virtues of Canadian medicare, clearly focusing on the common good (2004, p. 600):

First, it is that rare form of achievement: social justice combined with administrative efficiency. Although somewhat imperfectly (which is inevitable), it allocates service on the basis of need, not ability to pay. It reduces paperwork, lowers transaction costs, and frees personnel and programs to concentrate on delivering care, not fretting over coverage or itemizing the costs of the tissue paper and syringe.

Second, it signals that health care is a public good, not a market-driven commodity. One crucial element of a public good is the duty to use it prudently, manage it effectively and preserve its accessibility to everyone. To be sure, some aspects of health care have become commodified: heavily marketed drugs, ultrasound “movies” for the prenatal scrapbook, prestige once-overs including whole-body scans. This trend is precisely the problem. More is taken to mean better; utilization mistaken for effectiveness. Keeping health care public is the only way to challenge the more-is-better fallacy that is the real enemy of sustainability.

Third, it creates a community of interest in, and collective judgements about, access and quality. It places all Canadians in the same health care boat, irrespective of their wealth or station. If the well-off want a better system, it must be better for all. If it requires more tax dollars, governments have a warrant to raise taxes. In a world of hundreds of television channels and isolating technologies, medicare demands a solidarity that transcends class and region (Lewis, 2004, p. 600).

Nonetheless, many issues intrude, most with significant financial considerations.

As the federal government dealt with record budget deficits in the early 1990s, it

reduced monies transferred to the provinces for health purposes, resulting in increased complaints about lack of financing and in access (particularly waiting lists) to health care. During this period of time, health costs rose because of new technologies, new drugs and an aging population. “While most Canadians—80 per cent according to Statistics Canada—are satisfied with their access to the health care system, many experience long waits to see a specialist, receive diagnostic tests and undergo elective surgery. Others find themselves facing huge bills for prescription drugs they need to survive” (CBC News Online, 2004). These are areas calling out for reform. The *Canada Health Act* again became the focus of a lively debate.

#### **THE PURPOSE AND PROCESS OF THE COMMISSION**

In 2001, Liberal Prime Minister Chretien appointed Roy Romanow, former NDP Premier of Saskatchewan, to lead *The Commission on the Future of Health Care in Canada*. The purpose of the Commission, as described in a letter from the Privy Council, was “to inquire into and undertake dialogue with Canadians on the future of Canada’s public health care system, and to recommend policies and measures respectful of the jurisdictions and powers in Canada required to ensure over the long term the sustainability of a universally accessible, publicly funded health system, that offers quality services to Canadians and strikes an appropriate balance between investments in prevention and health maintenance and those directed to care and treatment” (Canada, 2002, p. xi). The Commission sought a comprehensive, inclusive and consultative process with

significant dialogue. The Commission team, in an effort to assemble the best available evidence, used a variety of methods including analysis of existing reports on medicare, submissions invited from interested Canadians and organizations, expert roundtable sessions and site visits commissioned, both in Canada and abroad, independent experts commissioned to conduct original research to clarify understanding of key issues where identified knowledge gaps or fresh perspectives were needed, and discussions with Canada's foremost health policy experts. The result was a process in which citizens were given both the time and the information to deliberate difficult choices. There were opportunities for Canadians to discuss the issues and present their opinions. "Tens of thousands of Canadians participated," discussing passionately and thoughtfully how to preserve and improve the system (Canada, 2002, p. xv).

The moral authority of collective judgments about policy depends in part on the moral quality of the process by which citizens collectively reach those judgments. Deliberation is the most appropriate way for citizens collectively to resolve their moral disagreements not only about policies but also about the process by which policies should be adopted. Deliberation is not only a means to an end, but also a means for deciding what means are morally required to pursue our common ends (Gutmann & Thompson, 1996, p. 4).

Taylor claims that in order to bring people "with differing moral sources into coalitions supporting agreed-upon political or social programs, we must take into account the different kinds or moral sources that are animating the people" (Taylor, 1994, pp. 184-185). He calls the awareness of pluralism an Aristotelian insight "which has tended to get lost in modern philosophy;" that there is always a

plurality of goods, vying for allegiance. Kingwell (2002) adds to the discussion that: “Not even Aristotle expected to find the good without reference to the view and actions of those around him” (2002, p. 111). Relating this to the Canadian process, Abelson and Gauvin (2004) contend that citizen engagement mechanisms in the Canadian health care system are in an early stage of development (2004, p. 3). The citizen dialogues of the Royal Commission generated great enthusiasm. One format of the dialogue involved twelve groups of 40 citizens, selected to represent the Canadian population.

They took their challenge seriously, they learned a great deal from each other, and they came to terms with the choices in ways that would astonish many political leaders and technical experts in health care. Citizens were quick to grasp the budgetary and technological pressures we face, and yet they were able to grasp the budgetary and technological pressures we face, and yet they were able to articulate a set of values-based choices about a system that is immensely important to them. They were remarkably pragmatic and clear about the choices (Maxwell, 2002, pp. 1543-1544).

The Commission set a new standard for transparency by releasing, in advance of its final report, all of the submissions it had received, the research it had commissioned and summaries from all of the consultative activities in which it had been engaged. As a result, the process included 21 days of public hearings in 18 cities, receipt of 640 formal submissions and over 7000 letters, preparation of 40 peer-reviewed discussion papers covering a wide range of topics and 45 speeches by Romanow. Commissioner Romanow summarized the process as:

I had the privilege of leading one of the most comprehensive, inclusive and successful consultative exercises our country has ever witnessed (Canada, 2002, p. xv).

The result of the Romanow Commission was verification that many Canadians strongly support the core values on which the health care system is premised—equity, fairness and solidarity—values tied to their understanding of citizenship. Equal and timely access to medically necessary health care services on the basis of need continues to be seen as a right of citizenship, not a privilege of status or wealth; Canadians “view their health care system as a national program, delivered locally but structured on intergovernmental collaboration and a mutual understanding of values” and want policies and programs that define medicare to remain true to these values (Canada, 2002, p. xvi). Romanow acknowledges, however, that health reform is essential on a national basis in order to avoid 13 clearly separate provincial and territorial health care systems, each with differing methods of payment, delivery and outcomes (Canada, 2002, p. xviii).

One of the 40 peer-reviewed discussion papers submitted to the Romanow Commission examined national values:

“Values” are subjective views of individuals about what is worthy or important. In politics, these are views about the ends that social institutions ought to advance, and the virtues they ought to embody. Values are general; they do not dictate preferences for particular institutional structures at any level of detail. Values also compete with one another. Multiple institutional arrangements may thus embody the same values, by giving prominence to them differently. But values may nonetheless play an important role in creating a

political community and in guiding its actions. Values are not a policy straitjacket, but there are certain choices they rule out. In the context of the Medicare debate, Canada's core national values have been well expressed by Michael Ignatieff: "We [Canadians] think that public taxation should provide for health care and that it is wrong for decent medical care to depend on the size of our bank balances" (Marmor et al., 2002, p. v).

Marmor et al. report that "data from OECD countries and evidence from Canada support our claim that national values and program structure in medical care are only loosely associated." There are various institutional forms that are consistent with broadly shared Canadian national social values. These authors reiterate that reform is how best to embody those values in 21<sup>st</sup> century (Marmor et al., 2002, p. vi).

#### **THE ROADMAP PROPOSED**

Amidst the significant influences of modernity, health care reform is underway with the expectation that governments, caregivers and Canadian citizens can work together for renewal. The Report of the Commission, *Building on Values: The Future of Health Care in Canada*, was submitted after 18 months of study. In the introduction to the Report, Romanow claims, "The reality is that Canadians embrace medicare as a public good, a national symbol and a defining aspect of their relationship. I am therefore recommending a series of measures to modernize the legislative and institutional foundations of medicare..." (Canada, 2002, p. xviii). The goal is to transform it into a system that is more responsive, comprehensive and accountable to all Canadians, with all involved working

collaboratively to deliver integrated needed services along the continuum from prevention and promotion through to end-of-life care (Canada, 2002).

47 recommendations “serve as a roadmap for a collective journey by Canadians to reform and renew their health care system. They outline actions that must be taken in 10 critical areas, starting by renewing the foundations of medicare and moving beyond our borders to consider Canada’s role in improving health around the world” (Canada, 2002, p. xxiii).

The Report, produced through a systematic and rigorous process of evaluation, contains major areas of comprehensive discussion and recommendations: sustaining medicare; citizenship and federalism; information, evidence and ideas; investing in health care providers; primary health care and prevention; improving access; ensuring quality; rural and remote communities; home care; prescription drugs; a new approach to aboriginal health; and global issues. The implications for values identified in previous chapters on moral dimensions and leadership underscore the discussion. The following section draws upon significant themes and key recommendations of the Report, beginning with a focus on values and vision.

A number of the Commission’s recommendations are directly related to retaining and/or reinforcing the vision and values of health care in Canada. Of prime significance are the proposed new Covenant and the Health Council. The



establishment of a new Canadian Health Covenant would be a “tangible statement of Canadians’ values and a guiding force for our publicly funded health care system” and “would confirm our collective vision for the future of health care in Canada and clearly outline the responsibilities and entitlements of individual Canadians, health providers, and governments in regard to the system” (Canada, 2002, p. xxiv). The creation of a Health Council of Canada would facilitate collaborative leadership in health by fostering collaboration among provinces, territories and the federal government.<sup>23</sup> The Report recommends that the Health Council of Canada hold a National Primary Health Care Summit to mobilize action, measure progress and report regularly to Canadians (Canada, 2002, p. xxviii).

Canada’s health care system has served Canadians well and is as sustainable as Canadians want it to be. In addition to the imperative for social consensus for a public health system, the issue of sustainability needs to be assessed from three dimensions—services, needs and resources. Effective governance is needed to bring equilibrium between these discussions (Canada, 2002, p. xxiii).

Sustainability of the health care system is a complex and thorny issue. Concerned that this significant issue has often focused only on finances, which does not enable an overall assessment, the Report provides a broader perspective to inform the debate. The need to clarify sustainability was apparent

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<sup>23</sup> “The Council would play a key role in setting common indicators and benchmarks, in measuring and tracking the performance of the health system, and in reporting results regularly to Canadians. Because of the important role of the Council in measuring results, the Canadian Institute for Health Information (CIHI) should form the backbone for the proposed new Council” (Canada, 2002, p. xxiv).

as the word itself can obscure the debate because of “multiple interpretations and misinterpretations” (Canada, 2002, p. 1). The Report examines sustainability from the dimensions of services, needs and resources. Maintaining adequate resources is “a deliberate act of will on the part of society and, thus, it is the overall governance of the system at all levels that ultimately decides how these elements are balanced.” The Report emphasizes that, “There is no ‘invisible hand’ that silently and unobtrusively keeps these elements in balance” (Canada, 2002, p. 2).

The high degree of costly sophisticated technology has raised core questions for a debate around “want” versus “need” regarding what specific services should be covered by health insurance. Clarity on the nature of health needs and the values-laden component of resource allocation is required before agreement on specific decisions relating to the provision of services and the response to individual needs can be reached. Veatch makes this point adamantly: “There will always be more demands for healthcare services (some of which are quite marginal) than there are resources. Limits are thus morally necessary” (2003, p. 127). As reform options are proposed, the lens of justice is a crucial one to view the choices.

Regarding services and sustainability, the Report concludes that more needs to be done to ensure timely access to quality services. “The answer, however, is not to look to the private sector for solutions. Instead, governments should seek the best solutions within the public system and ensure that adequate resources are

available and services are accessible to all” (Canada, 2002, p. 8). In the private for-profit versus public debate, the Report evaluated arguments for more private for-profit service delivery to bring more resources, choice and competition into the Canadian health care system and to improve its efficiency and effectiveness. The Report was clear in its final analysis that private for-profit delivery runs counter to Canadians’ values, is inequitable and less cost-effective than public delivery. The Commission concluded that direct health care services should be delivered in public and not-for-profit health care facilities (Canada, 2002, pp. 6-7).

The Report contends that, based on evidence both in Canada and internationally, progressive taxation continues to be the most effective way to fund health care in Canada. The consultations of the Commission with Canadians such as Citizens’ Dialogue confirmed that, “the large majority of Canadians do not want to see any change in the single-payer insurance principle for core hospital and physician services.” A strong consensus remains among Canadians that “ability to pay” should not be the predominant factor in how key aspects of the health care system are funded, namely hospital and physician services. “Our tax-funded, universal health care system provides a kind of ‘double solidarity.’ It provides equity of funding between the ‘haves’ and the ‘have-nots’ in our society and it also provides equity between the healthy and the sick” (Canada, 2002, p. 31). The principles of the “common good” and community are evident in the Canadian goals.

A number of recommendations relate to integration and expansion of services. The goal is for Canadians to have access to an integrated continuum of care 24 hours a day, no matter where they live. Funding to accelerate primary care beyond the stage of pilot projects to achieve permanent and lasting change should be provided by the new Primary Health Care Transfer.<sup>24</sup> A Home Care Transfer is proposed to ensure that all Canadians have access to essential home care services. Coverage for palliative home care services to support people in their last six months of life is also recommended, along with a new program to provide ongoing support for informal caregivers (Canada, 2002, p. xxxi).

Underlying values of respect and dignity are apparent in the section of the Report which discusses diversity, recognizing the challenge and goal of delivering care to “match the needs of different groups of Canadians, from men and women, to new Canadians, to visible minorities, people with disabilities and others” (Canada, 2002, p. xxx).

The Romanow Report recognizes problems in Canada’s health workforce as a result of continuing changes in how health care services are delivered combined with cost cutting measures for the past two decades. “Although the problems differ for different health care providers, the malaise is widespread and, in some cases, it has moved from mere discontent to outright anger and frustration”

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<sup>24</sup> The Primary Health Care Transfer defines primary health care across Canada with four essentials: “...continuity of care, early detection and action, better information on needs and outcomes, and new and stronger incentives for health care providers to participate in primary health care approaches” (Canada, 2002, p. xxviii). The Report recommends expanding services beyond hospitals and physicians to include diagnostic services and priority home care services (Canada, 2002, p. xxiv).

(Canada, 2002, p. 91). Significant attention was paid to the need for support and education of health care professionals to meet emerging needs. Education programs require a new focus on integrated, team-based approaches in order to meet health care needs and service delivery. These efforts for change can be assisted by the Health Council of Canada (Canada, 2002, p. xxvii). Education and human resources strategies to address the supply, distribution, education, training, and changing skills and patterns of practice for Canada's health workforce affect all provinces and territories; collaboration is vital.

The Romanow Report clearly situates health care as a human right within the public sphere, and not as a commodity of the marketplace. It aims to curtail commercialization and the privatization of health care. In spite of shortcomings, the Report is considered a milestone by many for its comprehensive vision of health care for Canadians.

Canada's Medicare program has retained its iconic status during several years of intensive scrutiny. It is still defended as embodying our national values and is held out by some as a feature that differentiates us from our neighbors in the United States (Detsky & Naylor, 2003, p. 809).

Responses to the Romanow Report were generally positive. The shortcomings as identified by particular organizations related to their area of interest in health care. For example, reports from national Canadian unions supported the recommendations opposing privatization and for-profit health care, urging primary care reform and new coverage for home care. They disagreed with the

Report's view, however, that ancillary services could be delivered by the private sector. The National Coordinating Group on Women and Health Reform and the Canadian Women's Health Network, while endorsing the Report, criticized it for failing to "recognize the significant ways in which health care is an issue for women" (2002, p. 37). Gutkin, Executive Director and Chief Executive Officer of *Canadian Family Physician*, supports many recommendations of the Romanow Report, but contends that it "falls short" by not addressing more fully issues around health human resources and the infrastructure of hospitals and acute care (Gutkin, 2003, p. 14).

The major criticisms, as expected, came from those with a neoliberalist perspective, exemplified in a response from the Fraser Institute. It argued that Canada should permit user fees and a second tier of private medicine, including hospitals (Esmail & Walker, 2004, p. 3). The Institute claimed that great disadvantages to the Canadian system include "a lack of responsiveness to changes in demand, a lack of user-determined investment as the system is governed largely by the political process, and a lack of choice for patients searching for the best provider" (Esmail & Walker, 2004, p. 10). A focus on economic issues as well as individual choice is apparent.

In a critique of the process of the Committee, Maxwell, President of Canadian Policy Research Networks Inc., commends the dialogue that she witnessed during the Commission (Maxwell, 2002, p. 1543). She contends that respect, transparency, objectivity and breadth of perspective were hallmarks of the

Report. The process—an intense dialogue—provided a unique opportunity to create a synthesis of the values of Canadians including the best-informed advice available from those who receive, deliver, manage and govern health care in Canada (2002, p. 1543).

The leadership theme of the Romanow Report illustrates concepts and principles discussed in earlier chapters. The underlying values of equity, fairness and solidarity are linked to an understanding of citizenship and community. The process of the Commission took into account principles of deliberative democracy. Recommendations of the Commission are based upon the underlying values of the majority of Canadians who see health care as central to the Canadian identity. Returning to the theme of policy development and implementation, Romanow discussed his perspective:

*I would say that essentially the following elements are required of the leadership in order to see a public policy to fruition. First, the policy must be based on a correct understanding of the desires and values of the Canadian people. Second, building from there, you must get the architecture upon those ideals correctly described and put together. I might add with respect to architecture in a field like health care, this is a very challenging task to build the appropriate system, because there are so many competing interests who would want to see the architecture in their own particular view.*

*Third, there needs to be an appropriate vehicle for the communication of the preceding two issues to the public itself. This is also very challenging because unless a leader is in a position of*

*authority, elected or otherwise, it is difficult to garner public access to the various forms of communication of the message. But, nonetheless, without communicating this in an understandable and clear-cut fashion to the public, it all becomes a bit of an exercise in hope only. One might say that what I'm really saying is that communication skills are important. They are, but I'm saying more than that. You need the communication skills but you need also the capacity to be able to command a vehicle to actually get the message out. That's the third dimension to it. And, fourth, there needs to be a set of supporting organizations and voices if the acceptance of the goal is to be realized (R. Romanow, personal communication, May 19, 2004).*

Prudent analysis of the Romanow Commission “has correctly situated the question of *values* at the heart of the matter” (Axworthy & Spiegel, 2002, p. 365).

Axworthy and Spiegel reiterate that there is no proof that privatization would improve the system:

We should recognize that some who wish to dismantle the public character of our health care system have a proprietary interest in doing so. But there is, to reiterate, no evidence base to suggest that user fees or privatization will provide greater efficiencies, let alone ensure access for vulnerable people. The burden of proof rests on those who would pursue radical restructuring. That being said, we should be imaginative in finding ways to improve organizational and administrative efficiencies (2002, p. 366).

Romanow reflects on the values expressed in the Report:

*The thing that gives me the most hope is my own experience and what I heard and what I read and what I saw as Commissioner that the values in the Report are correctly identified inasmuch as*



*Canadians strongly adhere to them in vast majority, not in unanimity, of course, but in overwhelming majority. I am also buttressed by the fact that a recent book called Fire and Ice by Michael Adams, written at a time when one would think that NAFTA would break down our values because of our close economic trading relationships with the United States of America and move them more closely to the American set of values. Adams, in Fire and Ice, which book won the award from Donner as being the most important public policy book of 2004, says that by his examination of all of the data, all of the public opinion research, that the Canadian values in two areas have been strengthened and become more distinct from America. Those two areas are social policy such as health care where Canadians feel very strongly that our model and system is the model which needs to be reformed and protected and in the area of international relations where Canadians believe that multilateralism as opposed to unilateralism in the solution of international problems should hold sway. ...Eventually the voice of the Canadian public will influence whether it's the disciplines or the political people or even the journalists to the appropriate necessary reforms and sustainability (R. Romanow, personal communication, May 19, 2004).*

The purpose and process of the Romanow Commission reflect a moral leadership concerned with assessing and clarifying values and establishing general policy based upon those values and analysis of the “outcomes.” Recommendations regarding fundamental reforms to the way health care is delivered—the need to align public expectations and sustainability, improve informational infrastructures, the integration of teamwork within health care, and primary health care—provide broad directions based upon values. The Report

emphasizes the need for improvement. It links sustainability to leadership, understanding choices and responsibilities at all levels:

Sustaining the Canadian health care system has always been about the choices we make and our understanding of what our responsibilities and entitlements are within the system. So it is there that we must begin—by laying a new foundation for the governance of the system. With that foundation in place, the challenge then is in the hands of government, and all Canadians, to seize on the opportunities for change, make the right choices, and ensure that Canadians get what they truly want—an excellent health care system that is sustainable not only today but for generations of Canadians to come (Canada, 2002, p. 44).

Detsky and Naylor reflect on important funding issues: “Canada’s constitution puts the authority for taxation largely in the federal sphere but the management of health care systems under provincial jurisdiction” (2003, p. 804). The Romanow Report spurred activity between federal and provincial jurisdictions with a “First Ministers’ Accord on Health Renewal” in 2003 (Canada, Health, 2003). A subsequent First Minister’s meeting in September 2004 resulted in an additional 41 billion dollars of federal money over 10 years to be allocated to the provinces through transfer payments. Included in this sum are early higher payments (three billion dollars over two years) to close the “Romanow gap” identified in his report as well as four and a half billion dollars over six years for a “Wait Times Reduction Fund.” The remaining funds are not specifically targeted. This could be a deficiency for, without targeting, the money may not go towards specific reforms (Eggertson, 2004, p. 847).

The agreement did commit the provinces to develop benchmarks of waiting times for certain procedures; to make public plans for increasing the supply of health care professionals; to provide by 2006 home care services for post hospital discharge and for home palliative care; to report by 2006 on a national formulary for drugs. A Health Council has been established with representation from federal and most provincial governments. This council's activities have remained relatively silent, although its role is to improve information that would lead to improved decision-making and accountability.

Commentators such as Eggertson (2004) emphasize that a number of key issues from the Report were not sufficiently addressed at the First Minister's meeting (Eggertson, 2004, p. 847). These include human resources shortage, catastrophic drug coverage, a pharmacare plan and a home care plan. Most significantly, fundamental change in the delivery of health care, particularly primary care reform, has not yet been addressed. This challenging part of the Romanow Report falls to provincial governments, singly or collectively, the health care professions and existing institutions. Equally significant is the absence of the concept of any form of private health care delivery.

In June 2005 the Supreme Court of Canada (*Chaoulli v. Quebec [Attorney General]*, 2005 SCC 35), by a four to three majority, ruled that the Quebec legislation prohibiting Quebec residents from participating in private insurance plans to obtain private health services violated the Charter of Rights of Quebec. The Court held that it cannot be concluded that any absolute prohibition on

private insurance is necessary to protect the integrity of the public plan. They stated that there is a wide range of measures that are less drastic and less intrusive in relation to protected rights. The Justice writing the majority report made her ruling solely with regard to violation of the Quebec Charter of Rights, but three other Justices, who concurred with her, stated that the prohibition also violated the Canadian Charter of Rights (which contains some differences in wording to the Quebec Charter). The four Justices held that delays in the public system are widespread and that some serious cases may die as a result of waiting lists for public health care and that the waiting results in physical and psychological suffering that reaches the threshold of seriousness. They concluded that, by so doing, the government interferes with life and security of the person as protected by the Charter.

Expert witnesses were called in a lower Superior Court to support the position that the integrity of the public system could be jeopardized by allowing insurance for private care. The majority of Supreme Court Justices rejected the opinions of these witnesses. Further, an overview of practices in OECD countries (Austria, Germany, the Netherlands, Australia, the United Kingdom and Sweden) cited in the Superior Court, all with public insurance that allowed private insurance, was considered by the Supreme Court majority to be evidence that private insurance was compatible with the public system. The Justices' opinion recognized that the basis for judicial intervention must be based on legal grounds, not on a socio-political basis, for they concurred that the latter must be left to the legislature to

develop. However, they ruled that courts have a role when social policies infringe on Charter rights. In their opinion, such was the situation in this judgement.<sup>25</sup>

The three dissenting Justices stated that the debate on private health insurance cannot be resolved as a matter of constitutional law. They claim that the current health plan does not violate principles of fundamental justice and so does not violate the Charters—Canadian and Quebec. They state that the majority fails to establish what are “reasonable services,” “reasonable times,” and lays down no constitutional standard. While admitting problems exist in the public health service, they say courts do not have competence for establishing solutions. They agree that the prohibition against private insurance may be essential for the single-tier system.<sup>26</sup>

Instead of rejecting the evidence of experts to the Superior Court, as did the majority, they placed much emphasis on these experts. They accepted the evidence of experts that in OECD countries an increase in private funding leads

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<sup>25</sup> The three other concurring Justices agreed that the prohibition violates the Quebec Charter. These three also agreed that it violates the Canadian Charter. As the law provided a monopoly for public service, it must conform to the principle of fundamental justice. The law, in their view, fails to do this. They contended that prohibiting private health insurance is not necessary to maintain high quality in public health care and that quality public care depends not on monopoly but on money and management. In sum, they ruled that, while the prohibition of private insurance might be constitutional where the health care system is reasonable as to quality versus timeliness, it is not constitutional where the public system fails to deliver reasonable services, and this offends the fundamental justice and, thus, the Canadian Charter.

<sup>26</sup> This raises the issue of what it is that would resolve these concerns. They quote the Romanow Report: “Some have described it as a perversion of Canadian values that they cannot use their money to purchase faster treatment from a private provider for their loved ones. I believe it is a far greater perversion of Canadian values to accept a system where money, rather than need, determines who gets access to care (Canada, 2002, p. xx). The three dissenting judges contend, “Whether or not one endorses this assessment, his premise is that the debate is about social values. It is not about constitutional law. We agree” (para. 166). They further claim that the aim of “health care to a reasonable standard within a reasonable time” is not a legal principle; there is no “societal consensus” about what it is or how to achieve it. It cannot be identified with precision. For these reasons it fails the test of a “legal principle” (para. 209).

to a decrease in public funding. They held that all reports indicate that “much is saved in a single-tier public system as a result of lower administrative costs and advertising expenses, the absence of overhead and the fact that the risk is spread over the entire population” (para. 253). Finally, they concluded: “Those who seek private health insurance are those who can afford it and can qualify for it. They will be the more advantaged members of society. They are differentiated from the general population, not by their health problems, which are found in every group in society, but by their income status.” They summarize: “We share the view of Dickson C.J. that the Charter should not become an instrument to be used by the wealthy to “roll back” the benefits of a legislative scheme that helps the poorer members of society” (para. 274).

The recent Supreme Court decision, while limited in its present scope to the Province of Quebec, has the potential for a huge impact on health care delivery in Canada. On the one hand, it may spur the remaining provinces to sufficient reform as to render “two-tiered” medicine unnecessary or, on the other hand, it may result in a second and private form of health care insurance becoming a reality, not only in Quebec, but in the rest of Canada. It is too early to assess the societal ramifications of the Supreme Court decision.

The editor of the Canadian Medical Association Journal reflects:

How did we get to this unexpected juncture? Some commentators point to resistance to reform within organized medicine; others blame a lack of political leadership and will, citing among other

things the inconsistent enforcement of the Canada Health Act (e.g., Quebec's disregard for portability is perhaps not immaterial to this case). Others have pointed to socioeconomic change, which has created a stronger voice among the affluent, who identify less and less with the poor. Or perhaps we have been brought here by the ascendancy of individualism, by which our long-standing commitment to the common weal in matters of health is now hoist by the petard of Charter rights. The spirit of fairness, reasonableness and public good that inspired the Canada Health Act has been trumped by the letter of the Charter (Canadian Medical Association Journal, 2005, p. 117).

## **THE NANCY OLIVIERI CASE**

Reflection on professionalism, moral dimensions and theories of leadership encourages analysis of the leader-power relationship in educational settings such as universities. There is evidence that the partnership of universities and industry may place industry imperatives, the duty to make profits, above the fundamental ethos of the university, the duty to seek truth (Lewis et al., 2001; DuVal, 2004; Rhodes & Strain, 2004). A Canadian manifestation of this relationship is evident in the case of Dr. Nancy Olivieri. This case demonstrates the excessive influence of industry, corporatization and commercialization on university research and academic freedom. Olivieri's relationship with Apotex Inc., Toronto's Hospital for Sick Children (HSC) and the University of Toronto over a period of several years has been reviewed in two reports (Naimark, Knoppers & Lowy, 1998; Thompson, Baird & Downie, 2001) that reached opposite findings. The issues have been discussed extensively, over several years, in peer reviewed journals, including the Oliveri Affair Symposium (Savulescu, 2004), as well as the popular press (e.g., Shuchman, 2005). Issues about research ethics, clinical ethics and

academic freedom in the case have attracted international attention. The following analysis of the Olivieri case illustrates a number of leadership issues discussed in previous chapters: the continued relevance to the individual researcher of character, virtue and ethics, and the ethical responsibility of professional bodies in issues of public interest, as well as organizational leadership.

Both principles of research ethics and clinical ethics are relevant to the Olivieri inquiry. The aim of research ethics is to ensure that participants in the research are protected from harm and that the research serves the needs of the participants and society as a whole. The aim of clinical ethics is to ensure patients are protected and respected, and that societal norms are reflected in the policies and practices within health care. It is relevant because an unexpected risk of a trial drug was identified early in the treatment contexts (Thompson et al., 2001, p. 68).

The saga begins in the early 1990s when Olivieri, a specialist in hereditary blood diseases at HSC, a teaching hospital fully affiliated with the University of Toronto, entered into contracts with Apotex Inc., a major international pharmaceutical manufacturer. The purpose of her research was to further study an experimental drug on thalassemia<sup>27</sup> patients at the HSC. One of the contracts between HSC and Apotex included a confidentiality clause granting Apotex the right to block

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<sup>27</sup> The term thalassemia encompasses many different inherited defects in the genetic structure coding for hemoglobin. The disease is fatal in early childhood if untreated (Thompson et al., 2001, p. 63).



communication of research data for a year after termination of the trial. During the course of the trials in 1996, Olivieri identified an unexpected medical risk and reported her concern to the Hospital's Research Ethics Board (REB). Consistent with ethical guidelines governing research in Canada, the REB instructed her to disclose her concern to all research participants. When she moved to comply with the REB's directive, Apotex abruptly terminated the two trials in progress in Toronto and also terminated Olivieri's consulting contract for a third international trial. In addition, Apotex threatened legal action against Olivieri should she attempt to inform patients or anyone else of her concerns. Some time after the trials were terminated, Olivieri identified a second unexpected risk for patients. Despite further legal warnings from Apotex, she directly notified patients and the regulatory authorities (Thompson et al., 2001, pp. 3-7).

There were several ethically relevant issues in this case up to this point. One was the right of participants in a clinical trial to be informed of an identified risk during the course of the trial by the investigators, and the obligation of the investigator to inform them. Without this information, the participants are not giving informed consent to continue in the trial. Also at issue was the academic freedom of Olivieri to publish her findings on the drug and thus inform investigators administering the drug in other sites. As a result, the public interest was at risk (Thompson et al., 2001, p. 5). Notably then, the principles of protecting the public good as well as the rights of the individual were issues.

The Olivieri drama continued to unfold. In 1998, two years after it began, the controversy became public. The HSC Executive issued a statement repeating allegations made privately to it by Apotex about the quality of Olivieri's scientific work. Shortly thereafter, the Hospital commissioned a unilateral appointment—Arnold Naimark, former President and, earlier, Dean of Medicine, at the University of Manitoba—to conduct a review of the controversy. The selection of the Reviewer and the structure of the Review were subjects of an unresolved controversy. Olivieri and supporters declined to participate in the Review (Thompson et al., 2001, p. 9). The Naimark Report concluded, in less than two months, that Olivieri was at fault, and no criticisms were directed to the University or Hospital for their failure to support her academic freedom to ensure defence of the broader societal and institutional issues. (The process and results of the Naimark Report continue to raise significant questions because the findings were refuted by the subsequent Thompson Report, which took two years to complete.) As a result of the Naimark Report, the HSC Board and its Medical Advisory Board publicly referred the allegations to the College of Physicians and Surgeons of Ontario and to the University of Toronto (in 2000), further damaging Olivieri's reputation.

In the interval, 1999-2000, an associate of Olivieri, Dr. Koren, was discovered to have sent anonymous letters and E-mails “disparaging” the personal and professional integrity of Olivieri and others involved in the study. He was ultimately identified by DNA evidence. It is important to note that HSC took this action against Olivieri two weeks after the Presidents of the Hospital and the

University had disciplined<sup>28</sup> Dr. Koren for gross misconduct. The Thompson Report claims that “the dishonest conduct of Dr. Koren was ample reason to doubt, and to re-examine carefully, the information he and persons associated with him had put forward,” and, if they had done so, would have seen that his allegations were contradicted by his earlier correspondence and documents available to him (Thompson et al., 2001, p. 12).

This drug trial controversy became connected to a large university-industry project. During this period, Apotex and the University of Toronto were negotiating a multimillion-dollar donation toward the construction of a biomedical research centre for the University and for its affiliated teaching hospitals. Apotex requested assistance from University of Toronto President Pritchard in lobbying the federal government against proposed changes to drug patent regulation. President Pritchard wrote to Prime Minister Jean Chrétien to this effect. The President later explained that “the letter had been written at the request for assistance from Dr. Barry Sherman, President of Apotex Inc. and the Apotex Foundation, because the new legislation might make it financially impossible for Apotex to fulfil its \$20 million donation to the university’s Centre for Cellular and Molecular Biology Research” (Thompson et al., 2001, p. 100). Pritchard’s lobbying efforts were unsuccessful and he later apologized to the University Executive Committee for

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<sup>28</sup> In a joint letter to Dr. Koren, President Pritchard of the University and President Starofolino of the Hospital listed the disciplinary action taken and the reasons for this: “We have based our decision on the admitted misconduct ... (regarding) writing and sending the anonymous letters, lying about this, and late admission of responsibility...” Dr. Koren’s unprofessional conduct was punished by the Disciplinary Committee of the University of Toronto: suspension, removal from an endowed chair and a fine of \$35,000 (Thompson et al., 2001, pp. 400-401).

his action, acknowledging that he had made a mistake and that his letter had “placed the University in an inappropriate position of intervening in a matter beyond the legitimate scope of the University’s jurisdiction” (Thompson et al., 2001, p. 100). This raises further questions such as, was there a systemic “blindness” to the issues by the University of Toronto leadership? How extensive is the pressure of industry on universities?

Finally, in 1998, a second inquiry was commissioned by the Canadian Association of University Teachers (CAUT). Its members were Jon Thompson (chair), Professor in the Department of Mathematics and Statistics at the University of New Brunswick; Patricia Baird, University Distinguished Professor at the University of British Columbia; and Jocelyn Downie, Associate Professor in the Faculties of Law and Medicine at Dalhousie University. Thompson and his co-authors insisted that they function independently<sup>29</sup> and that their report be published without alterations. In particular, the committee was to consider whether breaches of medical research ethics, clinical ethics or academic freedom had occurred. After two years of study, they issued a 540-page report that exonerated Olivieri and strongly criticized the HSC, the University of Toronto and others, including CAUT (Gibson, Baylis & Lewis, 2002, p. 449).

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<sup>29</sup> The members decided they would serve only on the understanding that they would be independent of positions taken by CAUT or any person or organization. To ensure this independence the Committee requested CAUT to agree to special arrangements. The independence of the Committee was confirmed by the Executive of CAUT by eliminating provision for CAUT editorial control of the report, in addition to ensuring that the complete report be published (Thompson et al., 2001, p. 497).

The conclusions of the Thompson Report were significantly different from the earlier Naimark Report. Highlights include:

Apotex should not have attempted to impede Dr. Olivieri from informing patients... This was against the public interest and inappropriate conduct by the company (2001, p. 14).

HSC and University of Toronto could and should have effectively supported Dr. Olivieri in the exercise of her rights and obligations as this was a matter of academic freedom and protection of the public interest, but they did not do so (2001, p. 14).

The Hospital for Sick Children (HSC) did not have an adequate policy infrastructure to protect patients and the public interest in the conduct of clinical trials, and this was a contributing factor in the development of the controversy. The University of Toronto Publication Policy in regard to contract research allowed industrial sponsors to impose confidentiality restrictions for one year following the termination of a project. This applied to sponsored research generally, including sponsored clinical trials (2001, p. 23).

The adverse findings against Dr. Olivieri in the reports of the Naimark Review and HSC Medical Advisory committee are incorrect and based on incomplete, incorrect and false testimony (2001, p. 31).

The Complaints Committee of The College of Physicians and Surgeons of Ontario fully and publicly vindicated Olivieri against complaints by the Medical Advisory Committee of the Hospital for Sick Children and filed by the Hospital (College of Physicians and Surgeons of Ontario, 2001). This report provided independent corroboration of the findings of the Thompson Report (Downie, Baird & Thompson, 2002, p. 121).

Courageously, Olivieri “spoke truth to power” (Wildavsky, 1979; Baylis, 2004). She contended, “Four years ago, I found myself at the centre of events which Professor Arthur Schafer, Director of the Centre for Professional and Applied Ethics at the University of Manitoba, later described as ‘the greatest academic scandal of our time.’ Those events show that for-profit companies have infested and infected Canadian public institutions” (Olivieri, 2000, p. 53).

The pharmaceutical industry is very powerful, and has substantial resources to promote its interests. Unless governments, granting councils, universities, hospitals, research ethics boards and researchers work in concert to protect the independence of investigators with nation-wide, well-publicized and effectively implemented regulatory mechanisms, the public interest is likely to suffer (Downie et al., 2002, p. 115).

The Canadian Tri-Council Policy Statement, *Ethical Conduct of Research Involving Humans*,<sup>30</sup> did not come into force until 1998. With it came requirements for universities and affiliated hospitals that receive funding from the federal granting councils (Thompson et al., 2001, p. 564).

Downie et al. discuss the highlights of the Olivieri review and summarize the need for legislation and monitoring:

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<sup>30</sup> This joint policy statement of the Medical Research Council of Canada, Natural Sciences and Engineering Research Council of Canada and Social Sciences and Humanities Research Council of Canada sets standards and procedures for research involving human subjects. The Councils have adopted this policy as their standard of ethical conduct. As a condition of funding, researchers and their institutions are required to apply the ethical principles and the articles of the policy (Medical Research Council of Canada, Natural Sciences and Engineering Research Council of Canada & Social Sciences and Humanities Research Council of Canada, 2003).

...All research granting councils should prohibit clauses in contracts, investigator agreements or protocols, that could be used to restrict communication (including publication) of risks to human health identified in research projects, particularly clinical trials. The councils should make compliance with this a requirement for all research carried out in any institution to which they award funds, and the councils should actively monitor compliance (2002, p. 118).

All universities and their affiliated hospitals should also have policies that ensure that fund-raising does not adversely affect the institution's willingness or ability to protect and promote academic freedom and the public interest (2002, p. 117).

TCPS (a joint policy of the three national funding councils) should be amended so as to give further explicit and prescriptive direction to REBs on the need and ways to identify and manage conflicts of interest (2002, p. 118).

The case analysis illustrates significant leadership issues, all with ethical underpinnings: the importance to the public interest that universities and their affiliated teaching hospitals act vigorously where large private corporations attempt to infringe academic freedom; the need to establish policies and procedures within the Canadian research granting Councils and Health Canada to protect public safety in clinical trials; and the need to meet standards of fairness and due process (Thompson et al., 2001, pp. 37-38). Other reviews emphasized similar needs for improvement (Schafer, 2004; Viens & Savulescu, 2004).

The Olivieri case further illustrates that responsibility rests with both the individual professional and organizational leaders. Using the language of Heifetz's leadership approach as discussed in Chapter Four, there is much "adaptive work" to be undertaken: reality testing, respecting conflict, negotiation and

diversity of views within an organization, increasing community cohesion, developing norms of responsibility-taking, and learning and innovation (1994, p. 26). The Thompson Report made recommendations that can aid the process of the University facing its significant challenges, its "adaptive work." For example, it outlines a series of recommendations for both local and national institutions, including research ethics boards, universities and teaching hospitals, clinical research funding councils and Health Canada. Fundamental to these recommendations is the committee's finding that Canadian clinical research participants are not adequately protected against potential injury. The recommendations aim to increase protections for research participants, to reduce the potential for conflicts of interest and, overall, to safeguard the public interest and foster public trust. The Thompson Report further recommends that the Association of Universities and Colleges of Canada establish a policy governing university-industry relations, with a focus on the protection of research participants. There are also recommendations addressed to Health Canada to significantly enhance the safety of study subjects. In addition to these broad recommendations, there are specific recommendations to the HSC and the University of Toronto as to measures they should take to redress the wrongs and prevent such a situation from recurring.

The reluctance of HSC and the University to act exemplifies leadership challenges that can occur within bureaucratic organizations. As discussed earlier, problems can arise if the main function of an executive leader is to maintain existing political arrangements, focusing on equilibrium and stability, if the



decision-making purposes centre on self-advancement, or if the leader's "power" is influenced by a variety of factors such as struggles for internal and external funding (Burns, 1978, pp. 369-378; Schafer, 2004; Rhodes & Strain, 2004; DuVal, 2004). The Olivieri case illustrates the lengths to which university leadership was prepared to go to appease a corporation and promote its interest. It demonstrates the dangers to the public interest when career success for university or hospital hierarchy can be measured by success in fundraising from corporate donors (Schafer, 2004, p. 12). It also demonstrates the dangers of their competing roles and responsibilities. Simply put, the best interests of shareholders do not always coincide with the best interests of patients, research subjects, the university and the general public.

The policy problems and issues of the Olivieri case were foreshadowed by Weber, as summarized by Samier:

The political and economic conditions of universities in modern society Weber saw as increasingly hostile to scholarly ethic. This problem is characterized by him both as a government intrusion into what should be the autonomy of the academy, in order to support government policy and activities, and the increasing transformation of the university organizationally into a marketplace sector (Samier, 2002, p. 33).

Lewis et al. reiterate that the role of research is to serve the public interest. Research findings "may advance knowledge and support useful innovation, or be filtered and twisted to support prejudices or gain commercial advantage. The capacities and integrity of researchers, and their universities, can be enhanced or corrupted in the process" (Lewis et al., 2001, p. 783). The editor of the Canadian

Medical Association Journal proclaimed that the “safety of patients who participate in clinical trials, the validity of scientific findings, the transparency of vested interests and, yes, academic freedom, are issues of public interest more significant than the reputations of individuals and their institutions” (Canadian Medical Association Journal, 2002, p. 413). Schafer claims that, to prevent researchers becoming “handmaidens of business” and universities becoming “adjuncts of large corporations,” universities and researchers must be sequestered from the process of commercialization. He acknowledges this would be challenging, requiring new methods of funding and taxation, but believes it is necessary for the long term good (2004, p. 23).

It is essential to emphasize the virtuous requirements of the researcher, educator, clinician and administrator in a changing and pluralistic moral climate in the current complex milieu of commercialization and corporatization. As Pellegrino and Thomasma argue, the person of character is still the indispensable unit of a morally good society (1993, p. 45). They elucidate: “To be sure, some of the more formal expectations, rules, guidelines, principles, and the like acquire their moral force within the context of human relationships. The social contract is precisely a theory of social obligations” (1993, p. 48). Faunce, Bolsin and Chan (2004) urge improvements to the ethical and professional culture of graduate medical trainees; their strategies focus on education that will support whistleblowers. Their research on a program of personal professional monitoring has positive results (2004, p. 42). Rhodes and Strain, following their review of the literature, claim that “academic medicine has failed to consistently,

effectively and appropriately respond to unethical behavior,” systematically ignores serious ethical problems, regards whistleblowers as enemies of the institutions and punishes them, and fails to support an ethical environment (2004, p. 38). To change the current status, whistleblowers need to be seen as helpful and valued colleagues of the institution. Transparency on the part of institutions is paramount—honesty and objectivity in processing allegations of whistleblowers.

The Olivieri case illustrates both positive and negative leadership. Olivieri demonstrated a commitment to clinical and research ethics. Despite horrendous pressures, she was a whistleblower for research and academic freedom. A group of colleagues who supported her and these same values did so despite significant losses to their professional and personal lives. Conversely, there is the unethical conduct of colleagues, who misinformed the Naimark Commission regarding research results and in general did much to undermine Olivieri and the circle of professional colleagues and bodies such as the HSC Medical Advisory Committee who, by accepting false information and neglecting further inquiry, failed to ensure due process. Finally, there is the administrative leadership at University of Toronto and HSC who failed to undertake appropriate inquiry, readily accepting accusations from the pharmaceutical company (corporation) and others who had much to gain from the controversy. They failed to ensure policies were in place that met standards for patient safety and academic freedom. The explicit lobby of the federal government by the University of

Toronto President captures clearly the powerful influence of the corporate world in university matters.

The Olivieri case became an iconic example of the intrusion of commercialism into academia. The challenges of industry-university relationships are succinctly summarized by Gibson et al.:

There are many intricate steps in the dance with the pharmaceutical industry. Before accepting an invitation from a prospective partner, one needs a clear idea of the choreography. When the music is unappealing, or the risk of missteps considerable, it is best to announce that one's dance card is full (2002, p. 450).

Lewis et al. reiterate this concern and continue the metaphor, "Some bargains are Faustian, and some horses are Trojan. Dance carefully with the porcupine, and know in advance the price of intimacy" (Lewis et al., 2001, p. 785).

The Thompson Report claims that collectively the case of Dr. Olivieri and her supporters "has become the largest, most complex and most expensive academic freedom case in Canadian university history. In view of the direct public interest aspects of the case, it may also be one of the most significant ever..." (Thompson et al., 2001, p. 416). The analysis of the Olivieri case illustrates the need for an ethical leadership approach that influences the university medical community to face its problems. An essential responsibility of leadership is to advance goals and design strategies that deal with difficult questions, that challenge the nature of meaning and value systems, and that

assist people to clarify priorities. As discussed in Chapter Three, Schein (1997) contends that a central element of any culture is the assumptions about identity and ultimate mission that often are not well articulated. A focus on the moral dimensions of leadership will bring to the fore again the goals of the university that focus on the search for truth, and welcome the whistleblower.

## **CHAPTER SIX**

# **CONCLUSIONS: A POST-MALAISE MODEL FOR HEALTH CARE LEADERSHIP**

This final chapter proposes a model for health care leadership in response to the central enquiry of this project: What is the nature of health care leadership and what does exemplary leadership entail in the midst of the malaise of modernity? The model establishes elements necessary for developing excellence in leadership in the 21<sup>st</sup> century. Before introducing the model, a synopsis of concepts—the theoretical fabric—of this dissertation is presented. Since this project is primarily a theoretical essay, scholarly literature is explored. Theories arising from the “quest for the good” and theories of “modernity” are used as a backdrop to highlight the moral, social and political issues that define Canadian health care. The components of the leadership model are then discussed. The chapter concludes with a discussion of the implications of this study for research knowledge.

### **THEORETICAL FABRIC**

Throughout the ages, philosophers have been engaged in dialogue about what has been described as the ultimate task of morality—that is, “how best to live” or how to lead the “good life.” Ethics refers to numerous ways to examine and

understand moral life. The application of ethics to health care provided insights to this thesis by examining the notion of the good applied to educational leadership and administration. Philosophical questions contributed to the inquiry: What is the good that health care leaders serve? What does it mean to provide good health care leadership? What types of virtues and skills are required that ultimately guide knowledge and skills? If the good of the health care profession is to foster the health and well-being of patients, families, communities and ultimately of society, then the development of a model for health care leadership must involve elements of theory and theorizing.

The analysis and integration of concepts from moral philosophy, social and political theories are necessary to respond to the three types of questions that can be posed: metaphysical or ontological (concerning what is), epistemological (concerning how we know) and moral (concerning what we ought to do and seek). First-order questions in philosophy are ontological: What is the nature of leadership? What is the essence of the leader-follower relationship? The second-order questions are epistemological: What is the nature of health care leadership knowledge? How can scientific findings be applied? The third order questions include: What are the essential values that underlie health care leadership? How ought a health care leader ensure that patient care goals are met? How has leadership been conceptualized (by scholars)? My evaluation of the leadership literature concludes that a major focus has been on questions of knowledge, with priorities relating to management, rather than on the nature and purpose of leadership.

This leadership model develops from a synthesis of concepts arising from major topics in Chapters Two to Five. Concepts are selected and integrated into a coherent foundation to generate insight about the world in which health care professionals interact, acknowledging the complexity of contemporary health care leadership. The model is based on the integration of concepts such as the relationship of virtue, practice and institutions, and the retrieval of the moral aspects of life that have been displaced in the malaise of modernity. Other bundles of concepts provide insights into the relationship of education, learning, role modelling and communication. Still others contribute to an understanding of agency, of community and of society—both private and public considerations.

A significant question is: What type of social relationship and what type of conception of the common good are required to support the values underpinning the Canadian health care system? Weaving concepts distilled from the work of MacIntyre and Taylor as discussed in Chapter Three, I claim that a commitment to a conception of the common good entails both the virtues of the independence of practical reason and the virtues of the dependence that recognizes the vulnerability of our human condition. When the institution of health care delivery is framed in such a way as to be seen as part of the general good, the challenges of fair and compassionate health care necessitate an approach based on communities and citizens rather than consumers in a marketplace. The profession-society relations are situated within the space of common citizenship. To safeguard patient dignity and equity, the connecting, synthesizing link is the morality of civic equality, an expansive framework of understanding—the “body



politic.” Since the inception of medicare, Canadians have come to value increasingly the underpinnings of the *Canada Health Act*. As discussed in Chapter Five, the majority of Canadians want the necessary health system reform to continue to be based on the values of equity, fairness and solidarity. Nonetheless, the Canadian health care system is situated within the larger philosophical political context of libertarianism and individualism as defined in Chapter Two. Tensions arise due to the different goals of the libertarian philosophy with the privatization perspective being that health care is best served by choices of the marketplace. Recognition of the nature of these tensions and other influences of modernity is of paramount importance to appreciate the challenges for contemporary health care and the implications for leaders.

A major focus of this project has been an analysis of the influences of modernity on health care. The design of a leadership model for health care must include an understanding of the “malaise”—the sense of alienation, anomie and loss of meaning that arises in a bureaucratized, legally rationalized, technocratic society. Chapter Two explored the emergence of the modern moral outlook rising from the Enlightenment and a hope for an improved quality of life. The old social, political and economic hierarchies, based on values from tradition or theology, were replaced by rationalism and a focus on autonomy—one can make oneself what one will; the knowledge of theology and established authority was replaced by knowledge and a sense of limitless advance. The new science and the Industrial Revolution changed the lives of most people in Europe, North America and, indirectly, the world. As the Enlightenment Project created a focus on

individualism and autonomy, a political framework of liberalism encompassing the economy and market—a new political philosophy—came to dominate the Western world. The prospect of a limitless advance of science and technology has continued to have an overwhelming hold on Western thought and is evident in health care. The significant achievements of science and the Industrial Revolution, when applied to health care, resulted in a rapid evolution of an array of advances. Technological development brought new diagnostic tools such as CT scans and MRIs; biomedical advances resulted in an ever-expanding compendium of pharmaceuticals, organ transplantation, new reproductive technologies and the recent progress in the area of the genome. Other influences of modernity such as bureaucratization, commercialization, commodification and technology, however, produce tensions and are a part of the landscape.

From the Enlightenment came a legacy of a “functional” self that remains today. In the Industrial Age, the primary drivers of economic prosperity were machines and capital. As well, many current management practices came from the Industrial Age, with a focus on control and management exemplified in the accounting view, that labels people as expenses and labels machines as assets. This approach can lead to a sense of frustration, discouragement and feelings of being unappreciated and undervalued, a sense of powerlessness to change situations—with little or no sense of voice or unique contribution. The managerial approach is limiting as it looks for short-term solutions.

A fresh paradigm to view leadership illuminates a mindset and skill set to inspire the vision and voice of others. As suggested by the poem quoted earlier, “leave the roots on ... and the dirt” to see from where they came, this theoretical framework recognizes the network of ideas, attitudes and hopes which shape a social consciousness inherited and further modified by our contemporary “zeitgeist” or spirit of the age.

## **THE MODEL**

This leadership model is woven from a web of ideas that bind the historical to the contemporary: appreciating a synthesis of the philosophical concepts underlying professional and leadership theories, as well as an integration of the themes from interviews with health care leaders. The interface of health care ethics with education and leadership provides theoretical underpinnings and principles to assess the current strengths and limitations of current approaches and to explore contemporary challenges in the complex socio-political climate in which health care is delivered.

At a philosophical level, education overlaps other branches of philosophy, including ethics and metaphysics, and deals with fundamental issues that arose with Socrates’ questions to Menno regarding whether virtue can be taught, what virtue is, what knowledge is, what the relation is between knowledge of virtue and being virtuous, and what the relation is between knowledge and teaching. For

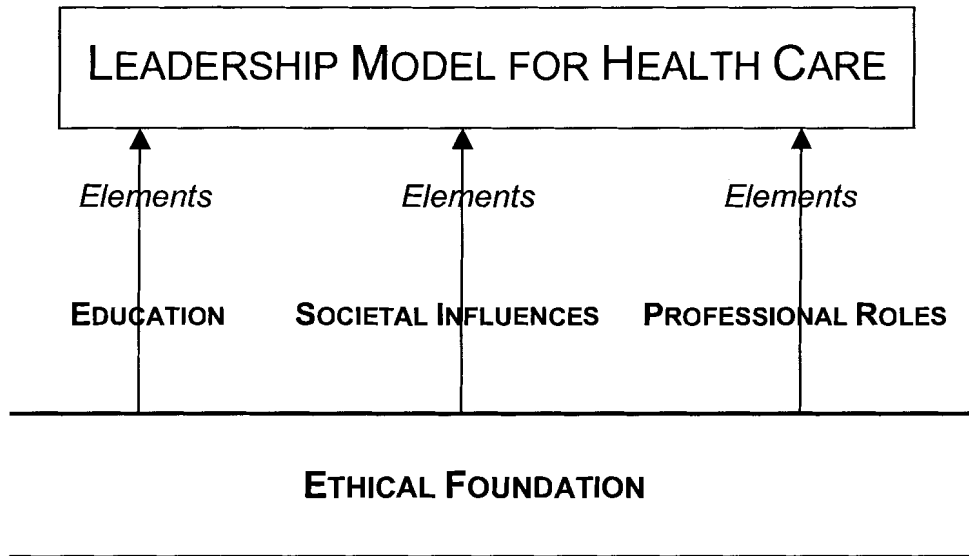
over 2000 years, philosophical conversations have continued to centre on these questions.

What is the common thread that intertwines moral dimensions, education and leadership? Character and virtue are an essential part of the full understanding of humanity, interrelated with education and an inquiring spirit. The best educators build independence and support self-directed learning. Moral authority—character, competence, initiative—is an important component of leadership and is necessary to inspire others. The intertwining of education and leadership is an underlying principle of this model: education and leadership complement each other and, at best, they are one. The common thread of character and virtue within a leadership and educational paradigm is one that guides humans to imagine, explore and develop creative solutions. This creative energy is essential in health care reform, to develop new ways of thinking and new ways of communicating.

The synthesis of major concepts results in a model for health care leadership (Figure 2) consisting of an ethical foundation and three main environments. The ethical foundation for the leadership model consists of moral philosophy and an understanding of the good. The first environment describes the contributions and issues of education and learning. The second environment, societal influences, recognizes the influences of modernity, the major implications for health care professions, organizational culture and, ultimately, for ethical leadership: an understanding of these societal forces is critical to this model. The third

environment encompasses professional roles. Elements are criteria that arise from each of the environments and guide leadership.

Figure 2: A Framework for Leadership in Health Care



### ETHICAL FOUNDATION

Philosophy provides a necessary link between theory, research and practice. The foundation for the model for leadership in health care consists of a moral philosophy and an understanding of the good: moral dimensions such as human dignity, common good, the moral agent, the professions “collectively” and society as discussed in Chapter Three. The attainment of the good society requires leaders whose knowledge about the good is essential. This vision of the good society has as its foundation the view of the human person as

multidimensional—with cultural, psychological, social and spiritual as well as political and economic dimensions. Human beings are understood as relational, embedded in a web of associations with opportunities and obligations for responsible living. An understanding of the good is required in order to care for and guard principles, the virtues, disposition and capacities that are acquired by habit and practice incorporated to develop wisdom. The leader is guided by the Form of the Good (as in Plato's *Republic*), thus examination of what counts as human excellence or well-being is vital to discover how one should act. Human excellence is the disposition that makes one a good leader and causes one to perform well. One cannot entirely separate the character of the moral agent from his or her acts, the circumstances when performed or the consequences. A moral agent cannot claim to be good if he or she performs immoral acts.

Based on the conceptual arguments developed in Chapter Three, this thesis claims that moral dimensions remain an underlying component of the health care professional. The philosophy and history of health care professions contribute to a moral meaning—the relationship of past meaning, moral communities and current practice—providing guidance for those in leadership roles. Health care professionals require a critical self-examination motivated by ethical considerations. The moral community is a foundation of the health professions interrelated with principles and moral rules within a profession and the wider society in which the professions practice. The complexity of contemporary health care includes elements of agency, where organization and agent are dialectically defined. Human action is conducted by knowledgeable agents who construct the

world through their action, but whose action is constrained by the world. Moral agency entails personal responsibility for advocating care to meet patient needs.

As discussed in Chapter Three, virtue, central to health care professions and leadership, is a complex, multilayered concept comprising three acquired qualities. The first is essential to achieve the good internal to practice and the second is essential to sustain communities in which individuals can seek a higher good as the good of their own lives. The third is essential to sustain traditions that provide historical contexts. Thus, the relationship of virtues to practices and to institutions is significant. The ability of a practice to retain its integrity depends on the way in which the virtues are exercised and sustain the institutional forms. The integrity of a practice requires the exercise of the virtues by at least some of the individuals. Internal goods or “goods of excellence” of practice are goods for themselves and for the wider society, because they promote justice, courage and truthfulness, and sustain the common good of society. Thus, good that is common to a number of persons is not merely instrumental to furthering their individual ends; rather, the common good is the sum total of social condition, of social living, whereby persons are enabled to move freely and flourish.

## **THE ENVIRONMENTS**

The three main environments—education, societal influences and professional roles—contain both positive and negative aspects based upon an understanding of health care as a moral enterprise. From each environment evolves elements

or criteria that provide direction to develop and sustain leadership excellence in the 21<sup>st</sup> century.

An environment of education is extensive and multidimensional, each perspective supporting health care leadership. This model highlights a number of significant educational dimensions and their relationships. The first dimension relates to bodies of knowledge necessary for leadership in health care. These include the nature of leadership and the required knowledge and skills, the influences of modernity on health care and professionals, ethics education, and collaborative team building and partnerships. A second dimension focuses on educational processes and relationships such as mentoring, role modelling, communication and transformational leadership. The third dimension relates to the context and audience, and applies to students, practitioners, professional associations and the public. Thus, this dimension relates to the learner, the subject matter, instructional strategies and teaching/facilitator approach.

Philosophy is a key leadership “tool” that supports the significant relationships between competencies and virtues. As discussed in Chapter Three, health care professionals (practitioners, researchers and leaders) do not always take the time to understand the nature of their work, their goals and, ultimately, their vision. Education for both students and professionals can cultivate understandings that will enable them to consistently apply their competencies in an ethical manner. Professional practice requires the support of leaders via role modelling.



Arising from the ethical foundation, curriculum content includes primacy of the role of the healer—trust, codes of ethics, ethical decision-making and an advocacy role for the individual patient. Other content areas include setting and maintaining standards, professional association functions, maintaining competency and influencing public policy for the common good. Professionals and general members of society need a clear understanding of the interaction of the role of healer and professional. Individual practitioners and professional associations need to clarify and redefine social contracts and covenants with society and resultant obligations where integrity (inner commitment) remains central.

Criteria for ethics education include conceptual coherence, integration throughout training, an academic rigor that demonstrates value-conscious professional practice and an interdisciplinary approach. Health care ethics can awaken sensitivity and a sense of responsibility as well as provide a method for analysing ethical issues. It is vital that health care professionals develop an ability to frame issues as matters of ethics: ethical concerns at the micro level (level of clinical care), at the meso level (level of programs and organizations) and the macro level (the level of governments and other societal structures). This requires an increased sensibility to ethics, knowledge to enter into ethical discussions (including a vocabulary that is able to describe these issues) and application of ethical decision-making frameworks. The analytic approaches and methodologies of ethical analysis inform a leadership framework. The analytic questions are of three basic types: descriptive (what does one say is the good

and right?), theoretical (how does one justify judgements of the good?) and normative (arguments for how one *ought* to choose rightly).

Health care ethics provides a connection among individual professionals, institutions and society. Bioethics, in particular, is a cornerstone of education and professional development that aims at improving the character of ethical understanding and behaviour in practice and policy of health care. The field of bioethics is expanding as bioethics education attracts various and growing audiences: students, practitioners and the public. While academics remain the core of the study of bioethics, the field has become a rapidly expanding circle. Bioethics education now includes practising health care professionals who have not had bioethics in their professional training, and other non-health professionals such as members of ethics committees, policymakers and interested citizens. Recent attention in the literature to ethical analysis of policy development, as well as of organizational ethics, exemplifies the heightened awareness of emerging moral issues in health care. Developing meaningful health policy demands an understanding of principles to guide the process.

Many of the challenges in health care leadership occur at the boundaries of organizations such as the interface between acute and long-term care, between service and academic departments, and between local and regional organizations, as well as regional and provincial bodies. Other challenges centre on the frequent discontinuity between the foci of clinicians, managers and administrators, where quality care frequently has a different meaning. Clinical

teams focus on clinical outcome and service, hospitals/health authorities focus on safety and reputation, and ministries of health focus on fiscal integrity and accessibility. Thus, leadership knowledge and skills related to communication, interdisciplinary team building and creative thinking become paramount.

Creative thinking and knowledge generation are necessary to create visions vital to meet the challenges of health care reform. This type of thinking needs to be developed and encouraged along with other models. The rational-technical model of thinking is relevant and necessary for many areas of practice, such as algorithms and critical pathways that help to guide practice. However, it limits the thinking about the sources of questions or issues behind the system. Informatics—classifying and categorizing information for retrieval, also known as knowledge management—is another contemporary model that may become a “proxy” for creative thinking.

Increased collaboration within and between interdisciplinary teams is essential to meet the various clinical and policy challenges and, ultimately, improve patient care. Different professions have limited understanding of other professionals with whom they must work. Education across the major clinical disciplines such as medicine, nursing, rehabilitative therapies and pharmacy will build collaborative skills. Increased attention to resolving differences among team members in a constructive manner will develop a common interdisciplinary approach and, consequently, improve patient care delivery. Role modelling will be essential to foster this development.

Recent studies in the area of ethics education in health care, such as those discussed in Chapter Three, have broad implications for leadership and mentorship, including the importance of reflection, beginning with the benefits of an innovative curriculum that includes knowledge and attitudes incorporating the skills of critical thinking. A learner-centred method of education supports mentorship within the health professions. Educators and learners benefit from the pedagogical dialogue or conversation with roots in the Socratic method—the humanist tradition—where students and mentors are inquirers, supporting each other in the shared pursuit of truth, eliciting new ideas and insights. This is an approach that is more exemplary and indirect rather than direct and informational, and is a holistic communication for the present and the future.

As the malaise of modernity affects health care professionals, an increased clarity and understanding of the impact of societal influences is vital for health care leaders. This will provide an essential foundation to support new learning and in turn develop new initiatives to counter influences of the malaise such as a sense of anomie, the end of heroism and loss of meaning.

As discussed earlier, the powerful steering mechanisms of the Western world—the market and bureaucracy—operate in impersonal ways and remove certain decisions from individuals. Bureaucracy supports the demands for fairness arising from the Enlightenment. It requires that rules be followed but, at the same time, may eliminate finding alternative ways of making decisions. Bureaucracy supports the demand for efficiency; however, over-bureaucratization produces

inefficiency. Since the emergence of capitalism, the basic structure of society emphasizes economic goods and efficiency. Modern bureaucratic institutions with a focus on profit dominate practices. The promise is wealth and private satisfaction; the images are ones of political individualism and instrumentalism. Thus, arising from the influences of corporatism is a societal ethos with an emphasis on power and efficiency. Health care administration has adopted the corporate model, resulting in health care professionals having proportionately less involvement in decision-making, with financial and business managers assuming an increased role. The corporate ethos, insinuating itself within health care, results in a particular moral climate where considerations of efficiency often override considerations of quality of care. A managerial approach that focuses on efficiencies can lead to a narrow and linear understanding of the human condition, and further commercialization and commodification of services.

The tensions apparent in health care arising from the predicaments of modernity are exemplified by the escalating vocabulary of commodification and commercialization—patients become consumers and health care professionals become providers—with a concomitant re-description of goods and services in market terms. The process of exchange emphasizes economic context, consumption and commodification of the goods exchanged. When health care becomes a commodity, professional relationships with patients and others in institutions are altered. The use of “consumer” in health care transactions is misleading because it ignores the inevitable vulnerability of the patient in most situations of illness. The patient is unable to negotiate appropriate treatment, as

one would negotiate the purchase of consumer goods based upon the principle of *caveat emptor*. This thesis in no way disputes the legitimacy of the marketplace and democratic capitalism, but states rather that commodification raises the ethical question regarding whether the marketplace is the proper instrument for the distribution of health care.

Although the benefits of advanced technologies to health care are enormous, the technological approach in medicine is criticized for focusing on the technical problem and not the whole person. When health care professionals are characterized as working within applied science, there can be a concomitant loss of recognition of the complexity of healing as a human practice that requires the context of a dedicated professional community. Related to advancements in technology is specialization. This development of expertise in a particular area frequently brings with it fragmentation of care. Recognizing and acknowledging these side effects is a first step to developing approaches to reduce this fragmentation and reinforce a broader professional context.

This model contends that right action of health professions cannot be adequately grounded apart from a conception of the good. Professionalism is defined as an outgrowth of moral philosophies. Scholarship is linked to training in virtues as well as in specific specialized knowledge and skills. Those who “profess” do so to act in something other than their own self-interest, whose behaviour and commitment are expressed in a “code”—not simply a set of rules, but a response in terms of character and disposition and values, and an obligation of fidelity to

trust. This places professions in a moral community based on a common commitment and shared and collective obligations. With this comes a fiduciary trust.

Conversations with the health care leaders further illuminated the relevance of the moral foundations to current professional practice, the moral community, virtues, role modelling and mentoring. Their articulation of the relevance of ethical foundations to the health professions provides insights on how to frame these ideas for education, communication, collaboration and policy development.

As a moral process, professional leadership shares values and goals with followers on the basis of the needs of both the followers and the leaders. This is the “genius” of leadership to appreciate their own and followers’ values. Core values of a profession define a standard of goodness or excellence that undergirds behaviour and decision-making and strengthens a commitment and energy of members to organizational goals. Professional leaders bring a vision and a clarity to patient-centred care, whether in an executive leadership role or in a clinical team leader role.

Professional leaders have an opportunity to establish and support a work environment that promotes ethical discussions and actions with a goal to translate ethical principles and values into compassionate care. Leadership that supports the development of phronesis—the virtue of practical wisdom—will build the capacity for moral insight, the capacity to discern what choice or course of

action is most conducive for the particular circumstances and particular policies. Phronesis provides the link between the intellectual virtues and those that dispose to good character, essential to the telos of the health care professional. It provides the capacity or disposition to select the right balance between means and good ends. “Practical reasoning”—all knowledge, even highly formalized science, is grounded in social activity. The process of forming a professional identity includes both the inculcation of certain knowledge bases, competencies and techniques, as well as a certain kind of professional identity.

A significant task of the leader is to build the capacity for organizational change. This includes developing the organizational and cultural capacity to successfully meet problems based upon values and purposes. Building capacity also includes testing competing values and understanding the relationships between means and ends. Critical and reflective thinking can be supported in practice settings as well as in educational settings. Strategies to increase critical thinking include critical questioning, critical incident exercises, critical analyses, role playing and crisis-decision situations. Critical and reflective thinking challenges the “given” approaches, examines assumptions, increases capacity to conceptualise different perspectives and develops alternate ways of thinking.

Professional leadership can mentor and support establishment of an ethical framework that is pertinent for analyzing contemporary issues. It is more recently recognized that meso and macro issues that impact dilemmas at the bedside are actually policy writ large. Policy is about substantial values, power, and who



analyses and names issues of value and power; thus, education and supportive leadership regarding policy analysis and development are imperative.

As noted earlier, “deprofessionalism” (a decreased sense of moral community and increased self-interest) can occur for a variety of reasons, influencing relationships among professionals, between patients and professionals, and among patients, professionals and society. The fabric of professionalism has been weakened by the forces of modernity in numerous ways. Increasingly, universities and hospitals are influenced by the marketplace. The education of health care professions occurs in the midst of strong corporate forces; universities are under increased pressure to become more “businesslike.” Productivity and profitability—priorities of the market model—are reshaping professional practice, reducing professional identity and morale. Practicing within the dominant culture of proceduralism, with an emphasis on cost-effectiveness and efficacy, is discouraging for health professionals and can lead to a sense of anomie and alienation.

A leadership model for health care professionals needs to address these predicaments and tensions. As the technical and corporate imperatives of modern society further penetrate the institutions of health care and education, leaders must not only manage efficiently and productively. Although these skills are essential, this view is a limiting one that minimizes critical reflection, collective deliberation and creative thinking, essential for these institutions. Practice implications relate to professionals working within health care

organizations, professional associations, on policy development and health care reform.

### **ELEMENTS: A SUMMARY**

Elements arise from each of the three environments. Elements from the environments of education and leadership clarify and reiterate how education and leadership are inextricably linked. One perspective is that education within health care requires well-defined leadership, where the focus of leadership is on educational excellence, guiding educational and institutional renewal, whereas a second vital perspective aims to develop and support practitioners of leadership within the various health care settings to facilitate learning, mentor and be a source of inspiration.

To accomplish these goals, bodies of knowledge are central, namely of theory and application of ethics education, of the influences of modernity, and of the nature, knowledge and skills of leadership. Further curriculum content includes knowledge and skills pertaining to collaborative teams such as education and crossover training in major clinical disciplines for team and leadership skills. The curriculum will necessarily be tailored to meet the particular context: academia (universities and colleges), practice settings (acute, long term and home care), and public policy development (macro and meso issues). Elements of pedagogical considerations include a critical and reflective thinking model, role modelling and mentoring, and a learning-centred approach. The curriculum

content is dependent upon the particular context—undergraduate, graduate or professional development. The expanded educational elements in this model are in addition to the particular curriculum and approaches that are required for each professional discipline.

Elements from the environment of societal influence focus on those challenges arising from the malaise of modernity. As discussed in Chapters Two and Three, these include deprofessionalism, decreased morale (increased sense of alienation and anomie, loss of voice), loss of meaning (loss of purpose, increased instrumentalism), increased bureaucracy, technocracy and managerialism (focus on efficiency and economics, whereby practices for the sake of goods of excellence are threatened), and commodification and commercialization of health care. These influences permeate both education and professional environments. The professional leader who understands these influences on health care professionals may counter these via a range of initiatives.

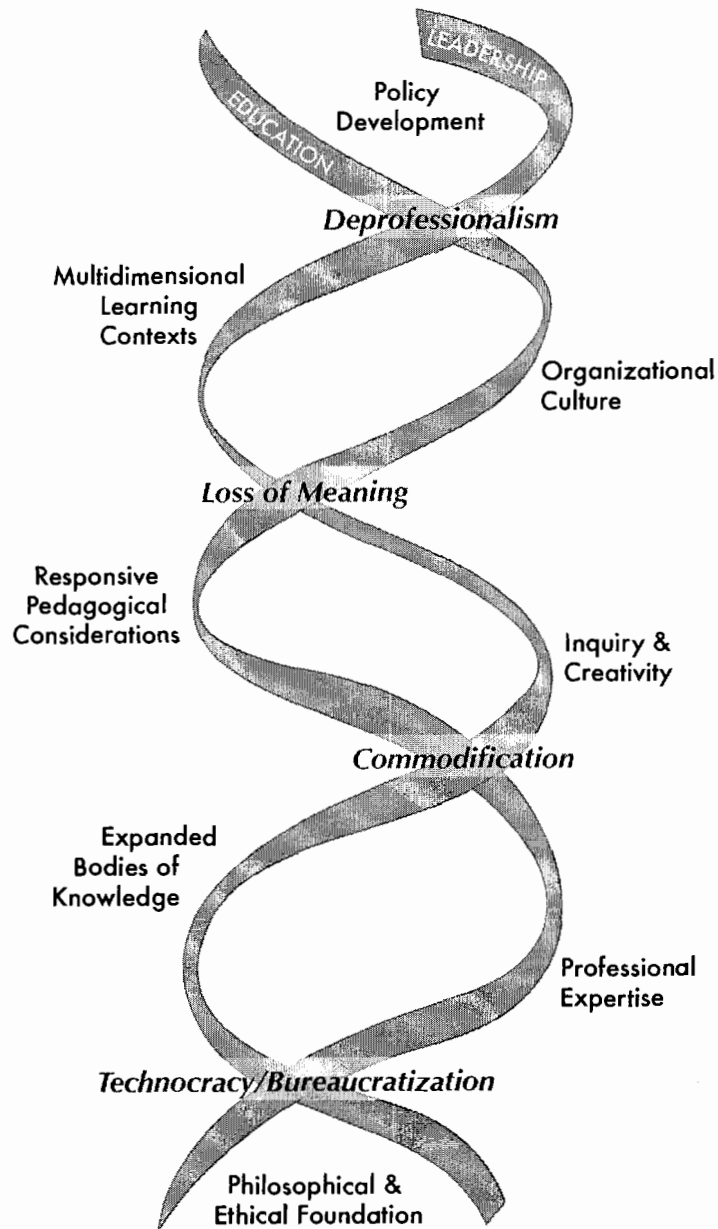
Elements that can arise from the environment of professional roles guide leadership, whether in practice settings or academia. The major categories are professional expertise, inquiry and creativity, organizational culture and policy development. The first, professional expertise, includes patient-centred care, competency and inquiry. The element of patient-centred care incorporates collaboration and coordination within and across programs and organizations, as well as ensuring the moral agency of the patient and respect for individualized

nature of the professional/patient relationship. The element of competency appreciates that the particular knowledge and technical competence on which the profession is based are supported. Ethics education can support competency. The moral obligation to maintain competence is a lifelong one—a moral imperative. The element of inquiry includes advancing inquiry, creativity and increasing capacity to conceptualize different perspectives. Critical reflection and analysis are vital for the individual professional and interdisciplinary teams. The third category, organizational culture, includes a focus on vision, building capacity and ethical decision-making. The vision component includes helping the organization to find meaning, and clarify values and purposes. Building capacity addresses setting priorities, problem-solving and adaptive work within academic and practice settings. The final category, policy development, is also relevant to education and includes dialogue, deliberation, consensus building and an ethical framework.

The core elements pertaining to education and leadership are depicted as integral to the educational leadership paradigm for health care (Figure 3), intertwined as in a double helix. The two strands of the helix, leadership and education, arise from a common philosophical foundation. The intent of this diagram is to demonstrate that the elements from each strand work together to overcome the intrusion of the malaise elements. The symbolism of the double helix captures several themes of this leadership model: the historical origins of ideas that continue to evolve over the centuries and spark further creativity, and the highly complex, ever-changing process that is part of professionalism.

Figure 3: Educational Leadership Paradigm – the Double Helix<sup>31</sup>

EDUCATIONAL LEADERSHIP PARADIGM  
challenging  
The “Malaise” in Health Care



<sup>31</sup> DNA is a highly complex, ever-changing organic process that is the physical mechanism for the force of life (Gamwell, 2003, p. 817).

## **IMPLICATIONS FOR RESEARCH**

Several areas of research arise from this project. Collaborative practice is one area for further inquiry, as interdisciplinary team collaboration is vital to health reform: expand knowledge regarding the types of teams within different settings—acute, community, as well as collaboration across boundaries. What are the pedagogical considerations for successful collaboration with different disciplines? As discussed, the interface of ethics and health policy has become vital to generate policies that address ethical issues and in critiquing existing policies for ethical implications. Interdisciplinary research relates to policy development, captured in the claim of Kenny and Giacomini that “new rigorous interdisciplinary scholarly activity from both the policy and ethics communities is urgently required” (Kenny & Giacomini, 2004). Research includes questions of a theoretical framework appropriate for health policy. What are the elements of the health policy decision-making process? What are strategies for integrating ethical imperatives into policy development? What is the role of citizens?

A related area of research in educational leadership is in the public arena where rapid advances in the health sciences place significant demands on public policymakers. “The response of Canadian politicians and legislators has been slow and less than adequate” (Manning, 2004). What education, relationships and communication will advance these challenges? What approaches will support an authentic public policy process and engage citizens in testing knowledge and assumptions?

## **CONCLUDING REMARKS**

This thesis has explored and speculated on the nature and knowledge of leadership for health care reform in the 21<sup>st</sup> century, claiming that foundations for leadership include an understanding of the good, underpinnings of the health care professionals and Canadian health care values. The proposed model reiterates Plato's idea that, at best, education and leadership are one, essential to guide professional practice and health reform in the midst of the malaise of modernity.

A quest is always an education both as to the character of that which is sought and in self-knowledge (MacIntyre, 1984, p. 219).

## **APPENDICES**



## **APPENDIX A: INTERVIEW GUIDE**

A general interview guide is used that outlines a set of topics to be explored with each interviewee. The interview guide aims to explore underlying ethical principles and values, using open-ended questions that unfold readily; an in depth dialogue, allowing illustrations and narrative examples. Notes will be taken and the sessions will be audio taped and transcribed.

### **QUESTIONS**

1. **Foundations:** What are the foundations of professionalism? Who are the foundational philosophers that have influenced you? What is the role of tradition?
2. **Education/Learning:** How does this apply to education? What is the role of covenant in the 21<sup>st</sup> century?
3. **The moral community:** How can educational leaders within health care support the professional moral community?
4. **Policy:** What does this mean in terms of policy? How do educational leaders most effectively influence decision-making in the area of health reform and social justice education?
5. **Practice:** What does this mean in terms of practice?
6. **Communitarian Ethic:** How is the communitarian ethic (“common good”) manifested by the moral community?
7. Have you experienced an Epiphany?

## **APPENDIX B: GRANT R. GILLETT, MB, CHB, FRACS, D PHIL**

### **BIOGRAPHY**

Dr. Gillett is a Professor of Medical Ethics and Consultant Neurosurgeon at the University of Otago, New Zealand. He graduated from the University of Auckland in 1974 with a MB, ChB. During his medical training he began studying philosophy. After obtaining his Fellowship in Neurosurgery, he proceeded to further training in neurosurgery as a Fellow at Oxford University. He also enrolled in the Faculty of Philosophy and in 1986 obtained his Doctorate in Philosophy. He was appointed a Fellow at Magdalen College where his research was in medical ethics.

Dr. Gillett is deeply involved in teaching at the University of Otago in both neurosciences and bioethics. He recently established the Bioethics Center at the Medical School.

Dr. Gillett is the author or co-author of several texts on medical ethics, and has published well over 100 articles on the philosophy of medicine and medical ethics. He has been a visiting lecturer at a number of Australian, European, American and Canadian universities.

### **INTERVIEW: MAY 1, 2004**

All of this relates to our Canadian communitarian ethic, so in the background, I'm concerned with the malaise of modernity and how a communitarian ethic lived and transmitted through the professional and personal interactions of exemplary leaders within the health care profession. That's a broad area, so thinking about all of the challenges to our Canadian healthcare system and professions working within that, how can educational leaders, whether formal or informal, help to support that? My first question relates to foundations, so from your perspective, what are the foundations of professionalism? And for you, who are some of the

foundational philosophers who have influenced you in relation to professionalism?

*Well, the foundations of professionalism for me are closely related to the Aristotelian concept, a skill informed by developed knowledge. For today this has become a range of skills informed by university-based knowledge, particularly in the biomedical sciences, but increasingly in the humanities. In fact, I think that increasing recourse to the humanities reinstates many of the values and foundations that used to be in medicine, because the pride of physicians as distinct from surgeons, used to be that they had received a university education and that their mastery of physic was based on and rated in that board or university education. Now this created in that group the Hippocratic awareness of their collegiality with all other scholars and their need to support one another in what was a collective attempt to discover more about the subject. It was no accident, I think, that many of the physicians formative in the profession were also much more broadly educated in the natural sciences—there were prominent astronomers, physicists, botanist, zoologists, and also in the humanities, so they were men of letters—John Locke being one—who made significant contributions in academic areas apart from medicine. And this whole ethos laid a foundation in which individual skills were very much exercised and informed within a community of letters, a community of free, open enquiry in which there was a delight in communicating new knowledge in which the satisfactions went far beyond any particular rewards that the individuals might individually command for themselves, although of course, always professional repute and the esteem of one's colleagues was highly prized. A number of them were prominent in the Royal Societies or equivalents in their own countries. Now those foundations philosophically I would very much relate to Aristotelianism, an idea in which scholarship is linked to training in virtue, so that it is not at all expected that anybody would develop their intellectual life but neglect their own personal development as a virtuous and well-rounded individual. And the prominence in the Hippocratic school of the oath that was taken with its fairly unbounded commitment to human well-being and to holding sacred things that were*

*conducive to human life endorsed that same kind of balance between the intellectual or the purely technical and the moral development of a practitioner. I think if we spring right forward into the present day, neglecting several major figures en route, it's no accident that Michel Foucault, the post-structuralist French philosopher, has used the Greek writings for inspiration in his own unfinished work on ethics, and the whole idea that ethics involves far more than just rightly governing the relationships between people. It also needs essentially to involve an attention to the state of one's own soul, with it not considered in any mystical way, but merely s a kind of summary of the character, personality and conduct of the individual concerned. So that idea of care of the self as a well-rounded human being is something that Foucault bodes into the fundamentals of his ethics and summarizes in that remark that ethics relates the subject to the truth. Personally my recent discovery of his writings and enjoyment of them has for me summarized a lot of things that when I reflect on it, is quite foundational in my own understanding of medical ethics and the nature of the medical profession. To me, to be a professional is not only to command a set of skills, but also to participate in an ethos in which you are set apart—you are privileged in certain ways and you bear certain responsibilities in proportion to that privilege and the esteem in which society implicitly holds you.*

Moving on, what is this application, this foundation to education and a related question, the role of the covenant? What do you see is the role of the traditional covenant in the 21<sup>st</sup> Century? Does this relate to education currently?

*To me it means that from the moment a young person steps into the context of medical education they must understand that they have taken upon themselves a vocation and that therefore they have accepted a certain kind of responsibility and put themselves within an ethos so that within that ethos they will learn the skills that are to be taught them. That then implies that one of the things we ought to do in medical education is not only in part intellectual and practical skills but also in part the ethos. Reinforce the fact that they are younger colleagues, reinforce the fact the fact that we and they are the inheritors and current bearers*

*of a tradition, reinforce the major tenets of that tradition, a putting of value on human life, and the love of humankind, and then acting out of the love of humankind in all our knowledge and all our clinical activities. Given that this central value on the lives and well-being of the individuals with whom we have to deal, because they are suffering and it has brought them into our path, bearing that in mind and bearing in mind the open-ended nature of the commitment that one undertakes, there is no other adequate way to conceptualize this except as a covenant. It's fortunate that the major model for a covenant that we in the Western tradition have inherited are the theological conception of covenant, which the most authoritative exponent of which reduced it to two simple elements, the love of that greater being in which we and every other human being finds themselves grounded, and the love of those human beings whom we ought to call neighbours, because they need our help. Within that we then learn that an essential part of loving your neighbour is also to love yourself, to have a due regard for your own worth as a human being and your own need for the kind of nurturing growth that you would wish for anybody else. So then, the most exhaustively outlined covenant we know about in our own traditions, we have all the elements of what medical education should be all about. It should be education and service of a good, an overarching good, a good in which we all find ourselves participating, that sometimes in powerful and effective positions and sometimes in very vulnerable and needy positions. And that participation really relies on two fundamental ethical orientations, an orientation towards the value of human life whether in oneself or another and a desire to do the very best one can to enhance human life or mitigate suffering where possible. And once that whole covenant, or ethos as it were, becomes a loving part of the spirit of medical education, then it will of course check some of our worst vices—vices of arrogance, of hierarchical vices and self-seeking vices, vices of profit, vices which would involve us in selling ourselves for currency that is not worthy of them. All the kinds of evils that one sees creep into medicine under various guises and in various kinds of background context would then be radically thrown into relief by that kind of orientation. So I see the covenant concept when*

*pursued not in any kind of airy-fairy way, but in terms of creating a context of value within which the relationship between doctors, patients and communities ought to be understood, as being quite a valuable one, even in the 21<sup>st</sup> Century medical culture.*

How can educational leaders within health care support the professional moral community? Do we have one moral community?

*Yes. It's implicit in what I've already said. There is a professional moral community and it isn't inappropriate to talk about it in those relatively unified terms. And therefore, even if descriptively one would like to say that medicine and the Hippocratic professions allied to it are becoming fragmented in contemporary society, normatively in terms of what ought to be the case, one wants to reassert that there should be a community with a moral commitment to healing and caring to the love of humankind in its most practical sense.*

*And therefore, as health care educators, the role one ought to play in this community is to do whatever is required to ensure that the very real need for those underlying values be reaffirmed and implemented and borne in mind at every point in the educational context—so that it is, for instance, not acceptable for teachers to exhibit vices that are inappropriate in that community—vices of exploitation, self-aggrandisement, self-seeking, arrogance, and abuse. Those things would all be intrinsically opposed to the development and growth of the kind of community that was going to end up with this kind of moral profile. So that means that teachers must be encouraged to share their faults, to admit their ignorance when they are ignorant, to learn from their students, to share what wisdom they have, to treat their own learning wherever it's taking them in their journey as medical educators as an adventure in which the young colleagues can be caught up perhaps from time to time, involved in research projects where they do learn to function collegially with those ahead of them on the way. And then involved in clinical commitment and care, where they are drawn into a team*

*atmosphere, where there's an unwritten assumption that the patient will be regarded as somebody to be respected and cared for and acknowledged.*

*So, to me, health care educators and leaders of health care education can help to create this atmosphere by exercising upon themselves those very techniques of care of the self and self-development that they are entrusted with imparting to their students.*

Moving next to the important area of policy development, how do you see educational leaders most effectively influencing decision-making in the area of health reform and social justice education?

*Leaders in health care education have a very important role to fulfil. Because they don't actually stand to gain directly from improvements in the health care services, and therefore the commentary on the provision of health care services can, as it were, be given from a certain distance and therefore have a certain objectivity about it and be seen as having that. For the most part also, our leaders in health care education are senior figures who have been through a significant period of clinical work themselves. And so they have a great deal of practical and applied wisdom which they can then share in the appropriate contexts. And I think they also need to encourage rigour of thinking and not believe that as soon as they move into the higher reaches of medical education they can be sloppy in their acceptance of habits of thinking from any other group. They do have to study and learn and become expert in that knowledge, just exactly as they did when they were mastering the clinical discipline, so that when the discussion turns to policy or planning of health services or political aspects of health service provision, they are, at least to some extent, knowledgeable with the conversation that's going on and they can take an intelligent part in it. And quite often, given the quality of the intellects involved, if they are seen as taking seriously the good work and thinking that is available in those areas, they will gain increasing respect for their ability to be a resource, to provide timely advice and to always provide well-reasoned opinions which don't leap on this or that*

*political bandwagon at any given time. Policymakers are, after all, usually trying to do the right thing. It's just that many of them come to the job extremely ill equipped to understand what the right thing is. And then there is almost no time or space given to them to become educated in what it is they are actually dealing with, so those of us who are used to educating ourselves and used to knowing where we can find the appropriate kind of understanding have a very real role to play in becoming valued partners and collaborators with policymakers, helping them in situations that are difficult, helping them achieve clarity about the tangles that they have come across and thereby earning for ourselves a voice in the councils of policy that becomes a valued voice rather than just an alienated or obstructive voice. Of course, on seeking to enter the conversation as an honest participant, willing to learn, and willing to try and get up to speed, you also model the exact values that you would like to see reflected from those policymakers themselves, a willingness to listen, a willingness to take on board clear, well-formulated arguments and to do something about it to actually learn to be transformative in terms of the actions that are done in a way that is intelligent and not just reactive or reactionary or politically motivated. So, to me, is a very good role to play here, but we must always be on our guard in a trusted senior position against people who want to recruit our seniority to strengthen their cause when aspects of the cause have not been well thought out in terms of the overall goals that we are all on about. So, personally, I see a very important role being played, but nevertheless a role which must be fulfilled within the context of remaining committed to the ideals and the integrity of health care as caring for suffering people and preventing and mitigating their suffering, those very basic ideals which we have talked about before.*

Role modelling is vital...

*Often policymakers come into their role loaded with ideology. They have often been promoted from relatively junior positions in the governmental hierarchy or from an advisory capacity aligned with some particular political agenda, whether it be right wing or left wing. And all ideologies carry assumptions, and part of the*



*Hippocratic ethos, Aristotelian ethos, are very similar, is to question assumptions, to hold them up in face of the actual way things are—they way the rubber hits the road or where health care actually gets applied in hospitals and wards and clinics and so forth. And therefore to bring that critical reflective function into those councils—not being obstructive, but always asking for elucidation, for clarity of thought. It seems to me this is just modeling exactly the kind of conduct we expect of each other, if we are a responsible profession. And therefore it's extending the boundaries of health care professionalism to people who themselves may not have been raised in that ethos. They may have been raised in a very different ethos—the ethos of a socialist faculty, or then perhaps a business feature of some kind, and those might not necessarily have conveyed to them any of the spirit of the enterprise that is health care. So it does seem to me that we carry with us a certain way of approaching things and dealing with questions and challenges that is extremely useful.*

How do health care professionals come together at an organizational level on policy development? “We’ve some issues and let’s develop some policy”—where there is little experience for this sort of discussion. How can one support these situations? What would be a lead participating role?

*Well, before I mentioned this concept of partnership, and in the context of various discussions, I have often remarked that one of the most useful things for a clinician to do is to outline as clearly as possible the problem that has been disclosed in investigating the patient and enlisting the patient as a participant in the problem-solving exercise. So to do that, the information needs to be conveyed as accurately as possible, and as understandably as possible, in clear and simple enough terms so that the patient can see what the problem is. And then the implicit question that the clinician asks the patient or poses the two of them as a team as it were is, so how do we now solve this problem now that we both understand its dimensions. How do we combine our talents to solve it? Well, of course, as soon as you translate that question into an organizational setting, exactly the same elements are in place. Let’s get a clear view of this problem.*

*Let's get information from whomever we need to, to delineate the problem, and then as a team we can pose ourselves the question, so how are we going to combine our talents to solve this. And there's no sort of an upper level at which that question can stop. Arguably, it can still go on right up to the level of the Minister of Health as it were, because everybody involved in every situation where there are problems to be solved is going to have certain talents to offer to the problem-solving exercise. And as long as they are all pulling in the same direction and if there are any conflicting agendas, those conflicting agendas are on the table to that everybody can take account of them in an honest and open-handed way, you are most likely to find a solution, perhaps even a compromise solution that everybody's going to be able to live with.*

And does that relate, in Aristotle's terminology, with the phrase about looking for solutions, perhaps not the ideal, but for good solutions for now, that will help us move forward?

*Yes. It's a phrase that Al Jonsen used about doing the right thing at the right time with the right people to the right extent. It's a concept of fittingness and I guess if one were to ally something to that which is all part of wrapped up in the same kind of practical problem-solving approach to these goals and ideals that need to be served. One would say fittingness and attainability in the current context need to be worked together. Now, of course, sometimes that may need to be a compromise, a compromise only entered in to only because everybody feels that they can live with it, given the conflicting agendas. And the compromise may be consciously made with the thought that it is going to be improved upon, but that at least it would be a step forward, and the ultimate solution may be very different in formulation from that interim solution which was required in that context to get things off the ground, that rather than aiming for a complete and ultimate pure and attractive, intellectually beautiful solution to the problem...*

Plato's ideal.

*Yes. The ideal, the way here it might be much more than conversation, adaptation to a strange situation with certain compromises, may just need to be taken and then a gradual edging towards a position from which initiatives which are going to be ultimately much more positive can be taken. And any doctor that's working in a reasonable size health care institution has had to learn skills of this kind, if they have learned to be a well-functioning practitioner or professional in that context. Because I have had to learn to work with other people. I've had to learn to give people purchase for their own different kinds of expertise, and I've had to learn to make adjustments according to conflicting agendas so that nobody gets alienated to the detriment of the overall project. And, well, that's what Aristotle calls phronesis, or practical wisdom—the ability to make the best in a way that's moving in the right direction.*

What does our discussion mean in terms of practice?

*I think leadership has always got to be practice or practice oriented. I think the other thing that leaders really have to get over is any tendency towards a cult of personality where what becomes more important than the successful prosecution of an enterprise or the successful engagement in a practice becomes the glory that's attached to any given individual, the recognition that they receive for the part that they've played in it. As soon as we allow that individual inflating value to in any way compromise any practice improving values, either personally or as an institution, we're going to just make it awkward or potentially awkward. Now with certain exceptional individuals, they just won't let that happen. And this is of course not to say that we shouldn't honour excellence or individuals who stand out and have done well and that we feel we want to honour, but those individuals, if they're worth honouring, will not want their own honour and recognition to obstruct...*

*...The leaders who most deserve honour are those leaders who will not let their own honour and recognition get in the way of a system that they are trying to improve to the point where those that follow will surpass them and be better than*

*they are in everything that they do, because that is almost inevitable. Our own abilities developed at a particular historical point in medical education and medical practice becomes obsolete. Society moved, technology moves, and what seemed impossible when we were mastering the art and practice of medicine becomes possible, even routinely possible, to those that follow us. We should genuinely rejoice when their skills and their insights surpass our own and give testimony to the kind of cultural improvement and growth in personal development that we are all trying to foster.*

How is the communitarian ethic manifested by the moral community? How can we in Canada support the communitarian ethic in our health care system and how can our professionals support that ethic?

*There are two possible ways in which a group can manifest a communitarian ethic. One is ultimately damaging and the other is ultimately very valuable. If we were to follow our nature, we would identify the first as the herd mentality, the ideal that nobody should be allowed to stand out too much and that therefore, as a community, we must maintain our uniformity and solidarity at the expense of expressions of individuality which would, to use the colloquial expression, raise the bar. (Nietzsche controversially celebrated the possibility of the overcoming man or the super man, a much-misused concept. The ideal is really an individual who exemplifies fully and joyously all the best characteristics of being human.) To me, the right kind of communitarian ethic is a kin or family type of ethic in which we long as a community to nourish those among us who can grow and develop and explore new heights of attainment because of their nourishment. And we celebrate these achievements and we jealously preserve the valued points in their tradition which make possible those achievements. So, for instance, were we to think about medicine, we would jealously preserve that spirit of dedication to human life and then within that dedication try and cope with difficult issues like euthanasia, the need for a comfortable death, the need to avoid mortal agonies as an inevitable accompaniment of death in some cases. We would try to accommodate some kind of response to the need of the young*

woman who sees her life being potentially destroyed by a pregnancy which is at a time when it is going to be incredibly disruptive. What we must be doing is seeking to find room for individuals to be individuals, to be excellent human individuals, but also seeking not to abandon those truly valuable things like the love of kin, like duty and responsibility, like loyalty, that have given rise to some of the most heroic moments that our community draws on for inspiration and strength. So, to me, the value of a community is the value of the human excellences to which it can give rise, in which its own internal morals are conducive to the process of producing. So, the kind of flat-footed communitarianism, that imposes uniform and often lowest common denominator standards in the name of equity or something of that nature, seems to me exactly what we don't want. The kind of communitarianism which is firmly fixed on our ideals like compassion, care, nurture, rescue, and within those, seeks to make room for the emergence of and the withdrawal, so we'll raise the level of community experience and achievement that we live with. That kind of community seems to be the right kind, to give an expression, to the communitarian ethic.

The language of duty, though it's not necessarily linked to the herd mentality, can become very stultified and restrictive. The language of value tends to be more open-ended and aspirational. But sometimes, particularly for those who are young or early in the development of the moral life, duty becomes learning duty, abiding by duty, becomes an important stepping stone in terms of writing into the life of that individual the value that you want to see them come to appreciate. So, for instance, writing into our young residents and scribing on them, as it were, a duty to save life where they can, is not a bad move, and it would be a great pity instructing to stop a resuscitation or just to acknowledge that they can't achieve anything more in this particular case. It would be a great pity if that resulted in cynicism, but then almost the only way to make sure, to try and make sure that it doesn't happen is if the senior individuals themselves allow their conflict to manifest in such situations. So, for instance, in the very act of terminating a resuscitation, it's very easy to make a dismissive comment, a kind of, well, so,

*another one bites the dust, kind of thing. But it's probably much more honest to what you really feel and it's much more honest to the ethos of the profession to allow a representation of the tragedy of the situation to be exhibited. So, to convey somehow that although the only realistic decision is the one that was made—well, these kind of sadnesses are part of their life, but they are sadnesses. They are never something one should just accept with equanimity or indifference...*

And you have led us back to role modelling. And our final topic—have you ever experienced an epiphany?

*Have I ever experienced an epiphany? I would say I have experienced a number—some in the presence of intense guilt, some in the presence of tragedy for which I could feel no guilt, and some in the presence of truly uplifting moments when somebody did something or said something that to me just crystallized an affirmation or reorientation of value in a way that felt just deeply satisfying. So, I mean, the first kind, the guilt-related kind of epiphany, is—these are all related to that kind of underlying ethos of the care of the self and that being seen as an undertaking and service of relating myself as a human being to the truth about me and my practice and what kind of person I mind. So, the first kind, the guilt kind, tends to occur when something very vividly or forcefully brings home to you the idea that the thought, what kind of person are you, that you could have done or contemplated this kind of a thing. And one has those thoughts at time. The second tragedy related kind of epiphany that seems to me, occurs when something truly tragic has happened, something in which you've got a great deal of emotional investment as a person and perhaps as a clinician. And where you suddenly realize that actually want to fail to feel the force of the tragedy. So you would never actually want to be the kind of person who wasn't disturbed by that kind of thing happening. So it's almost the obvious of the former. It's more comfortable in the sense that it reaffirms for you the depth of a certain strand in your own nature, but of course it is also deeply disturbing and it sticks with you and brings you back in touch with a very mortal context within*

*which we work. And the third kind of epiphany where something happens that just reaffirms or reorients your values can happen for instance when you are thinking perhaps fairly mundane thoughts or feeling kind of ground down or semi-cynical thoughts about clinical life and something that has happened and a colleague, either younger or older, suddenly just shows a reaction or makes a remark that makes vivid for you a value that you know really in your better moments you do hold dear. And at that moment, you kind of realize that actually, really, you're more comfortable being the kind of person that is being expressed in that remark or reaction than the kind of person you are being at that moment. And I think an accumulation of such events and an atmosphere in which you get to articulate such things, which may be a private atmosphere or if you are exposed to the right kind of literature and meditation and so forth, or it can be a more communal atmosphere, your workplace or your professional relationships provide you with the kind of person with whom you can share such moments. To encourage that kind of thing, it seems to me, is also an important part of what we are, and it makes such epiphanies things that people then can actually grow from rather than not quite know how to react to and ultimately lose sight of.*

## **APPENDIX C: ALBERT R. JONSEN, PHD**

### **BIOGRAPHY**

Dr. Albert Jonsen is Co-Director, Program in Medicine and Human Values, California Pacific Medical Center, San Francisco, California and *Emeritus* Professor of Ethics in Medicine at the School of Medicine, University of Washington, where he was Chairman of the Department of Medical History and Ethics from 1987 to 1999. From 1972 to 1987, he was Chief of the Division of Medical Ethics, School of Medicine, University of California, San Francisco. Prior to that, he was President of the University of San Francisco, where he taught in the Departments of Philosophy and Theology. He received his doctorate from Yale University in 1967.

The Institute of Medicine, National Academy of Sciences, elected Dr. Jonsen a member in 1980 and he has served twice on its Council. He was Chair of NABER, the National Advisory Board on Ethics in Reproduction (1991-1996) and a member of the National Research Council Committee on AIDS Research (1987-1992). He served on The President's Commission for the Study of Ethical Problems in Medicine (1979-82). He has been Visiting Professor at Harvard Medical School, Georgetown University, The Johns Hopkins Medical School, Masstricht Institute for HealthCare Ethics, Netherlands, and Visiting Scholar, National Library of Medicine, National Institutes of Health, Visiting Professor of Bioethics, Yale University in 1999-2000.

Dr. Jonsen's latest book is *A Short History of Medical Ethics* (Oxford University Press, 2000). He is author and co-author of a number of texts on medical ethics, including with M. Siegler and W. Winslade, of *Clinical Ethics* (McGraw-Hill, 1998, 4<sup>th</sup> edition). He has written chapters in over 70 books in medicine and health care, and his articles have appeared in a large number of scholarly journals of medicine and ethics.



**INTERVIEW: APRIL 29, 2004**

Dr. Jonsen, in terms of background, a central question of my work is, given the malaise of modernity, how is a communitarian ethic lived and transmitted in the professional and personal interactions of exemplary leaders in the health care profession? So, I'd like to ask you first of all about foundations. Who are the foundational philosophers that have interested you? How you see the role of foundations and the role of tradition in professionalism?

*Well, to start with the last comment about the role of tradition and professionalism, I think that the role of tradition in understanding what professions are and how they have come into being and what various values have been drawn upon, that the role of tradition is absolutely central. Tradition, in the sense of the way in which a body of ideas is passed through generations and undergoes changes without losing its essential message, so that you've got great variety in traditions and, at the same time, a message seems to be central and continually there. And of course, when you take that point of view, you also have to recognize that tradition may in fact utilize similar language and refer to similar historical moments, and so forth and so on, but that the language and the references don't necessarily mean that the interpretation and the perception is the same at a later date. You mentioned that you've used Alasdair MacIntyre's work, and he clearly makes that point very clearly with regard to ethics, and Taylor makes it as well. And so you have to be extremely cautious in attempting to utilize tradition and try continually to situate it in its success of historical moments. So when it comes to the tradition within medicine, I think one thing that has remained essentially the same in the Western tradition of medicine is something that's fundamentally very, very simple in expression, and that is the determination to attempt to benefit the patient. In the Hippocratic literature, the idea of bringing benefit to the patient and doing them no harm or injustice, I think remains throughout the entire Western tradition. I don't think one ever sees it*

*disappear and, in fact, not only in the Western tradition, but I think it's also true in the Oriental traditions of medicine.*

*Sometimes philosophers and tradition don't mix very well. Tradition in a sense is a folk culture and oftentimes it persists with very little analytic activity going on within it, relatively little analytic activity, relatively little philosophical activity, and I think that the Western medical tradition is not very philosophical. The literature doesn't refer in any depth to the concomitant philosophical streams of thought flowing around it. Certainly there are references, there are no questions about that, and you can do some very interesting studies of the interactions, like the studies that have been done recently with regard to enlightenment philosophers and Scottish enlightenment and Scottish medicine and the growth of the code of ethics manifested in people like Percival and so forth. You can do that and you can point to certain places where the philosophical tradition and the medical tradition touch each other, but tradition is not in itself a very philosophical phenomenon. And so, when you go to the philosophers, you're going to them as people who are talking at a certain historical contemporaneous historical time to some feature of the medical tradition. Take Aristotle, for example. You asked me what philosophers I think are foundational, and I guess I'd probably say philosopher's aren't foundational, but philosophers who are of interest in trying to understand the tradition—I'm probably more of an Aristotelian than anything else, I've always been dedicated to Aristotelian thought and I think I understand it pretty well and I've used it a lot in the way that I try to work with ideas. Aristotle was the son of a doctor, they say. It's very interesting when one reads the ethics with that in view. There's so much in there that reflects his understanding of the medicine of the time. And in particular, I think that the whole concept of virtue as a mean really is very much related to the Hippocratic understanding of the way in which the humours are balanced in the body and the idea of function and finality is Hippocratic, not that Hippocrates explicitly mentions finality, but the whole structure of the way in which he understands the body in relationship to the environment and so forth. And Aristotle seems consistently to be drawing that into his ethics and frequently as illustrations, but I think in a very basic way. A*

*most interesting thing about Aristotelian ethics is the concept of deliberation and the way in which practice—action results from deliberation, and that it has a great deal to do with understanding the circumstances, and that's perhaps the most Hippocratic feature of his ethics. That is, in Hippocratic medicine, it was essential that you do the right thing at the right place and the right time, and that's what the doctor's success lies in—and being able to ascertain what intervention is useful at this point in time and for this particular person. And so when you transfer that to ethics, it means that you understand ethics fundamentally, not as a structure of rules, but as a response to a situation in terms of a stable character or disposition—the virtues or the habits. And it seems to me that it runs all the way through our growing understanding of professionalism. A professional person is someone who can make those sorts of decisions in the situation with regard to the particularities that need to be dealt with at the time and they do so not haphazardly, but out of a stable character that's developed. And that's what a professional is, and professionalism as we understand it even today I think is very Aristotelian.*

*The problem, to go back to something you mentioned earlier, the problem that we face that you described as the malaise of modernity which is a very diffuse concept, and a lot of people have used it in different ways, but the challenge that it poses to Aristotelianism is that what he considered to be a fairly stable set of characteristics or virtues is clearly not the way in which we would express virtues. I mean, if he considers the courageous person and the generous person and so forth and the magnanimous person and even in the term that he uses in describing one virtue, the virtue of magnificence, really is a relationship to his conception of Athenian aristocracy. And these are not the virtues that we think of today, but we don't know what virtues we should be thinking of, and we continually make reference to virtues that sound like they're Aristotelian, but they're very different. He has nothing corresponding to the kind of altruism that we seem to continually call for when we talk about professional virtue. He doesn't have compassion, you know. So that we don't know what those things actually mean within our own culture and how they are to be imparted. So I think that*

*that—I'm a little dismayed by the professionalism literature that calls for virtues that we think are highly praiseworthy but don't really know how they fit into the world in which we live or how to train people to act in accord with them. And that's a question for Dr. Pellegrino, who really makes a great deal about the importance of the virtues and the profession. But exactly how—take compassion, for example. I think the ideal of compassion probably has Christian roots rather than Aristotelian ones, and has a good bit to do with the perception that all human beings are fundamentally equal and equally needy.*

*But in our culture, and by that I'll say American culture—I don't know the extent to which this is true in Canada—one of the most common characteristics of the way in which people think about other human beings, we're in a situation today where people are so concentrated on their own neediness. All this extraordinary industry of self-help, which presupposes that all we have to do is just take a moment to notice and we'll see how terribly deficient we all are in everything, and we have to find strength for ourselves, etc., etc. And it has very little to do with anybody else. The virtue of compassion would seem primarily nowadays to be a virtue of taking care of oneself. And if you look at Aristotle for anything that might shed any light on it, his discussion of friendship is a very interesting one, because his basic presumption about friendship is that friends are those who share the good and that they have to be good in themselves in order to be friends to another. So that his concept of friendship starts with a fulfilled person who then finds another fulfilled person. He does talk about unequal friendships—there are unequal friendships. But basically, friendship, in the Aristotelian sense, has a very strong basis in the fulfilment of the self. In fact, it even reads as if it's rather selfish. When you read the two books on friendship, it looks selfish rather than self-giving, yet he continually says, you do give the good that you have, you give to the other, you share with other and so forth. But I don't know that we understand what compassion really means in our culture. I don't know that we understand what altruism really means in our culture. And so we can't just affirm that these are virtues that the professional should have. You can't just say, go out and be altruistic, because we have very little basis for altruism. And people*

*who are altruistic are often genuinely altruistic are often seen as being all muddy. We're really a very powerful culture of self-interest.*

What are some of the foundations that we could still be relying upon and what do you see the role of the covenant being in the 21<sup>st</sup> Century?

*Well, let me go back a bit before I move directly to that and say something about the altruism and say another thing about the altruism and compassion concepts. I think perhaps the most fundamental value of the culture that we are most familiar with is the importance of personal achievement. You have to make it on your own. And I think when that becomes a dominant concept, it puts in the shadow—it doesn't completely eliminate from our things, but it puts in the shadow the idea of obligations to others and genuinely self-sacrificial kinds of action. It just simply, because we are continually taught you have to make yourself—you create yourself—yourself, your being is not a gift, it's something that you have to make. And so our education then, to go to your question, our education is really an education about how to get the skills to make yourself and to make yourself succeed in a whole variety of ways in the culture. And so, there's nothing either in the educational structure that leads to the kind of virtues that we ascribe to professionalism. Look what medical education does from the time that the student begins pre-med. I mean, it's an enormous course in self-actualization, with powerful heavy pressures to do that. And then somebody keeps showing up every once in a while saying you must be compassionate, you must be altruistic. But there is nothing about this powerful educational system that even begins to instill those thoughts from the beginning. The concept of self-sacrifice is simply non-existent, totally non-existent in our culture, and it comes to people, when it does come to people, it separates them from the culture. What would we need to do to educate toward the virtues of professionalism? If we think those virtues are such things as compassion and altruism, we clearly can't neglect competence, and it is the striving for competence that clearly puts these other virtues in the shadows. The idea that a virtue is something that comes into being by understanding a lot of them is simply inadequate. Aristotle stresses that virtues*

*come into being by practice, but other philosophers, the stoics, Epictitus, for example, stress profound self-discipline. And the stoic virtues are very hard to attain and very rare because they essentially require a person to come to the point where they can consider all goods as in themselves indifferent. And that isn't anything we're doing in our educational system.*

*So, how would we educate if we wanted those virtues? Well, I suppose you'd have to expose candidates to situations where they really saw and lived with genuine need and, this is entirely imaginative, and it's hardly anything that we could actually institute, but, say before, at the beginning of medical education or in the middle of it or at the end of it—whatever—every student would have to spend at least a year helping in an under-developed country, in Zambia, in Somalia—places like that where they would see need. Even that in itself is not sufficient, because the natural response to that oftentimes is to say, I want to get out of here as fast as I can. But if it were also a constant and accepted part of medical life that you cared for the poor all the way through your career and it was simply expected that this was something that you had to do—I mean, there was a time when it was considered very proper for physicians with good practices and so forth to spend a day in the public hospital to give that time, and those things were done, and there's very little of that today. But suppose it were an obligation. Suppose those students who had their way paid through medical school had to pay it back in that fashion. In the United States, when we had the federal grants for medical education that were paid back by doing a year's service in some under-served locale—well, that's good in itself, and it may have the impact of people seeing something that we changed their life for a long time, but I'm thinking about something more than that. So I think I'm something of a skeptic about the possibility of creating those educational structures and even bringing about these presumed professional virtues. And I worry that a lot of our discussion about professionalism may be talking about things that are in themselves not possible. But does that necessarily mean that we ought to give it up? I don't think so. I think there may be a variety of very particular ways of getting at the issues, not huge, big overall reforms that we may have to think of*

*not of the profession as a whole but of instances of the profession. That is, in particular places, particular clinics, particular hospitals, looking where the physicians can directly communicate about what makes it possible for them to serve their patients, and to formulate policies at very intimate levels of practice. That's what we hope we can do in our institution. That's why we really want to be there.*

*We want to see if our institution can become an instance of professional virtue, a place where those ideals are understood, even though they may not be built into individual habits of all parties, but that the structures, the institutional structures around the care of patients, are continually formed to assure that their care is appropriate.*

Talk a little more about that. That's very pertinent.

*Well, I think that's the Aristotelianism of it—that we don't want to work at these enormous reforms. We want to go at the place where you have power to make change. You may not be able to reform the system in any great sense as a whole, but you have every physician, every health care professional does have the power to participate in the structuring of the institutions within which they work. And for things like, just to take one example that's complained about a great deal, time spent with patients as institutions try to restrict the time that physicians can spend with patients. They clearly undermine the effectiveness of the clinical encounter. To some extent you can clearly do that, you can make it more efficient and more effective and communication can be improved in a variety of ways, but nevertheless, you can't package that 15 minute, 10 minute, 12 minute encounter as a standard and hold physicians to it. You can't do that. The only people that can change that are the physicians within that setting who say we will not do it that way. We will not. We cannot. And I think there's been success in many places. I don't know the extent to which that's a problem in Canada, but it's clearly a problem with managed care in the United States. And it seems to me that there are lots of features of the practice setting that can be very*

*much distorted by efficiency efforts by bureaucratization and so forth that the individuals involved can actually take on and say this is not the way it's going to be done here. And I think in order to make that effective you just have to be able to have face-to-face communication between the practitioners. And they have to understand better why certain forms of practice that are being kind of imposed really don't help. Take that one question of guidelines. I think practice guidelines are in one important way a very, very good and positive thing. But the moment that those practice guidelines begin to become kind of enforceable ways of approaching the patient, they fail to uphold that patient encounter because the encounter has to be highly specific. So if some organization attempts to penalize physicians for failure to follow guidelines, as insurance companies have attempted to do, they simply have to say we do not do that. We cannot. And they have to do that as a collectivity. In this group of physicians, this group working here cannot do that. And I think that the experience of the last few years has been that people, those who are trying to impose those sorts of artificial barriers and boundaries and so forth, back off. And we have then, of course, the enormous problem of the care of the under-served in the United States. (I think it's a different problem in Canada.)*

*But the idea that we have failed in the United States to reform health insurance so that it can deal more effectively with that, but that doesn't mean that health care institutions individually cannot much more successfully take up that segment without harming themselves in any great way. And those have to be honestly evaluated. What can we do? So it is possible for our institution, which happens to be a very significant health care institution and has a large clientele of people who are well insured. Why don't we have clinics in various parts of town where we can provide care? And it's always that it will overrun us if you do that. Well, try it. And we've seen there are examples where that's been successful. So, in general, what I'm saying is that it's not so much a question of professionalism and the profession in a grand sense. It's a question of instances of professionalism, instances where the profession forms itself and exerts itself in particular places and particular times. Because individual practitioners have been*



*very individualistic, very individualistic. And if we apply at least one of the features of modernity, a recognition that in our culture individualism has a very high place, nevertheless we also recognize that individualism requires collaboration and cooperation. It isn't individuals that make great corporations. It's groups of people that find ways of collaborating. And actually, Aristotle has a category of friendship built on utility. He said you find some common purpose and as long as you're able to pursue that purpose and promote it, you have friends. And you can do the same thing with the high individualism of physicians, which is built into them by this education that makes them so self-actualizing, recognizing that also in this profession, which has been very much a profession of loners, that there are possibilities of collaboration and cooperation, and around particular things, such as the care of the under-served.*

This leads into the question of policy development. How do educational leaders most effectively influence decision-making in the area of health reform and social justice education?

*Well, you've done a lot of reading about leadership and you know how diverse it is. Can it be said that there is any single concept that captures leadership? There is much discussion about leadership in business and so forth and so on and it's been going on, but I think that in the professional world, one feature of leadership is that the person who will be the leader in the profession will really be a person who has lots of other things to do. The medical leader is going to have to be a practitioner and it's not like being the leader of a corporation where that's what you do—you spend all of your time thinking about how this corporation can achieve its goals. Whereas, in the profession, the professional is a lawyer, the professional is an accountant, the professional is a physician, and you're not an executive. So, given that limitation, what is it that makes for leadership? Well, I suppose some of the standard sorts of things are pretty obvious ideas—the ability to articulate ideas and the ability to rally people around an idea. I don't think leadership is much more complicated than those particular skills.*

Dr. Jonsen, let's review the core, fundamental pieces that support the professional within the everyday work setting.

*In my experience over the years, I think what's my expertise, and that's been a debate in the field of medical ethics—what's the expertise? And I have no idea exactly how that ought to be answered. There's expertise in a very narrow sense. It means that I happen to know the literature in the field better than most other people who don't have the time and opportunity to keep up with it, so I do that, and because I teach it I usually understand it in a fairly analytic way. So that's an expertise. But that's not the expertise that's really relevant. When you're actually there, the discussion is a discussion that they perform. I mean, they're the ones that talk. They're the ones that do it with relatively little input from me, but the discussion wouldn't take place without me. Sometimes being able to keep a discussion like that on track is another special expertise as it were, but in general it's the legitimizing of a form of discussion that otherwise is not likely to take place. And when you have an institutional structure, like a program or a department or a whatever, that says that people who are thinking about certain things, like how do we take care of the poor in our area, can say, "Well, let's go to the people over in Medical Ethics and let's talk about that. And ideas are generated, and so, in a sense, the most important contribution that can be made by a medical ethicist is to create a forum for the discussion of new projects and programs and problems and so forth and so on.*

That's a connection to how one can effectively support or influence decision-making, hence have you suggested providing the opportunity or facilitating the opportunity for these ideas?

*Well, yes, I think that two things that have happened over the past 30 years or so, and they've happened in very complex ways, but I think that the medical ethics movement over those years has made a large contribution to it. One is the idea of the autonomy of patients and the other is the idea of social justice in health care. Now, the ethicists didn't make those up, and they haven't been the*

*exclusive promoters of them by any means. They have been very broadly movements within society, but the ethicists have actually given a kind of an imprimatur to those ideas and given a vocabulary, a language that can be used, given a certain shape to the ideas that have now become quite commonplace. I mean, we now have an understanding of those things that's fairly sophisticated, and I think that had the ethicists not been around with their kind of quasi-philosophical interventions from time to time, that those ideas would never have taken the form that they have had, and they've been immensely influential. And it hasn't been a top-down contribution. It's been lots of little discussions taking place in lots and lots of places where the problems were somewhat different, somewhat differently perceived. So I think that's generally the way in which the whole professionalism issue is going to have to go. It's going to happen the same way. We'll need a language for it, we need a better language than we have now, a language that acknowledges that some of the virtue discussions are unrealistic, and to find an alternative. I don't have the alternative. I don't know exactly what a better way to do it is now, but I think that that's the task that we face, is finding a better form of expression, finding forms of argumentation about these things.*

Am I correct in understanding that there have been some policy developments that you would feel that ethical leadership had a role, played a role in?

*Well, yes, I think there have been some. I think that the long discussion about the human subjects of experimentation was very much influenced by the ethical... And the way in which that issue was defined. And again, it's clear that there were many, many forces at work to bring that about. But I think that the ethical contribution by people working in ethics gave a language and a kind of a setting for going at those problems. I was part of that myself, and I saw it happening. And that other parties struggling to find a way of saying what they knew to be true were helped when language was given to them, when we pulled out of the philosophical discourse language like respect for persons and made that a key element, when we were able to criticize the inadequacy of utilitarian approaches which of course can kind of lead to a lot of abuse. I think those were big*

*contributions and they would not have been easily attained without figures of importance like Jay Katz and Hans Jonas and people of that sort. In the health policy world, in the health policy formulation much less influence with philosophers, probably because they have many, many, many more voices there, I mean, so many interests that the philosophical contribution in trying to articulate principles of social justice in health care have gotten drowned out.*

What does our discussion mean in terms of practice?

*Well, I think that that's an issue that the philosophers have to constantly be aware of. There's a temptation on the part of medical philosophers, and on the part of all philosophers, to feel that clarification and analysis of thought for the sake of argument and discussion is about all they do. And the really interesting thing is how should that thought move from thought into the way in which people are motivated to act? So the idea of practical philosophy is not just to think out theoretically what ought to be done, but to take really the next step and say what are the ways in which we can draw people's affection toward this sort of endeavour, whatever it may be. And there is a movement taking place in the world that seems to be very much concerned about doing precisely that, and that's the environmental movement. People who are involved in environmental issues are not at all interested in staying in the realm of analysis of ideas. They deeply feel that things have to be done to prevent the deterioration of our environment, and then they begin to look for patterns of action. Some will take the political involvement, some will take more activist roles, and that depends on personalities. But environmental ethics is very clearly action oriented. And I think with regard to professionalism, too, there's a sociological and philosophical analysis of professionalism that, if it just ends there, isn't going to contribute anything. We have to really find out what are the affections that people have. Just to take this as an example, we hear people say of an older generation, oftentimes saying, I loved what I did. I don't think I would love it now. And other people of a slightly younger generation saying I'm going to get out of this. I can't stand it anymore. So they have lost their affection for the values that we*

*associate with professionalism. And I think that it's a real danger that the youngest generation have never had the opportunity to even develop that affection, because the profession isn't there in any concrete way. So they finish their training, and they're out in practice, and they're working for this group or that group, and it's a job, and after a while the job gets to be burdensome, and they go. They can't take it anymore. Well, I think practical practice, the world of practice, really depends upon an intermediate step between ideas in practice, and that is affections. How do you arouse affection, love for what you do? I don't know how to answer that, but I don't think we do it very well. And I'm sure that they are probably again into the world of idealism. If, say young practitioners who find themselves in setting where they are pretty much on their own probably would be greatly benefited by a kind of a collegial support. And people are doing that in various ways, trying to find ways in which physicians can share with each other the kinds of experiences that they have in practices, to stimulate the affection that they have, that they should have for that work.*

That reminds me of the example that Alasdair MacIntyre uses when discussing practice: the group of fishermen - each one has his role, supporting each other as they go out fishing for the day, certain risks involved, hopeful to return successful...

*That's right. And we have very few mechanisms that provide that kind of mutual support and right now, they're not much in favour. I mean, a lot of people, a lot of physicians say I simply don't have time to do anything like that. And they become increasingly isolated from colleagues and so they don't have support. And I think we certainly are in a world where we've learned an enormous amount about how to create support systems and to create supportive environments and so forth, but it's not much done in medicine, not at all.*

What are the links that you see between the moral community, the profession and the communitarian ethic.

*First of all, the communitarian ethic has not been a great success in the United States, even though there's been an effort to import it specifically into medicine. Amitai Etzioni and Ezekial Emmanuel at the National Institutes of Health have been very eager to do that, and I think, I don't know quite why communitarian ethic has not taken off. I mean, it comes off against some obvious contrary forces, one of them being the individualism of Americans that's very deep. But we find ourselves with communitarian movements that are very successful, I mean the religious movements in the United States are very much communitarian, and so communitarian—I think one reason why is that communitarian ethics attempts to build itself around a set of ideas and it doesn't really build itself around a set of objectives, and of real endeavours. I mean, that is communities, communitarian formulas work when people have very specific objectives, so you can create a community of people to clean up a toxic waste dump.*

*You create moral communities around endeavours, not around ideas. And I think that the communitarian effort in the United States has been too intellectual, I think it's been too much of an idea movement. Now, I have to be very honest with you and say that I don't read that literature very much, and again it comes back to this idea that moral communities are local, there is no moral community as such, there are moral communities and they come out of tradition as many of the religious ones do, and they are built around endeavours of very particular sorts that arouse affection and enthusiasm. So it's again, I guess I keep coming back to the same story. If one wants to think about the profession as a moral community, one has to think about how these instances of moral communities will come into being in various settings and with various purposes and objectives and the moral community will build from the bottom up rather than from the top down. I suppose you asked me early on what philosophers influenced me most, and I only really mentioned Aristotle, and I suppose my other philosophers are James and Dewey. I think probably I'm more interested in American pragmatism as a philosophy than almost anything else. And, also, I mean, I have a very big dose of Thomistic scholasticism in me too, like probably never will shake out, but*

*I don't know how much influence it has. But Dewey and James are very significant figures, and in one sense they describe American life and they draw on American life very powerfully and yet, on the other hand, whenever their thought moves to what we would think about today as communitarian, particularly in Dewey's thought—he has some very powerful expressions and very compelling arguments about the moral community—but they have not caught on. You don't see that quoted much. You see a lot of other things quoted more and more frequently about ideas and action and so for...*

Well, let me finish with one last question in relation to our conversation. Have you experienced an epiphany in your work and would you like to add that to our discussion?

*Well, my answer would probably be the story that I tell in the beginning of my book with Stephen Toulmin, *The Abuse of Casuistry*, and to some extent tell it again in *The Birth of Bioethics*, but I think that if there was an epiphany in the sense, it was not a great moment of insight, but it was the recognition of the importance of the singular case that understanding the general principle. That is, when we found at the National Commission what worked, that we could get extraordinary amounts of concurrence and agreement around cases that we could not get around theoretical discussions; and I think that my dedication to casuistry was the epiphany. That is, the recognition from my point of view that the particular was the place where one ought to start and to which one ought to always return. So I wouldn't teach a course, I wouldn't teach a class in medical ethics without a case. I wouldn't—my inspiration about things comes from cases. So that's my epiphany. It's the casuistical epiphany.*

## **APPENDIX D: ABBYANN DAY LYNCH, CM, O.ONT, L.M.S., PHD, LL.D., D.S.L**

### **BIOGRAPHY**

Dr. Abbyann Day Lynch is Director of Ethics in Health Care Associates, a private consulting firm in Toronto. This group provides service on a national basis (e.g., organization of workshops, presentations at professional society meetings), as well as to provincial groups (e.g., drafting policy, formulation of a code of ethics for a health service professional organization), and to local organizations and individuals (e.g., assisting with initiation of agency ethics committees, health care educational seminars for agency boards and staff, personal consultation re: health care ethics concerns).

Previously, Dr. Lynch completed a five-year term as President and Chairperson of Associated Medical Services, Inc., a charitable foundation that provides funding for research, particularly in the areas of history of medicine and health care ethics. She served as founding Director of the Bioethics Department at The Hospital for Sick Children in Toronto after completing a term as Director of the Westminster Institute for Ethics and Human Values (London, ON), a research group particularly focused on health care ethics.

Her academic appointments have been numerous: as tenured faculty in the Faculties of Medicine (Paediatrics, Obstetrics and Gynaecology), Arts and Science (Philosophy), Dentistry, Nursing, Social Work at the University of Toronto, and in similar positions at the University of Western Ontario. Dr. Lynch has been a visiting lecturer at numerous Canadian universities (e.g., Queen's, Dalhousie, UBC, Memorial, McMaster), and abroad (Xian, Kyoto). She was elected a Visiting Fellow at Cambridge University while completing a SSHRC-funded research project in the UK.

Dr. Lynch has served on numerous government and voluntary committees: Past President of the National Council on Bioethics in Human Research (now



NCEHR), Vice-President of the U.S. Society for Bioethics Consultation, President of the Canadian Bioethics Society, Board Member of the Lifestyle Television Foundation (WTN), Member of Health Canada Expert Committee on Blood Regulation, and Board Member of St. Elizabeth Health Care (Toronto).

The Prime Minister has appointed her as one of three Canadian representatives to two Summit Conferences on Bioethics, and in 1993, she was awarded the Order of Ontario, followed by award of the Order of Canada in 1997. She holds two honorary degrees (University of Windsor, University of St. Michael's College in the University of Toronto). She has received special honours from the Canadian Bioethics Society and the Canadian Dental Association; the Royal Society of Canada and Associated Medical Services, Inc. have established the Abbyann Day Lynch Medal in Bioethics (an annual award) in recognition of her leadership in the bioethics area.

Dr. Lynch has given many named lectures, and her publications cover a wide spectrum: death with dignity, ethics and reproductive technology, ethics and nursing, research involving children, distribution of scarce health care resources, ethics and genetics.

See listings in: *Canadian Who's Who*

*Who's Who of Canadian Women*

**INTERVIEW: FEBRUARY 13, 2004**

Our first area of discussion relates to foundations. How you perceive professionalism and the foundations of professionalism? Would you like to discuss the philosophers who have influenced you?

*I understand professionalism to be the practice of the profession by the individual professional, i.e., the personal adherence to the tenets of the profession as expressed by the (one identified as a) professional in that individual's personal behaviour.*

*Of course, there is ongoing debate as to what counts as a profession, but we can leave that for the moment. A minimalist description of a profession would include identification of a certain area of competence, and a public commitment (professing) to practice that competence in the service of others.*

*As to the foundations of professionalism, I'd include competence, and a strong sense of guiding values in practice of that competence, as well as values that are personal and social. Add to these an abiding spirit of inquiry (curiosity and adventure), a determination to persevere, an openness to change, and an ability to cooperate with others.*

*All of these imply that the individual knows what the profession is, what its core competence is, and the goal to which that competence is to be directed. Thus, for example, the dentist knows (and continues to learn) what the practice of dentistry involves (its science and the art of applying it) as well as the goal to which such competence and actual practice is directed (for example, prevention of harm to the patient, benefit to the patient, community well-being).*

*However, in addition to learning/knowing, the dentist must also put these abilities into practice. This requires commitment to practice the values of dentistry, as well as actual practice that demonstrates the values espoused by the profession. Such values-in-practice can only be exercised within a personal values framework, as well as within the context of social values in which the dentist lives and works.*

*If one can speak of clinical ethics as a profession, this means that the professional clinical ethicist must be competent in ethics (at least), as well as in the area of ethics-in-health-care practice. Basic competence here thus extends beyond speculative knowledge of ethics only so as to include some competence in ethics as related to the practices of medicine, nursing, social work, pastoral care, etc. Competence in clinical ethics would also include some competence as well in legal aspects of the practice of these disciplines, as well as in psychology, in group dynamics, etc. Further, since clinical practice is directed primarily to the*

*care of patients and families, the would-be clinical ethicist must also see clinical activity from the perspective of those others who are dependent on non-ethicist professional personnel for the care they seek. Briefly, the clinical ethicist must put on several minds so as to be competent in the ethical work to be done.*

*Moving beyond the competencies required of the clinical ethicist to the related areas of health care ethics teaching, the competence of the health care ethicist here would include some knowledge about how to teach, as well as competence in the disciplines of health care ethics in which the students' involved. If the clinical ethicist wishes to be involved in the area of health care policy, analogous duties of knowledge would be used in determining competence.*

*Such two-way or three-way knowledge is not a once and only. The professional person keeps up with the disciplines involved. So, utilitarianism as understood today, is similar to but also quite different from that enunciated by Mill and Bentham; indeed, understanding and practice in the matter of health care rationing (for example, its utilitarian and deontological implications) are changing as we speak. The same can be said, a fortiori, of health care sciences. The human cloning practice in place according to recent South Korean news announcements, for example, is quite different from its earlier human and animal prototypes. Evidently, those involved in current health care ethics practice (teaching, clinical work, policy formulation) must continually update their knowledge bases. An abiding spirit of inquiry, then, and a commitment to perseverance, as well as openness to change, are all fundamental (foundational) to professionalism in the matter of health care ethics (particularly clinical ethics).*

*There remain (at least) two other prerequisites: a spirit of cooperation (and practice of it) among those involved in health care matters, and a firm commitment to values-based practice.*

*Care of patients/families is necessarily interdisciplinary, even as it is intradisciplinary. While we all know this, we do not always learn how it might best*

*be done, or how to practice it. Suffice to say: if this practiced ability is lacking, we will all suffer.*

*Personal integrity is the ultimate foundation on which any professionalism rests. The knowledge of personal values to which I am committed, the knowledge of how those values must be practiced within the context of the values of my professional group, and the values of the society in which I live and work, the commitment and courage to practice such knowledge, indeed comment on personal integrity, and its fundamental importance requires a detailed essay of its own. In short form, however, professionalism cannot long be practiced in the absence of values commitment; the harm of a continuing gap here will be self-destructive, as well as seriously detrimental to those who depend on an individual's professional promises.*

*I'll mention a few comments concerning philosophers who have influenced me, without giving lengthy reasoning: Socrates (Plato) as teacher, Aquinas as elucidating clarity regarding the distinction between theological and philosophical thinking, Maritain as illustrating humane philosophical concern regarding society and its institutions, Marcel as providing an existential philosophy regarding the matter of interpersonal connections, Hans Jonas regarding respect for persons in the scientific context, Isaiah Berlin regarding various aspects of personal freedom, Freedman as philosopher-author and practitioner who combined his religious commitment and philosophical deontology so seamlessly.*

As a bioethicist supporting the education of a health care professional, how do you help them to understand the important ethical foundation?

*I think there are two key points here: (1) Do I (ethicist) understand the world of the people (health care practitioners) I'm asked to help? This is basic to communication with this group. How do I get to understand that world? (2) If I understand a little of what health care professionals do, then how can I help them to understand what's important in what I do (ethics in health care)? How do I illustrate how ethics and health care practice come together?*

*(1) As to learning to understand what health care practitioners do, the first rule is: listen and find out. In my experience (and speaking of physicians, nurses, dentists during their pre-professional education) it seems that these people are not particularly interested in questions of justice, truthfulness or confidentiality as such. Much more interesting to these pre-professional students is the drama of the complicated neurosurgical case, or discussion of questions about interdisciplinary collaboration, or questions regarding the perfect amalgam. So, in trying to help my own students to help these health care pre-professional people, I've tried to impress on them the importance of learning first the language and habitat of the persons they're trying to teach. I've cautioned them to refuse invitations to teach ethics in the medical faculty, for example, until they've done some church basement work/local small group discussion—ideal places to listen and learn what popular concerns about health care ethics are. So, start at the populist level, learning from future patients what their problems might be, since these will be the problems the professional practitioners must assume as their own.*

*The second part of this preliminary learning has to do with learning from the people you're trying to teach. Can you speak their language? Why would they listen if you don't? How do I learn that language (not my own) so as to make it easier for me to communicate with them while attempting to help them by speaking about ethics in health care (my language)?*

*Once again, listen and find out. Read their journals, attend their grand rounds, try to learn the vocabulary, make friends with some of the professional staff, find a mentor in that group, etc. There is no gain to be made in the matter of helping pre-professional students by saying, "I'm a PhD, so listen to me talk about ethical theories or the rare problems ethicists can imagine on their own."*

*Once some of this basic work is done, start to work with pre-professional students by asking them what they think ethics is? Listen well and then try to put that into the context of their current study topic (make it relevant); try to find*

*problems in their own texts or better something like CMAJ/NEJM/Canadian Nurse as the basis for opening discussion of an area of ethics (most, if not all health care problems, have at least one value issue). Again, try to get these students to raise their own ethical problems as they learn their professional material; then, use their ethical problems to open up the ethical considerations basic to all health care ("What does respect for life mean in this case?" "How can I have a conflict of interest with my dental patient?" "But the MD and parents don't want to tell the adolescent he's dying.")*

*To summarize here, at the beginning, everyone is learning to communicate. Let teaching about that move in both directions; we're all learners in this.*

*(2) More specifically, how can you help these pre-professional students learn what's important about ethics, once you've learned about the world of patients and pre-professional students?*

*How can you make the most impact in the few hours assigned to ethics in the curriculum? (This is not the recommended approach, but it is the usual request!)*

*My own experience tells me that the best approach is to try to have with you at any lecture (even better, teaching with you at any lecture) a senior person from the faculty concerned. Thus, ask the surgeon (or the resident) to come to present a case, and prepare with that surgeon (resident) ahead of time so that there is a dual focus here: we'll learn/teach a little about surgery and a little about an ethical problem often experienced in surgery, for example, consent. Try this at nursing bedside rounds, for example, with the nursing instructor as your partner (maybe the problem would concern the patient's wish for confidentiality, contrary to what the family seeks; the opportunity presents itself when discussing home care medications). As a matter of personal history (and I'm most indebted for it), I have always had a professor of dentistry (head of department) at each of my lectures in dental ethics over the last many years. This person has helped me answer any student questions regarding procedures; he kept me on my teaching toes. His observations on the cases we introduced were timely and authoritative;*

*the students seem to have prospered in this arrangement, and I believe both the faculty have as well. Most importantly, students realized, via his activity in the class, that ethics was important to the faculty; his participation made it much easier for a philosophy professor who knew little, initially, about dentistry to bring all of us to speak more comfortably about real dental ethics issues. In the past, teachers of bioethics began by introducing philosophical topics to students: Plato said this; Mill said that, etc.; this was what ethics was about. We learned (sooner or later) that, for most pre-professional students, this was a waste of time. Then, we tried to use fantastic cases that interested philosophers (only), for example, the prisoners' dilemma. This interested some students, but didn't move the group to what was considered their turf. Then, as public interest in the area of bioethics grew, and there was some demand for required ethics in the health care curricula, we were asked to look after this gap, and some of us thought we could do this by assuming we could speak nursing (or other health care) language without real preparation. We accepted invitations to teach Nursing Ethics 100—6 hours in the absence of any assistance other than our own texts. Failure—again. Finally, we have come to recognize that we cannot do it alone, that if ethics is important in the health care faculty, it's important to make it some kind of interdependent effort. (Of course, that's the way ethical issues in health care arise in real life in the midst of a life-threatening or small illness. Ethics in health care practice is embedded in the experience of practice; everyone involved must learn to recognize it there, and learn to resolve its difficulties in that context.)*

*There is another equally (possibly more) important side to this matter of teaching pre-professional (and professional) students, however—the matter of practice. If we are helping our students learn about truthfulness in their care of patients, do we practice that value ourselves? If we ask them to be respectful of privacy in patient care, are we respectful of them in this regard? While effective ethics in health care depends to some degree on an intellectual understanding of ethical values and principles, it also requires that the values and principles be put in practice.*

*Students learn from personal example as well as from their lectures and texts. Those who teach ethics should be sure to continue trying to walk the talk on a daily basis.*

Could we look at the question of the role of covenant for health care professions?

*What do we mean by covenant in terms of the health care professions? In my view, this means that a promise has been made, a promise that, as a first consideration, I will put my medical/nursing competence at your service so as to provide you with its assistance for your well-being. The promise made is more than personal; by claiming to be a professional (using the professional group's initials [MD, RN, etc.]), the nurse, physician, etc. has made that promise of service a public one.*

*There are many ethical challenges to be expected when making such a promise. For example: (1) "I must earn my living." "I must have time for my family." "I don't really like working with people who abuse me verbally." (There will be competing interests and conflicts of interest.) (2) "My patients know what is really best for them; whatever they think is best, then, within my competence, I'll do it" (my responsibility is to do whatever they require: I'm at their service). (3) "My personal integrity (possibly conscience) requires that I do/do not do what the profession (my peers) tell me is ethical" (how to balance personal and professional commitment).*

*Without elaborating here, a serious concern in pre-professional preparation for practice is concern for personal moral development. Much time and effort is spent on learning nursing science; for example, much attention is given to developing practical skills. The critical point is reached when the student must decide when and how to apply this knowledge and skill (disciplinary competence) for the benefit of this patient at this time in this place. If it were an ideal world, perhaps there would be no other considerations but the well-being of this particular patient, taking account of his physical/psychological/spiritual considerations only. There are other concerns, however, such as the patient's*



*family, my conscience, legal constraints, personal dislikes, and professional norms. Balancing all of these factors, the physician or nurse, etc. must make personal choices, set personal priorities while still keeping to the professional covenant (“My competence is at your service”). All this requires a steady development—professional and personal—towards moral maturation; this process is non-ending.*

*The question, of course, is, Whose responsibility is it to assist/supervise such moral development? If technical knowledge and skill is insufficient to the moral challenges here, how shall it be developed?*

*Some can be learned from the family; some may come from personal religious commitment; patients are good teachers. Faculty can and do serve as role models (for better or worse); legal constraints are helpful; the professions’ licensing bodies exercise positive and negative powers in this regard. Colleagues can assist with this, as can acquaintances with social and cultural norms of behaviour. In the end, however, ongoing fulfillment of the personal commitment to caring for others will be, first, a personal responsibility and, second, the responsibility of the professional body which continually strives to be worthy of its status as profession via the performance of its members. In this personal and professional endeavour, continuing health care ethics education is imperative.*

Keeping in mind the challenges that you’ve raised, what specific additional support do you recommend? What approaches are helpful?

*It seems to me that there are two kinds of support necessary here: personal and institutional. My own experience has permitted me to be part of both endeavours.*

*(1) The first necessary support is that for the benefit of the group. As an example, it is important for members of the group for which you’re somewhat responsible to know that their questions are heard and answered respectfully; if you can’t deal with the difficulty, indicate that, and try to find someone who can be of assistance (a colleague, etc.). Dismissing difficulties, diminishing persons who*

*ask for explanations are not helpful for the group or the individuals within it. Courage is required to say, "I don't know, but I'll try to find out before the next meeting" (and, of course, to follow up on that).*

*When my husband and I were both teaching, we made it a practice to have groups of students come to our home for dinner. This encouraged them (I think) to believe we were human and approachable. In later years, many of these students came back for individual counselling; some did graduate work with us; many asked for references regarding their future endeavours. This was not an easy practice for us; it was expensive, and we had numerous small children to care for. However, I think we all (parents/professors, students, children) learned something about the need for obvious support via these informal meetings. We must each do what we can to support these groups entrusted to us.*

*I recognize that medical school learning, nursing studies, etc. are difficult. Students know this, as do staff and members of the public. My view is that we don't help these students to succeed in their development by arguing, "These pre-professional people have to be toughened up; they have to learn to be disciplined, to do without sleep, etc." The work of pursuing such difficult disciplines as those in health care is difficult and frightening enough. Let's try to bring persons along respectfully, encouraging them on the way with social and moral support.*

*There is a point, of course, when some firmness/correction is required in the case of the group. Any teacher knows that, and has developed a means for dealing with it on some kind of an escalating scale. At the same time, there is always the need for respect in such interventions, for judgment as to means/ends, for discretion and a continuing supportive attitude.*

*(2) The second type of support here must be institutional. This can be done in some rather formal way, for example, providing the support of a named senior student for a named new student; providing personal mentors for students, setting up small group discussions to ensure that individuals experiencing*

*difficulty can have a close source for receiving help. Again, the institution can be helpful in setting out timetables that are reasonable, in responding to students' formal requests regarding workload, in recognizing that this type of education is difficult and personally stressful—and in taking certain steps to mitigate the more obvious points of disabling discomfort.*

*In many cases, this second type of support will require the graceful and generous donation of faculty persons' time and individual presence—for meetings, for counselling, for mentoring. It may require modification of past tradition; it may cost some money. It may be not in my contract; it may be difficult to achieve. If successful, the result will be rewarding; if the efforts fail, at least there will have been an attempt made and lessons learned towards future proposals of this kind.*

*I believe the bottom line here is that students must be treated as persons, even as we ask that they treat their patients and peers, as well as their leaders similarly. Persons are de facto interpersonal. To treat them otherwise is to neglect them, and to encourage them to mimic that behaviour in their professional work. At the same time, learning to be supportive and respectful without overstepping the boundaries of personal limits is a lesson students must also learn; they can do that more easily by way of imitation than by way of lecture or theory.*

*Briefly, teachers are in an enviable position—of authority, of achievement, of opportunity to help others be good. We should use that position with care and respect if we expect to find care and respect exhibited in our students' later performance. In short, we must be, not only seem.*

As you say, autobiographies consistently acknowledge how a particular teacher and mentor has affected the individual significantly and, in many cases, it wasn't a major time commitment on the individual teacher. It's subject to that spark or that meaning or that moment or that sense of that caring.

The moral community—how can educational leaders within health care support professional moral community?

*We must first be clear about the meaning of professional moral community. In ethical terms, a community is more than a collection of similar inanimate objects, for example, a pile of stones. Rather, a community is formed through explicit choice between persons who share common values and work towards the same moral goal. To speak of a “professional moral community,” then, is to speak of a group of persons in a similar discipline (or similar disciplines), each of these individuals having made a personal public commitment to certain common values and goals as well as a commitment to work with other similarly-minded persons (peers) towards their shared end-point.*

*If we speak first of nursing or medicine or physiotherapy for example, we can say that each may well be a professional moral community. At the same time, individuals within the group may be very different culturally, nationally, etc. Such differences may be mitigated by their agreement to adhere to a common code of ethics, by the understanding that they are all committed to put the best interests of their patients first.*

*Can we say the same generally regarding various groups of health care communities, for example, nurses, physicians, dentists, etc.? Do these various groups speaking to the same goal (patient well-being) form a professional community (or is each separate and distinct from the other)?*

*Which community is the focus of the question? My hope is that we are seeking to support both kinds of community. Support for the individual disciplinary community may be more readily achieved by way of work within the one group of nurses, physiotherapists, dentists, etc. However, in theory, at least, these groups should somehow be seen as (and really be) one large moral community. Having said that, the differences between them, in theory and in their practice towards each other, often cause outsiders to pause—we find the practitioners often*

*seeming to disagree with each other; we hear students wondering why there is not better collaboration, etc.*

*Evidently then, if we're asking pre-professional practitioners to support professional moral community, we must first try to ensure that there is support for that among the members of individual professional groups for their own professional moral community, as well as for (a common) professional moral community across the disciplinary differences. As a first step in attempting to achieve moral community in both areas noted, I think leaders (indeed, all members) should try to stimulate and strengthen moral sensitivity in themselves and in the group(s) more generally. This requires some clarity about what ethics is/not. In trying to achieve that clarity personally, or in a group, reference to a code of ethics is not necessarily the starting point. Rather, on the personal level, we can begin with choices we have made; why we've made them in relation to the values we think important; then consider the results of those choices; our views about the adequacy of our performance in regard to those choices, etc. At a group level, for example, among pediatricians, we can start by noting that, "We are all interested in the care of children; we don't want them to be harmed; what are the ways in which they can be harmed," etc. and then move to the more complicated questions about how this common view works out in practice, and then how it should work out in practice, and then how we can help each other ensure that our common understanding here does work out in practice.*

*Generally, then, we begin with what a community means, examine whether we have one, use personal and group experience to strengthen what we have. Some of this can be achieved by formal teaching, but the first steps, individual and group, depend on persons and on their reaching out to each other. Moving on, we must try to help those who are struggling with the ethical problems common within the community, first by helping them identify that component of any problem encountered that is identified as ethical. Thus, there is a problem about shortages, for example, What is the ethical part of this problem? Lack of money is not the problem, ethically speaking, unless we see that the goal is to*

*achieve “X”, and “X” costs more money than we have. Or, we can say that money may not be the problem, really, since there may be different ways to resolve the difficulty. In other words: what are the goals; what are the values; what priority do we put on the values involved; what options do we have here about goals and approaches to resolution of the presenting difficulty, etc.?*

*This is all to speak about ethics in the context of what professional practitioners do every day. Ethics can be a uniting force here; it can help to build and strengthen the community which professional practitioners seek. It comes into play every day by way of continuing education and research, as well as in the efforts made by individuals in the trenches. This ethics cannot be helpful on its own, however; individuals have to help each other, encourage each other, talk to each other about their differences, and work very hard so as to achieve this moral community to which we aspire.*

Let's discuss policy and the influence that educational leaders could have or have had when it comes to influencing decision-making in the area of health reform and social justice issues.

*In ethical terms, policy is concerned with the application of principles to practice in a very individual milieu. Policy directs specific actions in a specific way for a particular place. Guidelines, in contrast to policy, direct action within a set range of options, so as to meet a stated goal. Guidelines thus may have a wider sphere of influence than policies.*

*(1) A first consideration here: policy in one place, hospital “X,” for example, may not be identical to policy in hospital “Y:” similar, perhaps, but not identical. Why? Patients are of a different kind (children, not adults); mission may be different (a religiously-based practice in one case, not the other); staffing may differ by culture (for example, language and experience differ). Thus, while the policy regarding action in a fire emergency may have a similar goal (safety first) everywhere, the way in which this is to be carried out in “X” and “Y” differ. A more general difference here: policy will also be coordinated with the legal*

*requirements of the area, for example, the policy regarding consent for medical intervention in the care of cognitively-impaired persons may differ between hospitals "X" and "Y" because these hospitals are in different provinces and provincial laws may differ regarding consent for intervention.*

*As a practical matter, it will be important to ensure that the policies of concern are not in contradiction with each other. Thus, an agency's policy regarding consent should not be radically different when comparing its directions in two different units, unless the difference is significant in terms of behaviour expected (one could expect that there would be different rules regarding distribution of medication, for example, regarding care of dying patients and children with a less serious diagnosis. Nonetheless, the general direction of the policies would be similar (provide competent care,) even as there would be a difference in regime for dosage, etc.). Such differences should be carefully explained in each case.*

*(2) Second: common to all health care policies will be the need for focus on values, and on the activity of putting those values to work in the matter concerned. These values will reflect the mission of the agency as well as the goals of the various professions involved and the values of the society within which the agency functions. This is not to say that we must work hard to find the ethical kernel in the policy a hospital/clinic has about putting overshoes by the door, for example. It does mean that someone in that hospital/agency should be aware that there are safety issues in this area, quite beyond the matter of keeping mud off the floors.*

*(3) Third, any policy, particularly those which are newly-introduced, requires education among those who are expected to enforce that policy as well as those expected to observe it. This requires the attention of administration personnel, as well as of those responsible for leading the various professional groups within the agency. Ancillary to this activity, attention to updating policy such that expectations for behaviour are consistent with acceptable scientific, disciplinary, social and ethical values.*

*(4) Fourth, the requirements, then, for those people who are leaders in the matter of health care practice in the matter of service in the policy area are several. First is the matter of knowledge. So as to be involved effectively in the matter of policy formulation, review, enforcement, etc., leaders must know the science in question well, as well as the focus for the professional group in this area. They must know the institutions involved well (for example, health care at the national or provincial or agency or professional level). There must be some acquaintance with the law guiding this area, or at least access to direction in this matter. This all implies a good grasp of what is possible/probable in the area of action under consideration. Most importantly here, when setting policy, or attempting to ensure its observance, one must know the mission and values of the constituency involved as well as the values and goals of those directly involved in the policies' implementation. Second, with attention to the area of health care ethics, and the questions of health (care) reform and social justice issues more particularly, leaders must have an adequate acquaintance with relevant ethical theory, as well as some experience in the matter of health care ethics in practice. Needed, too, is a certain sense of the general areas of ethical concern here, and the ability to foresee how these might play out in the matter of practice. Thus, for example, one needs expertise in foreseeing when the issue of consent should be raised, even though it appears that the main issue is quite different, for example, helping to write policy regarding rationalization of the use of the agency's access to emergency health care resources (there will be people who wish to refuse emergency care in certain circumstances!). Attention to all these matters helps to make the resulting policy-document well-grounded, ethically speaking; even as it helps ensure relevance and completeness regarding practice.*

*Your question dealt specifically with health reform and social justice issues. What are the ways in which educational leaders can influence decision-making about policy with reference to this general area? Of course, there is the requirement for some expertise in politics. I cannot speak to this point. In the matter of education regarding policy-making. I think educational leaders can be enormously helpful in several ways. First, starting with the basics. I've noted the requirement for*



*knowledge of the field. Thus, for example, the daunting matter of ethics literature in this area must be addressed. How to work out the requirements for familiarity with the many reports already available? How can members of a profession share responsibility here such that they and their students are well informed about what is already being said? There is the question of knowledge about the ethical principles involved and the priority the profession places on them. There is concern that various health groups work together in discussion of policy so that there is some consistency and collaboration. There is need for educators to bring these various requirements to the attention of their students, and to assist their students in taking part in these processes in terms of their own level of expertise. There is the need to have leaders who are good models regarding practice in policy-formulation or review; students learn from example. All of these are obvious, and yet many are ignored in regular practice (or so it appears to me). To set out a particular curriculum regarding ethics in health care reform and justice issues goes beyond what can be said here, but I think that educators must pursue that with their students on several levels.*

*Summarizing here: (a) explore the general ethical issues; (b) discuss how these are seen in practice, and how that can be improved; (c) examine how this is done elsewhere, and why it is that others practice better or worse than what we have; (d) have students attempt to devise relevant policy in an educational setting—join a junior committee within the particular profession so as to learn more about the profession and its policy-making activity; (e) have students then join a more senior group (in which other members have more expertise than the student) so as to learn and work with others so that, ultimately, you will be able to participate in the whole process in some meaningful way. None of this is easily achieved; commitment, openness to new advances, perseverance and ongoing practice are all required.*

*A last word here and not to be dismissed is the need for collaboration with others—those directly involved in the disciplines concerned, as well as those affected by their practice. Policy requires input from many resource persons, and*

*the better they understand each other and work together, the more helpful their endeavours will be. This means that ethicists never work alone, and that professional practitioners do not, either. The resulting policy will be the better for the effort this collaboration demands.*

The next topic is practice. What does this mean in terms of practice? Thinking back then to our earlier discussions of foundations and learning and covenant, what threads come through, what are the implications that you see in everyday practice?

*If the question is to be focused on preparation for leadership in professional health care practice, then would-be leaders, in addition to understanding the requirements of professionalism (for example, knowledge of the discipline, competence in hands-on activity, understanding of ethics as working within professional practice), and particularly the other-directedness of such activity, must have leaders with whom they can identify, leaders they can imitate. These leaders need not be currently active in practice, but there must be a culture which has reason to respect certain individuals who have contributed to today's profession. Such persons are not always the Presidents. Chairs, or other obvious front-page persons; still, the profession knows who they are.*

*It seems obvious that tomorrow's leaders in practice must also have some kind of continuing encouragement to be as good as you can be in professional practice; these people should be challenged in some way to set high goals for themselves, even as they are given the support they require to begin to achieve those goals.*

*Even though there will be just a few individuals who can take on leadership roles in health care professional practice, these few individuals must remain close enough to their other peers so that the leaders-to-be still have a good sense of what the group requires, and so that they will always have a sense of continuity with others in the goals they are trying to reach. Again, this will require guidance and assistance from current professional leaders.*

*This may all sound very elitist, and thus contrary to the sense that everyone counts. My own view is that everyone does count, but not everyone is able to be counted in the same way, nor does everyone wish to be. Thus, let's watch carefully for early signs of leadership in the individuals whom we teach or have as junior colleagues; let's encourage and mentor them on the basis of their talents and aspirations; let's then look to them for leadership, and hold them responsible for the care, encouragement and protection they have had.*

The next question: how is the communitarian ethic manifested in the moral community?

*I think the best example of the communitarian ethic at work in health care occurs in Canada. I'm speaking of the Canada Health Act with reference to the thinking behind it, the way its implementation was arranged, and the way in which it is (supposed to be) observed. The general sense is that no one who needs health care should have to suffer lack of it. In other words, the group will look after its members; health care is a responsibility of the community of which we are part.*

*As we continue to observe, there are many difficulties in terms of reaching the ideal, or even the best minimum in terms of practice. Thus, the questions of finance, definition of health, illness, need, wish; thus, the struggles for control of this very important aspect of human living.*

*At the same time, there is clear evidence of the detrimental effects of contrary approaches in this area. As an example, on a recent visit to the U.S., I accompanied a senior psychiatrist on her rounds in a large public hospital. We literally walked over numerous persons lying on the floor waiting for a chance to see the doctors in her service; these were persons who were unable to pay for service, the so-called charity patients, those lacking insurance coverage. My guide remarked that an obvious major moral problem here was that so many persons were not covered for payment for their care and thus did not receive what was needed. Very important from her perspective as well – "These (poor) patients have so much to teach my residents, much more than could be learned*

*from the worried well.” The lack of community interest in these patients is not only harmful to those who remain without care, and their families; it also hinders education, even as it encourages a certain sense within in the so-called community that many persons are inadmissible to it, that there is no moral reason to include them within its ranks.*

*A very real fear for those of us who wish to be communitarian with reference to health care remains, however. What will we do when the help we require is not available because of shortages, waiting lines, etc.? As a personal anecdote, two of my children recently required MRI examinations in terms of the anticipated need for shoulder surgery. They were told that without the MRI, the surgeons in question were loathe to operate; they were also told that the waiting list for MRI meant postponement of surgery for at least six weeks (each had been waiting a month already). An opportunity for MRIs exists outside Ontario in Buffalo, about two hours away, and the cost (\$1000 for each) could have been met (not too easily). The question, then, “Should we use the non-Canadian route?” We were very conflicted about making such a choice (what did we believe as communitarians; what was our parental obligation to these children; what was our moral priority here); which parents would not be? Fortunately for us, there were cancellations within the week, and the MRIs were arranged for 3:00 a.m. in two days’ time with successful surgeries completed in ten days’ time. While we were/remain thoroughly convinced that the communitarian ethic reflected in the ideal situation across Canada is the good/right one, we still wonder whether we would have walked the talk in our own case had we not been so fortunate.*

*These examples indicate only that what we accept as correct in communitarian theory with regard to health care, may take much more effort in its realization than we first thought, whether in the larger context or in a personal one. And thus, we come to consider (re-consider) the matters of ethics in health care practice, the role of policies and the matter of education of professional personnel and public in this area.*

*As practical examples of seeking moral solutions within the communitarian context here, we find more attention given now to the waiting-list phenomenon at the political and professional levels; we find more attention given to media articles regarding prevention of illness. Professionally, there appears to be more concern for effective and efficient practice; individuals are learning to look after smaller health concerns rather than flooding the emergency rooms for removal of splinters. There is more community effort in other senses as well: people are sharing responsibility for ecological well-being; individuals are volunteering to take on certain aspects of care for those who are house-bound, etc.*

*The overall problem, perhaps, is that we may have thought our problems had been solved because we had a sound theoretical and legally-proclaimed universal start here in helping each other in the matter of health care. The reality is that we are finite, living in a finite world with finite means at our disposal. We must learn to use them well, all the while reaching for the ideal in which we believe.*

I would like to ask, throughout your career, if you have had an experience that could be called an epiphany?

*I understand epiphany in the sense you are using it here to mean presentation of an insight important to the person experiencing it, suddenly, and in such a way that there is a singular impact on the perceiver. If that is an accurate description of the epiphany in your question, I believe I've had several personal epiphanies and I'll comment on two.*

*(1) Many years ago, at a time when I was beginning to work towards introduction of what I think was the first course in bioethics at a Canadian university, I was invited to present a short paper at a small international meeting to be held in Milan. I did not recognize the names of any of the other speakers listed on the program; the meeting was to be held at a small hotel on the outskirts of the city, an environment foreign to me. On the morning before the meeting was to begin, I went to the hotel dining room (it seated no more than twenty persons), and noted*

*on entrance that a person sitting alone was known to me by sight, and by reason of the many papers he had written in the field of bioethics. We had met two or three times only, but in a crowd, and I thought there was no reason for him to remember me. At the end of my breakfast, since I had met this distinguished physician-philosopher, even if only casually, I thought it would be courteous to say, "Hello." I was also curious to know whether he would be attending the same meeting as I. I very much doubted the latter to be true, and was convinced he would not recognize me at all.*

*On the contrary, he knew my name, and had read some of what I had written; he encouraged me to tell him how I was progressing with the work of introducing ethics to my university community. I was astounded at his recollection of our previous casual encounters, and even more astounded at his polite interest in the progress I was making with my endeavours. We spent about half an hour together over coffee, and he was gracious enough to tell me something of his early activity in getting bioethics started in his own milieu, identifying some of the difficulties encountered and some of the decisions he had made in trying to bring his goal to fruition. He knew well about the possible complications I had been experiencing. (Bioethics is not philosophy from my philosophy colleagues. Why would medical students want to learn ethics, given their already crowded curriculum? Why would they listen to an ethicist—physicians teach their own. What has ethics to do with our work?—from some of my peers in the medical faculty.)*

*While I did not learn from this senior physician exactly what I could do about the problems I was pursuing at the time, I did learn much about the need for more experienced people to help those with less experience; I also learned that even the most experienced people had known frustration at the start of their careers. This chance meeting set an example I've tried to imitate since then with my own students and those who have asked for counsel—polite respect, openness, encouragement, perseverance are all essential in the work that I say I am trying*

*to do. If I were consistently lacking in these, how could I expect to succeed, either in my own activity or in the role of counsellor and teacher?*

*(2) A family experience in 2000-2001 gave me particular insight into the need for so-called role models to walk the talk. I also learned that we can use daily events as opportunities for teaching. By the time this incident occurred, I had written several articles regarding ethical aspects in the care of dying patients; I had taught several courses in the area, helped to write some relevant policy, attempted to assist professional staff in their palliative care work, and been asked to work with several families as they made the difficult decisions involved regarding cessation of nutrition/hydration, implementation of their relatives' wishes regarding discontinuation or non-initiation of certain types of therapies, etc.*

*Stated briefly: my children and I brought an older, well-loved family member home from hospital, at his wish, so that he could be with us as he was dying. We were fortunate to have 24-hour nursing staff with us during this time; as well, we had the almost daily physical presence of a supervising palliative care physician. During the following two-month period, there were numerous interdisciplinary concerns, as well as some inter-family concerns; as well, there were concerns between the family and various caregivers. My own role was to serve as temporary head of the grieving family, as well as decision-maker for our loved one. In that regard, I had received very careful instructions. The situation was heart-wrenchingly difficult.*

*Suffice to say: now that I look back at the experience, the epiphany was quite clear and instructive. When pushed in some ultimate way, do we keep our promises; do we act in the way we have taught others to act? The occasion provided a challenge to my sense of personal integrity as most precious to my personal identity. As well, I now see that it also provided an opportunity for teaching my family the need for courage in keeping promises. If we really mean to teach others, we use our opportunities, not only by way of explanation and*

*discussion, but also in the way in which we model what we teach: we walk our talk.*



## **APPENDIX E: EDMUND D. PELLEGRINO, MD**

### **BIOGRAPHY**

Dr. Pellegrino is *Professor Emeritus* of Medicine and Medical Ethics in the Center for Clinical Bioethics of Georgetown University Medical Center. He is also a Senior Research Scholar of the Kennedy Institute of Ethics, and Adjunct Professor of Philosophy at Georgetown. He is the former Director of the Center for the Advanced Study of Ethics and founder of the Center for Clinical Bioethics at Georgetown University. He received his B.S. from St. John's University and his M.D. from New York University. He served residencies in medicine at Bellevue, Goldwater Memorial, and Homer Folks Tuberculosis Hospitals, following which he was a research fellow in renal medicine and physiology at New York University. He has been a department chairman, dean, and university president.

Dr. Pellegrino is the author of over 550 published items in medical science, philosophy, and ethics and a member of numerous editorial boards. He is the author and/or co-author of 24 books and the founding editor of the *Journal of Medicine and Philosophy*. Dr. Pellegrino is a Master of the American College of Physicians, Fellow of the American Association for the Advancement of Science, member of the Institute of Medicine of the National Academy of Sciences, and recipient of 46 honorary doctorates, in addition to other honours and awards. Dr. Pellegrino's research interests include the history and philosophy of medicine, professional ethics, and the physician-patient relationship.

### **INTERVIEW: AUGUST 4, 2004**

What are the foundations of professionalism?

*This question has arisen in a serious way only in the last several decades. It reflects a serious identity crisis in medicine and the other traditional professions. All are asking themselves the same question—What is it to be a physician?*

*(lawyer? minister?) What is so special about what I do that requires me to adhere to higher levels of moral obligations than other occupations?*

*The resulting identity crises are of concern to those these professions serve, to those who educate them and to legislators and policy makers as they are to the professionals themselves. They are of utmost importance for all of us, inasmuch as all of us, at some time in our lives, will need the help of these professions.*

*The root causes for this state of confusion are deeply interwoven into the values of modern society. To adumbrate them adequately is not the task of this interview. But it does help me to mention them before addressing your question, which I take to be a reflection on what are the “true” foundations of the professional life.*

*Among the major forces for deprofessionalization, I would list the following: Commercialism and commodification of the services the traditional professions offer, the bureaucratization and institutionalization of the ways the professions provide them, the proliferation of self-oriented life styles, and the antipathy to “elitism” in norms, traditional values and duties, especially those that limit personal satisfaction. Many of these forces represent the continuing effects of the social revolution of the sixties of the 20<sup>th</sup> Century, the end of which is not yet in sight.*

*The result for the professions are several: a down drift from the more altruistic standards of a profession to the more mundane tasks of an occupation, a disaffection with the idea of a profession as a way of life in the direction of a profession as an encapsulated part of one’s day leaving the rest for “having a life”. Simply put, using medicine as an example, there is the growing attitude of a nine-to-five job on the one hand, as an employee. Or, on the other hand, there is the idea of the physician as entrepreneur, living by the rules of the marketplace.*

*These tendencies and attitudes have deprofessionalized medicine. Educators, professional associations and physicians, as a result, are seeking to “re-*

*professionalize” their work. A variety of measures are being used: teaching “professionalism” in medical schools, issuing a new “Charter” (the American College of Physicians and the European Society of Internal Medicine) of professional commitments, or by teaching courses in medical ethics.*

*None of these efforts is likely to be wholly successful. In my view, most share the post-modern disaffection with foundations, especially moral ones. Instead, they seek solutions through new social constructions. This approach is bound to fail since the heart of professionalism, as it was conceived originally, is moral and not recoverable by social reorganization.*

*I have suggested in my own work that the foundation of the professions is precisely what the term “profession” means etymologically—a public act or declaration of commitment or promise. This is exactly what happens phenomenologically when a physician says to a patient—“How can I help you?”. This is how physicians, many times a day and innumerable times in their lives, greet patients. Like it or not, this is taken by the patient as a declaration of at least two things—a promise of competence, of possession of the knowledge and skill the patient needs, and a promise to use that knowledge and skill primarily in the interests and for the good of the patient. Thus, what makes medicine a profession is the doctor’s promise to act in something other than his own interest, to avoid harm and exploitation of the patient’s vulnerability for his own selfish self-interest.*

*I have developed this idea in my writings alone and with David Thomasma. From this simple phenomenological clinical fact of an act of profession, I have deduced the virtues crucial to being a physician—those essential if the promise profession entails is to be fulfilled. Some of the most important of these virtues are—benevolence, ability to trust, keeping promises, a degree of effacement of self-interest, courage, intellectual honesty and compassion.*

*At its most fundamental, medicine is a profession because it “professes” to act in something other than its own self-interest—and it is expected to do so in ways*

*“jobs” and “occupations” are not. It is this requirement for altruism that vexes many in the professions today because it is so infrequent in other occupations and simpler ways of making a living. What I have outlined for those who “profess” medicine applies analogously to the other professions like law and ministry. The lawyer also asks, “How can I help you?” to a person seeking justice; the minister does so to the person seeking spiritual consolation or reconciliation with God. Both make their acts of profession in the presence of vulnerable, anxious, dependent persons who can only be “helped” if the professional keeps his promise of competence used in the patient’s behalf.*

*The vulnerability, anxiety, need for help of patients, clients, seekers of spiritual consolation, raises ethical accountability and obligation of those who promise to help. This is a degree of obligation which goes beyond the accountability of the businessman, tradesman, bureaucrat—even though we know that persons who seek their help may also be vulnerable. Unless the gap in ethical responsiveness between a profession and an occupation is sufficiently broad, a true profession does not exist.*

*Using that as a background, we can now discuss the foundational philosophers that have influenced you personally.*

*Let me preface my response to this question by saying that the core of my work has been to develop a philosophy of medicine, that is to say a moral philosophy of medicine and then a philosophy of professionalism as it is exemplified in medicine. My papers on specific issues in clinical and theoretical ethics all point in this direction.*

*My sources of method and ideas have thus been two: First, are the philosophers I studied in College and have studied for most of my career—Plato, Aristotle, the Stoics, Thomas Aquinas, and, in modern philosophy, some of the more realistically grounded phenomenologists like Erwin Straus, Dietrich von Hildebrand, Maurice Natanson, and Robert Sokolowski. I have perhaps used their work idiosyncratically, but feel indebted to them as well as to my colleague*

*David Thomasma. In virtue ethics, in addition to Aristotle and Aquinas as well as the Stoics, I would add Alasdair MacIntyre and, to a lesser extent, Elizabeth Anscombe.*

*My second source of ideas and inspiration has been in the humanistic and philosophically minded physicians of the past—the Hippocratic authors, Galen, Thomas Percival, John Gregory, and Sir William Osler. Their perceptions of the centrality of the physician patient relationship have served to help me synthesize my own clinical experiences into a conviction that the heart of medical ethics and the philosophy of medicine is the clinical encounter—the meeting of someone in need of medical help with someone who professes to have the knowledge and skill that person needs to be helped.*

With that foundation could you comment on the quest for the good?

*My pursuit of the good in ethics is based in the first sentence of Aristotle's Nichomachean Ethics—"Every art and every inquiry, and similarly every action and choice, is thought to aim at some good; and for this reason the good has rightly been declared to be that at which all things aim (1094a-1). This I take to be a teleological ethic particularly apt for a philosophy and ethic of Medicine. The good in question is the good of the individual patient insofar as clinical ethics is concerned and the good of social or public health medicine is concerned. The virtues of the good physician, as well as the obligations and norms of medical codes and Oaths, are grounded in the degree to which they facilitate achievement of the end or the good of the patient.*

*Following the analogy I suggested above, the good of the lawyer's client or the minister's supplicant is the telos or end to which the ethics of these professions is directed. This end is what is promised or "professed" when these professionals ask "what can I do to help you?". The good sought by the patient is health, healing or relief of suffering and pain. The good sought by the client is a just settlement of his claim or just settlement of claims against him. The good of the supplicant is spiritual consolation, reconciliation with, or union with God.*

Would you summarize your thoughts on virtue ethics?

*The virtues are important in professional ethics for several reasons.*

*First, the physician patient relationship is a personal and intimate one between one person who needs help and is vulnerable and another person who offers to help and possesses the knowledge needed to help. There is an imbalance of power between doctor and patient. As human beings, of course they have equal dignity and worth. But one is dependent on the other and can be exploited. Moreover, one has made a promise to help and at least not harm.*

*This existential situation places the patient (client, or supplicant) more or less at the mercy of the physician. How faithfully and carefully the physician fulfills his moral obligations will depend on his character on the degree to which he can be trusted to act in the patient's interests. The patient has only limited opportunity to determine what kind of person his physician is. The physician invites trust and the patient is compelled to trust—no matter how well educated he may be. When a physician becomes a patient, he is in the same state of dependency on the character of the physician who cares for him.*

*The second reason for the importance of the virtues is that the act of profession or promise to seek the good of the patient entails certain character traits, certain dispositions to act in ways that will facilitate the end of healing. We have mentioned some of these traits above—fidelity to trust promised, courage to treat contagious patients or patients in dangerous circumstances, intellectual honesty to keep from exceeding the boundaries of one's competence, suppression of self-interest to avoid taking advantage of the patient's vulnerability, humility to counter the temptation to arrogance, benevolence to make the good of the patient the gold standard of clinical decisions.*

*These character traits are usually joined to fidelity to certain normal moral precepts and principals expressed in Oaths and Codes which provide more*

*specific action guides. Principles and Virtues re-enforce each other in the best physicians.*

*Finally, virtues, or the character of the moral agent, provide the channel through all principles and norms must function. How they are interpreted, and with what degree of stringency, is a measure on the character of the moral agent. The intention of the agent (the physician, in the case of medical ethics) will be good or bad depending on whether the physician is a good or bad person—in the sense of possession of the virtues outlined above.*

Could you situate your perspective on professionalism, in relation to Robert Veatch's theory of medical ethics as a species of social contract?

*Dr. Veatch has, in his writing, denied the importance of the virtues, and, therefore, he opposes a theory that rests so heavily on them as mine does. I do not deny the existence of a social contract. Society does permit physicians a certain degree of freedom in practice and self-governance. Veatch analyses the contract as a tripartite contract. My objections to his theory are, briefly these: The most fundamental contract—that between physician and individual patients—is a misnomer. Given the inequality of existential states between doctor and patient I have already described, there is no possibility of a contract. Contracts can only be made between equals, or at least between persons with bargaining power. The patient's bargaining power is of a minimal sort when he is sick, in pain, frightened, anxious and in urgent need of the doctor's skills.*

*Moreover, even if a contract were possible, it would reduce the relationship to a legalism—a minimal statement of what each owes to the other. Physician incompetence, failure to follow professional norms would be breaches of contract—not serious moral failures. They would be settled in course which they are ill-equipped to adjudicate what are ultimately moral failures on the art of the physician.*

*Finally, who, including the clinicians themselves, can anticipate the details of the clinical situation in advance and draw up a specific contract of expected performance? This is a foolhardy enterprise calculated to generate a false sense of security on the patient's part. There is no substitute for ultimate trust in the physician's judgment and advice. It need not be followed, of course, but a decision will not be better because a contract was written. One may vet a physician's record, his morbidity or mortality statistics, his qualifications and certifications. But, in the end, we select some physician. When one does, he must ultimately ask him what the best course to follow (on the medical evidence) should be.*

In your view, Virtue ethics is extremely important, but it doesn't stand alone—

*This is true. Virtue ethics does not have specific action guidelines. It tends to a certain circularity of reasoning—e.g. the virtues are what virtuous persons do, the virtuous person is the one who exhibits the virtues. There is also a certain subjectivity in that moral agents are apt to define their actions as "virtuous" (also subjective). Virtues of course are more solidly based philosophically in the Aristotelian—Thomist tradition, but they are not formulae to guide decisions about specific issues.*

*Moral actions have at least four dimensions—the agent, the act, the circumstances, and the consequences. Virtue ethics focuses on the moral agent, deontological ethics on the act, situation ethics on the circumstances and consequentialism on the outcome. Clearly the moral agent is indispensable for all theories since principles and duties must be expressed and actualized by the moral agent.*

*It is important therefore to integrate virtues, principles, and duties—I agree with MacIntyre that this is a necessary development of virtue theory. I do not think anyone has yet done this well. As a result, virtue ethics is usually complimentary and supplementary to other theories of ethics. It cannot be ignored since every theory must eventually account for the moral agent.*



*Physicians as a profession do enjoy a social contract relationship with the greater society, as Talcott pointed out a long time ago. By this, he meant that society permits physicians a wide latitude of discretion in decision at the bedside setting and accrediting educational standards, policing its members, etc. In return, society expects a dedication to service, standards of quality care, up-to-date educational practice, etc. This becomes a legal contract only when society sets criteria for licensure or safety.*

*Within a broad sociological concept of a “contract”, medicine and society may be said to live symbiotically for mutual advantage. The physician-patient relationship may share some of this symbiotic contractualism, but it is not a contract in any legal sense. There is, however, a social contract of sorts in the education of physicians, which derives from the fact that medicine is a practical art, and it is best taught by supervised practice.*

*Medical students, when they accept the privileges of a medical education, are ipso facto entering a moral covenant with society which permits certain acts which might otherwise be illegal. For example, medical students dissect human bodies and are permitted to do so. They participate in the care of patients; they examine their bodies, invade on their privacy, and put them at some risk and discomfort when they practice procedures like suturing wounds or chest and spinal taps. They do this when they are not competent to do so. It is true they are under supervision and patients at least give tacit assent. But obviously the patient cannot give consent to every teaching event in which she might be a subject. Social sanction for relaxation of consent, acceptance of the delay and discomfort—even danger—of medical student performances of procedures is implicit if medical education is to revolve around actual patient care. Medical students cannot be supervised except intermittently. As they grow in knowledge, they are allowed to act more independently. This is part of the process which will make them “safe” enough on graduation to become residents and interns.*

*For these privileges, they and their faculty owe serious ethical obligations both during the training period and throughout the physician's professional life. In effect, physicians cannot claim proprietorship over their knowledge or skills as if they were a commodity. They are stewards of their medical knowledge, obliged to keep it up-to-date and to improve it. But they are stewards of skills sick people need and they were permitted by socio-sanction to acquire it.*

Would you elaborate on the concept of the good?

*This is a major question in philosophical ethics, and I will limit my comments to the importance of the concept of the good in medical ethics, and, more specifically, to the good of the patient. I will adhere to the classical notion of the good as my definition and prescind from the work of G.E. Moore, A.D. Ross, and others who have wrestled with this topic in modern philosophy.*

*I take my cue from Aristotle. The opening line of the Ethics immediately confronts the question of the good—"Every art and every inquiry, and similarly every action and pursuit, is thought to aim at some good; and for this reason the good has rightly been declared to be that at which things aim" (1094a 1-3; W.D. Ross translation, Richard McKeon, editor). Aristotle then distinguishes the differences among ends and, therefore, among notions of the good. He defines the end of medicine as "health" (1094a, 8).*

*Thomasma and I have devoted a book to our clarification of the concept of the good of the patient (Pellegrino and Thomasma, For the Patient's Good, Oxford). I will only summarize here what we consider the "good" of the patient to be.*

*We will see the good—the ends of, and achievable by, medical science and knowledge. Its focus is health and healing of our body and psyche.*

*The next level is the good for humans—the good of the patient as a human being. Here, we focus on what are called "human rights"—equal respect for all, non-discrimination, protection against harm, self-determination, many of the "rights" enunciated in the U.N. Declaration on human rights.*

*The highest level is the spiritual good. For many, this would be summated in religious beliefs, for others in "spirituality", but not necessarily linked to religion and variously defined. This is the good or end which recognizes in some way the existence of a realm of transcendent reality not accessible to the senses or scientific demonstration. We place this highest because humans as rational beings do put their "values" into priority at the moment of decision making.*

*Thomasma and I argue that, in true healing, each of these four dimensions of the good must be taken into account. The physician who violates any aspect of the patient's good is unfaithful to his act of pro-fession, i.e. the promise he made when he offered to be of help, to the patient. In the case of the spiritual good of the patient, there can be, and often is, dissonance between the patient's and the physician's perception. The physician is not expected to replace the minister, priest or imam. But, he must recognize the need the patient might have for spiritual guidance and make the appropriate referral. This is irrespective of his own belief or lack of belief.*

*To respect the patient's spiritual good is to respect the ethical precepts of the patient's belief system as well. If those ethical precepts are offensive to the physician's ethical norms, he should respectfully withdraw from the case of the patient. The physician cannot violate his own personal moral integrity to please the patient. But neither can he violate the moral integrity of the patient.*

*The physician too must have some concern for the common good. In emergencies, natural catastrophes and war, the common good may take precedence over the good of individual patients. But in ordinary circumstances, the physician's covenant of trust is with the patient he is attending. The physician, therefore, cannot be the practitioner in a cost conscious health care system; he cannot be the primary protector of the nation's health care resources; he is not primarily an agent of the health care organization, of the partnership to which he belongs or the pharmaceutical company that pays him to recruit patients or clinical trials, for example.*

*These are all violations of the fidelity to trust that the patient has a right to expect. The physician serves society best when, first of all he does is place the sick person first, then when he practices rational evidence-based medicine, which is the most economical medicine as well. The physician also has an obligation to play a role in policy formulation providing the most accurate information about the efficiency, effectiveness, dangers and untoward outcomes of proposed therapies and procedures. Finally, the physician serves the common good as citizen and member of a moral community when he is an advocate for a just health care system—either as an individual or member of a professional organization.*

*In essence, I am suggesting an order of priority between social justice, expressed as fidelity to the promise to the patient. At the bedside, in ordinary clinical decisions, the physician must serve the good of his patient as far as he can. When not bound in that moral relationship, the physician can and should serve the common good as outlined in the paragraph above.*

*I would therefore reject the currant insistence of some bioethicists that the physician is primarily a social servant, that justice (distributive in this argument) should replace beneficence in medical ethics. Such a transformation would depersonalize, dehumanize and commercialize the physician patient relationship. It would replace it with a bureaucratic-entrepreneurial relationship inimical to the individual and thus eventually to the common good it proposes to serve.*

How does your concept of the good of the patient relate to the good of the physician herself? Is there conflict?

*There is, in today's world, where the pursuit of self-interest is so widely adulated and justified.*

*To be sure, there is a domain of legitimate self-interest. The physician is not expected, even in the most ethically demanding system, to be a hero or heroine of self suppression. Physicians have obligations to care for self, family, and personal well-being. But this cannot be the primary end of medicine, else it would*

*be simply an occupation, a pursuit of wealth, power or prestige with the patient as the means whereby these ends are attained and not the end to which medicine is ordained.*

*The potential conflict between the demands of patient care and the requirements of one's family, of recreation, or of "having a life" as it is called, is, in my opinion, exaggerated. I cannot go into detail here on how each person should balance legitimate self-interest and the obligation to patient welfare. Suffice it to say that it requires a degree of psycho-socio-ethical maturity each physician must strive to attain herself. Balancing professional and personal obligations has to be examined within the context of each physician's life situation. It cannot be formularized. One size cannot fit all.*

*Suffice it say that every ethically serious physician knows sooner or later whether he or she has been faithful to the promise made everyday to the competent and to use that competence in the patient's best interests. There are amply opportunities for temptation to self-interest and conflicts of interest with patient welfare. Too ready an acceptance of the emoluments offered by pharmaceutical companies, other opportunities for personal financial gain by ownership of stock, shares, or partnerships in dialyses, imaging, or laboratory facilities, dispensing prescriptions in one's office, ownership of a health maintenance organization, doing research totally dependent on pharmaceutical company support, accepting retainer fees as "consultants" for medical instrument producers, etc.*

*None of these activities is intrinsically immoral. They present too many opportunities for gain which even the best intended too often find it hard to resist. Protestations that these arrangements do not affect the physician's clinical decisions have a hollow ring. The true professional foregoes these benefits the better to assure fidelity to his profession promise. The fact that there are few in our society who are willing to act for something other than self-interest is evidence enough of the moral status of medicine and the other helping professions.*

Where do you situate virtue ethics within the other theories of medical ethics?

*Virtue ethics focuses its major interest on character, motivations and intentions of the moral agent. Deontological ethics places its emphasis on the action; consequentialism on the outcome; and situation ethics on the circumstances within which the act is performed. I speak here of emphasis because each of these elements may play a role in a particular ethical decision. Each may interact with the others. The distinguishing feature of each theory is which aspect of the moral act it emphasizes or uses as its justification.*

*Virtue ethics, therefore, does not constitute a complete ethical theory, but it is an essential element of all ethical theories since all theories must take the moral agent into account. In professional ethics, I believe virtue ethics is primary since the patient (or client, for the lawyer or minister) is so dependent on trust. To be helped, patients must trust some physician ultimately—no matter how assiduously they study their qualifications, morbidity and mortality statistics or reputation, some physicians must be chosen. Whomever is chosen must be trusted at some point because no contract can be written to anticipate all eventualities of the clinical encounter.*

Alasdair MacIntyre emphasizes the importance of integrating virtues, principles and duties to be successful morally. What do you think?

*I agree totally, as my response to your previous question indicates. I do not think any of us, MacIntyre included, has convincingly linked these elements conceptually. I have tried, but not convincingly. I will spare you the attempts I have made. Since the moral life is all of one piece, however, I think there must be an ontological and moral synthesis between, and among, duties, principles, and virtues. We need a unified theory of moral philosophy.*

*Suffice it to say that whatever theory we select must eventually be actualized in a decision and act of the moral agent. For it is the agent who selects the theory, who applies it, who offers justifications for its conclusions and who personifies it*

*for his patient. How permissively or rigorously a principle is applied, how the moral calculus is done by the consequentialist, how the circumstances are weighed, will reflect the character of the moral agent, i.e. what he hopes to be or thinks he is. Virtue ethics, while not sufficient of itself, is necessary for comprehending and judging any moral decision and action.*

In your experiences as an educator, what have you found to be the most helpful approaches to the student?

*I will divide my answer to this question into two parts—teaching virtue and teaching clinical ethics.*

*a) Teaching virtue is a question posed to every virtue ethicist. Many believe it is impossible to teach virtue since students have formed their characters indelibly long before coming to medical school. I do not think this is the case. Every true teacher has three ends in view—to impart information, to shape ways of thinking, and to shape ways of behaving, that is character. If we did not think we could accomplish these ends to some degree we would not be teaching. It is true that students will have been formed by church, family and community—but few would deny that people often change, add to, or even reject these influences.*

*b) So far as virtue goes, they are best taught, as Aristotle said they should be—by example of a phronimos, a wise person. A wise person in this context of professions is one who possesses the virtues entailed by the nature of the profession in which he is teaching.*

*For medical students, the model can be either a basic science or clinical teacher or both. Each has something to teach in the way of the intellectual and the moral virtues—the virtues ordained to truth and the virtues ordained to the good. The teacher must believe and act coherently with what he teaches to have any verisimilitude for the student.*

*This obligation is especially heavy on the shoulders of his medical teachers whom he admired so much that he wished to model himself on that teacher. This*

*is most acutely the case in the later clinical years and residency when a specialty has been chosen. The student or resident identifies first, with someone whose clinical skill he admires. Then, subtly perhaps, the student begins to imbibe the virtues and vices of his mentor along with his technical expertise.*

*Part of the moral maturation of the student is to discern how to distinguish his mentor's virtues and vices. Only in this way can the student become a mature clinician. This may take years but every truly mature clinician must pass through this phase of becoming a moral person with his own identity. This is a process which ends only with death since it can never be finished except asymptotically.*

*Clinical teachers teach ethics at the bedside, by the way they treat patients and their colleagues. One obviously serious and culpable lapse in a teacher's behavior to patients destroys years of lecturing about virtues. Medical schools, in my opinion, do not pay enough attention to the character formation of students or faculty. I recognize the difficulties of such an undertaking. But I believe it is as important as the technical training our schools provide.*

*Courses in "professionalism" which now are gathering favor at many medical schools will not replace the example of teachers. The moment of truth is at the bedside, in the laboratory and in the clinic—not in adherence to certain approved behavioral characteristics. The heart of professionalism is commitment to the good of those we serve—not a formula for professional decorum. I do not quarrel with the major assertions of the "charter" of the American College of Physicians, and the European Society for Internal Medicine. But the idea of a "charter" has less moral weight than an "oath". It sounds legalistic rather than moral. It does not carry the notion of universality and grounding of the Hippocratic Oath which has stood for true professionalism for so long.*

*While virtues are best taught by example, there is a place for courses in virtue ethics though they are limited. No one has been made virtuous by a course in ethics. What courses can do is to raise the level of ethical sensitivity so that students can recognize an ethical issue when they encounter it. There is much*



*confusion about what constitutes an ethical issue. In clinical consultation I am often called to give ethical “advice” in what are fundamentally disputes in interpersonal and inter-professional relationships. The disagreement is often not about the right and the good, but about whose opinion should be given precedence.*

*Ethics courses also provide access to the swelling bioethics literature. They teach something of the terms and “language” used in bioethical discourse. Courses allow access to the breadth of opinion on particular subjects. Most important of all, a good course in ethics compels the student to understand his or her own moral values better, and how to become more critical of one’s own opinions. This critical ethical self-appraisal has been the practice of ethicists of every school, from Plato and Aristotle through the Stoics to the modern world.*

Would you elaborate on Aristotle’s discussion of practical wisdom and prudence? You identify it in your writings as one of the very important virtues.

*Prudence is indeed a central virtue usually classified as an intellectual virtue, which I have said little about. Intellectual virtues are habitual dispositions to act in such a way that the truth is attained as closely as possible. The intellectual are listed by Aristotle as art, knowledge, practical wisdom, philosophic wisdom, and comprehension (NE 1139b 4-5). These are the virtues that enable the physician to do his work competently, to make diagnoses, select treatments, prognosticate, and carry out procedures safely and with minimum discomfort.*

*Prudence is especially important for the clinician. The modern way of referring to prudence is probably best as clinical judgment. It is the capacity developed over years of practice to be able to select the right means to attain the ends of medicine. The prudent physician has the capacity to decide which of the other virtues is most appropriate for a particular situation. It enables the clinician to meet a new situation and select the best means even when everything is in doubt.*

*Prudence is not the virtue of protecting oneself from necessary risks. It is the virtue of correct judgment even when there is a crisis and the risks to be run are great. In the Middle Ages it was the central virtue, the one that could pull together the moral and intellectual virtues to attain the good. It is a power of discernment; it knows when to be rigorous, when to be permissive and when to proceed in the face of grave uncertainty.*

What about ethical decision making?

*Ethical decision making is the most practical technical aspect of professional ethics. It is really in the realm of procedural ethics. Its ethic is an instrumental ethic. It uses the ethical theories we have discussed to guide its choices and identify them. I tend to regard the ethical decision as the product of the ethical "work-up". This is analogous to the clinical work-up. Clinicians have an orderly way of making their diagnoses and of analyzing a set of clinical facts. The same is true of the ethics work-up. Clinical ethics differs from theoretical ethics in that a decision must be made.*

*Ethical decisions must have a framework and an orderly procedure or they easily become lost in a confusion of details. This is not the place to go into detail about my personal ethics work-up. A few general remarks will, however, help to define what I mean.*

*I divide my work-up into three parts: (1) What is in the best interest of the patient? (2) Can I implement my decision? and (3) What options do I have if conflict arises? Each of these questions is answered by a consideration of the relevant clinical facts and the ethical decision for the choice.*

*In part, we begin with the facts of the case, look at the options under consideration, and the ethical reasons for, and against, each option. One option must be selected. This is clinical medicine and action must be taken. Reasons against this option are considered. A bottom line decision to act is made and*

*ethically justified. This action must be what is technically correct, and morally good for this patient.*

*The second question is whether or not this decision can be implemented. Is there disagreement between, and among, the clinician, the family nurses, other health professionals, pastoral counselors, lawyers, etc.? What is the source of the conflict? Can it be resolved? If not, we go to our third question—What moral options are open?*

*If moral compromise is impossible, should the physician or nurse be discharged by the family or surrogates? Should the physician or nurse ask to be relieved of the responsibility? Would an ethics consultation be helpful and acceptable to the conflicting parties?*

*At every nodal point in this work-up, clinical prudence or judgment is essential. Thus, prudence is the most important intellectual virtue that safeguards the logical and epistemological propriety of the decisions. But the logic and epistemology used in no different form that we use in the judgment of what is medically good. Doing an ethics work-up is as much a part of being a clinician as making diagnose, or selecting a treatment. Indeed, so important is the capacity to do an orderly ethics work-up that it is an intrinsic part of being a good clinician.*

*There is no question that, from time to time, the complexities of the ethical issues of the psychological dynamics cannot be resolved by ordinary means. Then, ethics consultation is indicated and often helpful. But, even then, the clinician who signs the order for an action must remember that he is accountable no matter what the consultants suggest or decide. There is no way to escape moral complicity for the clinician, no matter how many options he elicits. He must opt for one and be accountable for its effects on patient welfare.*

How do you teach this to medical students and residents?

*I have found that classroom teaching in ethics does not prove very useful at the bedside. This is not to depreciate its value. It provides the language of clinical*

*ethics. But clinical ethics is taught, like any clinical subject, at the bedside and with the student's own case if at all possible. My aim in teaching clinical ethics is to refine the ethics work-up, reaffirm the clinician responsibility for making decisions and drawing on theoretical foundations as necessary in individual cases. When a student or house officer has to decide what the morally right thing is for his patient, he cannot escape thinking about ethics and how to approach the problem he faces.*

*The most useful and effective way to teach bedside ethics is through ethics rounds on a regular basis. A case is chosen by the residents—one that is a problem for them. Lacking this, I use actual cases I have seen in consultation. Case books are of limited value. They are often contrived to make a point and so lack verisimilitude. Real cases are “messy”.*

*There is nothing mysterious about the methodology. It is Socratic and emphasizes student participation. It is the same method I use in teaching medicine itself or the basic sciences as they apply to clinical medicine. Theory is not neglected but always related to the case at hand. In this way, the student or resident is made to realize that he must have a certain acquaintance with theory if he is to make his clinical decision intelligibly.*

*At the bedside, the student sees the immediacy of ethics and recognizes his responsibility and accountability for being morally correct. He can anchor his learning firmly in a case with which he is involved personally. There is no greater impetus to acquiring knowledge than finding that we actually need it to do our work well. This is the same technique I used for years teaching acid-base reliance or electrolyte metabolism. The theory only becomes meaningful when the clinical problem cannot be resolved without it or when ethical justification must be provided for a choice.*

What is the role of the covenant in the 21<sup>st</sup> Century?

*The basis of the “covenant”, which I take to be the moral commitment of the physician (or nurse) to act in the patient’s best interests in a competent ways, is fundamental to the clinical encounter. It cannot change in essence. By this I mean that the phenomena of being ill, seeking help, offering to help and actually helping are all universal human experiences. Science and culture can alter the nature of disease, and man’s response to its effects upon him. But there will always be disease, always the need for healing, and always the need for healers. I do not think that those who hope for a genetically transformed species in which disease and death no longer exist are at all realistic. We may, by genetic or chemotherapeutic manipulation, prolong life, but immortality will continue to be a grand illusion and delusion.*

*Given today’s cultural trajectories, it is more difficult to remain faithful to the covenant. I have already alluded to the many factors that threaten to change the moral nature of the clinical relationship—the comodification of medicine, the mechanisms of managed care, the conversion of the physician from professional to employee, institutionalization, industrialization and bureaucratization of health care, the emphasis on profit making, on patients supposed freedom to make choices among insurance plans, etc.—the list is long and a true test of the physician’s moral endurance as well as his patience.*

*Despite these difficulties, I believe there will always be physicians dedicated to what it means to be truly a healer. They will always be the moral beacons of the profession. Many others, however, will see the covenant differently, mostly as a contract for services. These physicians will be employees of large health care organizations, not necessarily bad physicians, but neither will they see themselves in a moral covenant with their patients and society.*

*The forces acting to change the covenantal relationship will unfortunately divide the profession. On one side will be the true professionals, on the other, the holders of jobs, tradesmen and entrepreneurs. We will, in a sense, have come full circle to where the profession was in ancient Greek times, when the*

*Hippocratic physicians developed their Oath. That Oath served to set them apart from the majority of Greek physicians who were indeed tradesmen, itinerant healers and businessmen. Though the majority of ancient Greek physicians were not dedicated to the Hippocratic ideal, the moral trust expressed in the Oath were valid nonetheless.*

Given that the covenant is still central, how can educational leaders support the medical professional community?

*Educational leaders in medicine are concentrating for the moment on reviving professionalism especially in medical school curricula. This is an admirable idea but it is somewhat off the mark. The problems attributed to “deprofessionalization” are moral in nature. What is essential is a recapturing of the moral center of the patient-clinician relationship, as I have suggested at more length earlier in this interview.*

*“Professionalism” smacks a kind of elitism of the wrong kind—one grounded in a charter, group loyalty and identity and a quasi-union mentality. It misses the fact that the essential moral distinguishing fact of a true profession in medicine, law, ministry, or teaching is the act of professing to serve others competently and in the interest of their well-being.*

*What needs to be recaptured is the primacy of the good of the patient as that which takes precedence over other considerations. This moral center cannot be recaptured by some of the devices fostered by some professional bioethicists whose influence in medical education is growing.*

*On the contemporary view of medical and professional ethics is a social construction changeable with changing mores; it cannot be trans-cultural or trans-national. It is more in the nature of a social or legal contract, not a covenantal relationship. Even more worrisome is the growing tendency to see the organization as the patient’s safeguard, not the doctor. We must reconstruct the system of health care and constrain the individual physician’s discretionary*

*latitude so that medical error or malfeasance cannot occur. Clearly those who hold this view do not see much hope in “re-professionalization”. Rather, they believe patients should place their trust in the health care organization and not the physicians who work within it.*

*I will not belabor the consequences of trusting organizations, especially if a profit is to be made. Suffice it to say that anyone who has ever tried to enter a complaint in today’s corporate world and tried to run the minefield of the automated telephone system knows instinctively how faceless, cold and cruel the “organization” can be. Clearly, both the profession and the organizations that “provide” health care need drastic reform. Unless it is morally motivated in the long run, the welfare of the patient only increases with the complexity of the “system”.*

Have you seen any examples that give you hope that individuals or the profession as a whole are taking these issues seriously or devising solutions to the problems you have raised?

*We cannot and must not give up hope. Caring for the sick people is too important to the claims we make to be a just society or to be compassionate persons—within and outside the health professions. We must remember that there never was a time of perfection. Having lived through sixty years of medical history personally, and having read many pages of medical history, it is evident to me that medical virtue and vice have always coexisted, sometimes one, then the other being ascendant. Never has one obliterated the other, and never will vice or virtue be unchallenged.*

*There is hope and it resides in individual physician primarily, and the organizations inspired by those individual physicians who truly believe that the gold standard of medical and professional ethics is the welfare of the patient. We must remember that the Hippocratic physicians were a small minority within the Greek medicine of their time. Yet, they formulated an ethic of patient care that influenced many physicians in many countries. Similar groups of physicians like*

*Susrut and his followers in India, or the Confucian physicians of ancient China did the same thing for their parts of the world.*

*I see hope today because there are still groups of physicians, young and old, who do not believe they are selling a commodity, producing a product or running a business. They recognize in the unique phenomenology of treating sick people a set of obligations and virtues which are the direct antithesis of a system that regards the sick as consumers, customers, insurees, etc. It is from this group of physicians and their professional organizations that the pathway to compassionate, competent care can emerge.*

*Of course, their endeavors can be sustained, and re-enforced, by good professional organizations as Relman and I pointed out in a JAMA editorial some years ago. The recognition of the need to reassert certain principles by the American College of Physicians and the European Society of Internal Medicine is a hopeful sign. They have chosen an unfortunate title of “Charter” for their reform, but their intention is in the right direction to be sure. Would that our professional organizations concentrate on the ethics of the profession and paid less attention to their corporate interests.*

How do educational leaders most effectively influence decision making in health reform and social justice?

*Clearly, the role of educators is to educate. In the influencing of decision making, they do this best by their personal example, by their activity within the institutions wherein they teach and, of course, by influencing future practitioners and leaders. This means authenticity within their own institutions, solid research and clear argumentation. If the educator wants to influence the future, he must train students who can act as viruses that will invade the cells of the body of society, and by changing those cells, change the society itself.*

*If, as the 9-11 Commission put it—the character of the person is more important than the wiring of the institution—then we teachers must concentrate on making*



*a good case for our students. They can change the culture of the institutions within which they work. To do this, they need secure knowledge of the directions these institutions should take and the character to learn wisely and well in the right directions.*

Training people who are morally secure so that they can move on and take leadership roles in the future?

*Yes, that is precisely what I mean. Professional schools are only part of that kind of education—the part which focuses on the specific moral obligations of a profession. More important in the long run is the liberal education one is presumed to get before entering a professional school. Sadly, as a teacher of medical students, graduate students in philosophy, as well as practicing physicians and even undergraduates, at the time I am disappointed in the quality of liberal education today. The classical ends of a liberal education—the capacity to think, write, speak and judge good and evil, recognize beauty or understand what is good for humans is about—are extremely difficult to come by. To expatiate on why this is so is to suggest a critique of our culture, and I will spare you that.*

*In professional schools, some have been trying since the mid-sixties of the last century to make up for this deficit by providing work in the humanities, ethics, and human values within the medical curriculum. (See my paper with T. McElhinney, in 2001). This has had some success as have courses in medical ethics. Our hope is to lay the groundwork for an appreciation of what has been lost, and to instill a desire to make up for some of that lost through self-education throughout one's professional life.*

*The focus of a liberal education in the long run is to know oneself—not in the self-fascinated, emotionally immature way of the popular media, but in the deeper sense a good education makes possible. What does it mean to be a human being? What makes us different? What does that difference require of us? It is fashionable to call such an endeavor at critical self-knowledge*

*“speciesism”, so be it. Man is unique in the biosphere. He is the only creature that can knowingly change that biosphere. No other species has that capability or the responsibilities it implies.*

Somehow, within each health care profession there has to be time for that discussion?

*I strongly believe so. This is true for any other profession as well—law, ministry, teaching, etc. One must be a good person before one can be a good professional in the full sense of that term. Being technically proficient is not enough. Even in today’s pragmatic pursuit of self-interest, virtue counts for something. In a professional virtue is the disposition to act well with regard to the persons we serve. To do this well, we must know who we are, why we are doing what we do and why a profession is not a mere occupation.*

Where does the communitarian ethic fit in your theory of medical ethics? Does your emphasis on the individual patient and the individual health professional conflict with communitarianism?

*I understand communitarianism as a political philosophy that derives from Hegel in which persons are constituted by the institutions and practices in which their lives are embedded. They derive their rights and obligations from the social roles they play. This is not the same socialism which emphasizes equality but accepts coercive measures to attain equality particularly in resource allocation.*

*Communitarianism is a species of non-coercive socialism. Communitarianism emphasizes the connectedness of individuals and is opposed to the kind of atomistic individualism characteristic of John Locke and of modern-day libertarianism. For the communitarian, the way to the good life lies in communities in which collective values construct the lives of individuals and not their individualistic definitions of values.*

*While I reject atomistic or absolutized individualism, I would also reject social construction of values. Values, human rights and dignity are grounded in what it*

*is to be human, not in the social institutions and practices in which they happen to be embedded at a particular time. Social constructionism is not self-justifying. It needs grounding in a sound philosophical anthropology. Lacking this, there is no way to judge what is socially constructed as good or bad.*

*Does this mean that I reject the social matrix of medical practice? It definitely does not. Rather, I interpret the social dimensions of medicine in terms of the common good, i.e. in the tradition of Plato, Aristotle, Aquinas and others. Human good cannot flourish in a society which does not sustain that flourishing; a good society is impossible if its members cannot flourish within it as human beings.*

*Thus, the good for humans is the metaphysical foundation for a good society and the common good, i.e. the expression of human potentialities. The good society is one which is so structured as to achieve this end for as many of its citizens as possible. Communitarianism fosters human welfare in terms of social constructs which precede the human good, while the common good fosters human welfare in terms of what is most suitable to the nature of man qua man. The good community is shaped by what is good for humans; the good for humans is not what a society at a particular time determines it to be.*

*A more apt idea than communitarianism is the idea of solidarity and the interconnection of humans. It links them to one another because man is a social animal and needs society to flourish. But the values that connect us are grounded in our human nature, not in the nature of the societies we construct.*

*I have spent a little time on this because so many take the fact that I start with the defining phenomena of the clinical encounter as a denial of the social context of medicine. This is not the case, as Thomasma and I have repeatedly argued.*

Before we close, is there an epiphany you would like to share?

*I assume you are using this term in a literary rather than a theological sense. I take it to mean the sudden revelation of something, or the symbolic representation of such a realization. In this secular sense, I suppose the*

*realization shared by David Thomasma and myself that the moral center of medicine lies in the human relationship between healer and the one to be healed could qualify as a modest “epiphany”. It centers our philosophy of medicine but it needs further and deeper comprehension than we have given it thus far. It does not exclude the societal context, but one thing at a time is still a good motto—even in Bioethics. Incidentally, if Thomasma and I had an “epiphany” of the kind I describe, it was the inevitable result of our phenomenological realism, confronting us with the existential realities that distinguish medicine as the specific kind of activity it is.*

## **APPENDIX F: ROY ROMANOW, BA, LLB**

### **BIOGRAPHY**

Roy Romanow is a graduate of the University of Saskatchewan where he earned his Arts and Law Degrees. He was first elected to the Saskatchewan Legislature in 1967. Between 1971 and 1982, Roy Romanow served as Deputy Premier of Saskatchewan.

Throughout those 11 years, he also served as Saskatchewan's Attorney General, and was responsible for the introduction of a number of justice system reforms, including: the introduction of a provincial legal aid plan; the creation of the Saskatchewan Human Rights Commission; the introduction of a Saskatchewan Human Rights Code; and the creation of the Provincial Ombudsman's Office.

In 1979, Mr. Romanow was appointed Saskatchewan's first Minister of Intergovernmental Affairs. He was one of the key players in the federal-provincial negotiations that resulted in the Constitutional Accord of November 1981. In 1984, he co-authored a book on those negotiations, *Canada Notwithstanding*.

Mr. Romanow also served as a member on the Canadian Medical Association Task Force on the Allocation of Health Care Resources from 1983 to 1985.

On November 7, 1987 Mr. Romanow was acclaimed Leader of the Saskatchewan New Democratic party to succeed Allan Blakeney. On October 21, 1991 Mr. Romanow won a 55 seat majority government, and assumed the duties of Premier on November 1, 1991.

Mr. Romanow's government introduced a number of fiscal, economic and social reforms. These included an expansion of the ground-breaking Action Plan for Children, the introduction of the Building Independence strategy to help move families off social assistance, and enhancements to the provincial health care system.

Mr. Romanow retired from politics in February 2001.

In April 2001, Mr. Romanow was appointed a Senior Fellow in Public Policy at the University of Saskatchewan and the University of Regina, and is also a visiting Fellow in the School of Policy Studies at Queen's University.

Mr. Romanow was appointed Chair of the Royal Commission on the Future of Health Care in Canada in 2001.

**INTERVIEW: MAY 19, 2004**

I would like to hear your thoughts on some leadership issues beginning with a broad perspective of leadership. What would you suggest are vital leadership components that need to happen to bring forward the *Building on Values* Report?

*This is a very difficult question because in some respects I believe that leadership is sometimes not definable. It depends on circumstances which exist in society, the political climate, economic and even the cultural values together with other similar factors or other factors can conspire to derail any of the definitive thoughts that one might have. With that caveat, nonetheless, I would say that essentially the following elements are required of the leadership in order to see a public policy to fruition. First, the policy must be based in a correct understanding of the desires and values of the Canadian people. Second, building from there, you must get the architecture upon those ideals correctly described and put together. I might add with respect to architecture in a field like health care, this is a very challenging task to build the appropriate system, because there are so many competing interests who would want to see the architecture in their own particular view. Thirdly, there needs to be an appropriate vehicle for the communication of the preceding two issues to the public itself. This is also very challenging because unless a leader is in a position of authority, elected or otherwise, it is difficult to garner public access to the various forms of communication of the message. But, nonetheless, without communicating this in an understandable and clear-cut fashion to the public, it all becomes a bit of an*

*exercise in hope only. One might say that what I'm really saying is that communication skills are important. They are, but I'm saying more than that. You need the communication skills but you need also the capacity to be able to command a vehicle to actually get the message out. That's the third dimension to it. And, fourth, there needs to be a set of supporting organizations and voices if the acceptance of the goal is to be realized. A lone voice tends to become a voice which sounds like Johnny One Note and is therefore probably sooner than later forgotten. However, if you can garner the support of other organizations who act as external validators of what you're saying and what you base your sayings, in addition to being just additional voices, they will be able to assist. Finally, access to the policy decision-makers is vitally important. Often for people like myself in a former Royal Commission capacity, this access manifests itself through public communication. Sometimes you can actually get access by face-to-face meetings, conversations, an exchange of views and opportunities to persuade, or even motivate people to adopt what you recommend. In the case of health care in Canada, as I suspect in other major policy areas, the access on a direct basis to policy makers is not easy. They are obviously preoccupied with a whole range of issues, of which health care is only one, and this being a very regionalized nation with competing interests and a small country on top of it all, making those regional differences all the more pronounced. The political leadership is difficult to access, but if you can do it, it's a marvelous additional tool that you bring to getting your goals realized. Now all of that that I have said carries around it a combination of these other earlier opening statements which I made—respecting climate and atmosphere. You can be a wonderful communicator, for example, and you might even know a particular Prime Minister or two, but if the architecture or the values or other issues have simply knocked you out of the arena of relevance—political relevance---then the best of leadership won't work. It's a very difficult and unpredictable set of circumstances which you are trying to describe here.*

Thank you. Another perspective on which I would appreciate your thoughts is moving to the leadership required by professionals themselves, the sort of leadership that's needed to move these values forward.

*Again, a very difficult question to answer for these reasons. First, in the health care field, the disciplines are so many and varied and so technical and scientifically oriented that the disciplines tend to be focused very much within a very narrow band of interest. That band of interest of course being the particular field of expertise. If it's nursing there will be a set of issues which will speak to that profession, which predominate the whole larger concept of organization and structures. You can say that virtually of other of the caregivers, and you can also say it of the health policy people who are not actually hands-on caregivers. They tend to become very specialized in health economics or policy respecting quality care. One can identify tens of these and I have found that one of the difficult, really challenging aspects, coming back to my point about validators, has been attempting to get various disciplines to understand that, as important as their individual work is, it's still at the end of the day a part of a larger role that they have as citizens in a civil and hopefully compassionate society. It is the latter part that they must concentrate as much as they do on their specific discipline. Perhaps I overstate it when I say as much as they would with their discipline—that is probably unrealistic—but there needs to be a greater awareness of the civil responsibility.*

*And that involves also some capacity to compromise, to understand that I might not be able to, for example, as a nurse, advance my vision of the nurse's role in a primary health care model at this particular moment, but I'm going to accept that because I see before us a larger fundamental debate about the nature of Canadian society surrounding the issue of whether or not health care is viewed as a public good and therefore the responsibility of all of us or whether it is viewed as a commodity and something that is bought and sold like a car. I have found that to be one of the biggest challenges of the whole business of trying to get the large elements, the larger elements, as I would see them in any event for*



*reform, implemented, and the vision implemented. One might add to the very first question that you asked about the components of leadership, a doggedness and a tenacity and an even physical and emotional strength which a leader is required to have in order to keep at the task of advancing the vision or the cause or the program, however one would describe it, in this case health care, to the various people in the various ways that I talked about earlier, but as well in the area of the health disciplines and the health policy experts. The latter has been very challenging and I have found that my Report has been sometimes criticized from those who believe in the fundamental structure and the underpinning of that structure by the values which I have articulated, but object to the Report because it is not specific enough with respect to their particular discipline. And the converse, they think that too much sometimes, they meaning opponents, has been paid to the particular discipline or perhaps they don't agree with the values. It's the function of history, habit and inertia that we have practiced our health care system in silos more than in the concept of a continuum of care or in the concept of a political, small p, social economic major policy which defines not only the program itself but defines the nation. And that is a constant, never-ending struggle. Again, it is compounded by the fact that made all the more difficult by the fact that if you are in no position of authority to influence the Minister of Finance, to pony up more money, or the Minister of Health, you cannot do this. Then you are forced to go back into the various elements that I have talked about in the first question. I have not seen very many voices step forward in written support from the health disciplines. They tell me privately and sometimes publicly when I appear at various panels or meetings that they like the Report, but—and here's the but—attaches their own individual concern. This has been one of the disappointing features of this whole exercise for me because when the Report gets beaten up by those who don't like anything about it, or mostly they don't like it, you would like to see somebody write a letter to the editor saying, "Well, it has the fundamentals correct." There just seems to be a reluctance and/or a refusal to do so. I attribute that to the nature of the disciplines in the professions as I have just described.*

One strong link that I hear relates to a conversation that I had with an ethicist who works in health care. When asked for her views on how to support policy development at all levels, including at the meso level of the organization, she spoke about the need for the disciplines to come together and policy makers to come together around the table, taking the time to get to know each other and each other's disciplines, that understanding and hearing each other's voices would in the end produce the best policy. Do those comments fit with your understanding?

*Yes, I think it is vital and it would be very helpful not only in the context of advancing the Report's recommendations or advancing any policy, if that could happen in the sense of getting the disciplines together. They would get to know each other better, but in the case of health care it would be even more important because it would foster the spirit of cooperation and integration of delivery of service and tying the service into the needs of the community and being more responsive to the community. I just don't think that one or two or three meetings would do the job and I tend to be more pessimistic in that context. I don't argue against it being tried. I advocate that it would be worth giving an attempt, with attempting such a reconstruction; however, I guess, at the end of the day, the same barriers faced those like Emmet Hall and Tommy Douglas. And in that case, they decided that they had to appeal directly to the public and communicate with the public. If that's true today, and I suspect it is, then you're back to the communication and bridge building and alliance building concepts that I talked about earlier.*

What gives you the most hope in the midst of all the challenges?

*Well, I think that the thing that gives me the most hope is my own experience and what I heard and what I read and what I saw as Commissioner that the values in the Report are correctly identified inasmuch as Canadians strongly adhere to them in vast majority, not in unanimity, of course, but in overwhelming majority. I am also buttressed by the fact that a recent book called *Fire and Ice* by Michael*

*Adams, written at a time when one would think that NAFTA would break down our values because of our close economic trading relationships with the United States of America and move them more closely to the American set of values. This does not seem to be the case. Adams, in Fire and Ice, which book won the award from Donner as being the most important public policy book of 2004, I guess just a few weeks ago, says that by his examination of all of the data, all of the public opinion research, that in fact, if anything, the Canadian values in two areas have been strengthened and become more distinct from America. Those two areas are social policy such as health care where Canadians feel very strongly that our model and system is the model which needs to be reformed and protected and in the area of international relations where Canadians believe that multilateralism as opposed to unilateralism in the solution of international problems should hold sway. So I take Adams, who of course had his own public research firm and has all of this information over many, many, many years and has tracked it very carefully, and the book has been in effect peer reviewed by virtue of the award that it has won. And I couple that with what I heard earlier, eighteen months ago or so, what keeps me inspired is that I think we've got it right, and I think if we've got it right, eventually the voice of the Canadian public will influence whether it's the disciplines or the political people or even the journalists to the appropriate necessary reforms and sustainability. (I've got to believe that in any event because, if I don't, it would have been, I would be in the position of saying that it was the most unhappy time of my life, and it wasn't.) It was one of the most rewarding periods of my life!*

One of the topics I have been studying is "the malaise of modernity," such as the major impacts of the marketplace and technology. While awaiting the Report, I wanted to learn whether Canadians still have the values that they held over the past decades. I discovered that the Report concluded that these core values have remained.

*Well, a little response to that, if I may. I'm not sure, however, the extent to which the influences of internets and modern-day communications and technology and*

*corporate capitalism—if I can use a phrase of international trade and globalism really has subverted our Canadian values. I think it has affected them in some areas, there's no doubt about that, but in some ways, there is the prospect that our public is much more informed by virtue of the fact they have had more access to information and various options that are before them and they are able to see the world, the good and the bad of it. One only hopes at the end of the day that the history of our country and the way we have built our institutions and our programs and that the intelligence of our people—I'm not saying they are more intelligent than others in the world—but I think an intelligent and thinking population will be able to sift through the bad in order to find the good. Citing Adams one more time, I think there's some strong evidence that that is the case and, if I may be so immodest as to say citing the Report on Health Care, that certainly was my experience without a doubt. Now, whether that will be the case ten years from now or not, we'll see, but I am hopeful, might even say confident, that it would be so. But we'll see.*

I'm reminded of a poignant quote by Pondy, speaking of Martin Luther King, who said that the marvel of the man was not only his great vision but his ability to articulate and to draw others in with that articulation. I believe that the vision that you brought to the Report was a similar articulation. I would like to thank you for that.

*Thank you very much. Good luck to you.*

## **APPENDIX G: JANET L. STORCH, PHD**

### **BIOGRAPHY**

Dr. Storch holds a Bachelor of Science in Nursing, Masters of Health Services Administration (University of Alberta), Doctor of Philosophy in Sociology (University of Alberta), and Certificate, Kennedy Institute for Ethics, Georgetown University, Washington, DC.

She is Professor, School of Nursing, and Chair of the Human Research Ethics Committee for the University of Victoria.

She previously held positions as Director of the School of Nursing, University of Victoria; Dean of Nursing, University of Calgary; Director of the Masters in Health Administration Program, Professor, and Sessional Lecturer, Faculty of Nursing, University of Alberta; and Staff Nurse, Victorian Order of Nurses and Montreal Children's Hospital.

Dr. Storch was President of the Canadian Bioethics Society, 1992-1993, and on their Executive 1989-1994; President, National Council on Ethics in Human Research, 1999-2001 and on their Council 1993-2002; Ethics Scholar in Residence, Canadian Nurses Association, 2001-2002. She is a member of the BC College of Physicians and Surgeons Ethics and Standards Committee; Chair of the BC Medical Services Research Foundation Advisory Committee; Member, Regional Ethics Committee, Vancouver Island Health Authority; and Chair, Bioethics Advisory Committee, Associated Medical Services, Toronto.

Her teaching and research includes Health Ethics and Health Administration Ethics, Research Ethics, Nursing Ethics, Nursing Management/Administration, Professional Ethics in Multidisciplinary Program HSD, and Canadian Healthcare History and Social Policy.

In 2004, a text she co-edited and wrote with P. Rodney and R. Starzomski titled "Toward a Moral Horizon: Nursing Ethics for Leadership and Practice" was released. She continues an active research program with a team of nursing colleagues. Her most recent funding in November 2004 was from CHSRF (the Canadian Health Services Research Foundation). In 2003 she received an Award of Distinction from the Registered Nurses Association of BC. In 2004, she received honour awards from the University of Alberta Alumni and from the Canadian Association of Schools of Nursing. In June 2005 she received a Doctor of Science (*honoris causa*) from Ryerson University.

**INTERVIEW: OCTOBER 20, 2004**

My first question relates to foundations. I'd like to ask you to discuss foundations of professionalism from your perspective - what you believe are key foundations of professionalism. This relates also to the philosophers who have been instrumental in your background, who particularly influenced you.

*Certainly when I started looking at the whole area of professionalism it was probably through the eyes of sociology, although I might not even have realized that focus at the time. But when I really got into it in the late seventies and early eighties, from that sociological perspective it was through people who wrote about the descriptive part of what it was to be a professional. The criteria of professionalism were often discussed as falling into four quadrants, a pattern that served as an "ideal type" and as being very important: a distinct body of knowledge, an ideal of service, professional self-regulation and a code of ethics. So that sat with me for a while just because I was doing a lot of work in the sociology of professions and occupations, and then as I started to bring that alongside the work I was doing in ethics, some of the people and resources that influenced me early on would have been a little book by Frankena (which I know is a synopsis) who had some very interesting ways of putting some of the philosophers' work together. That led me to people like Kant and Rawls, because I was doing work in areas of social justice and also studying one-to-one patient-*

*nurse/patient-doctor relationship. That's where I would have started the grounding. I think of those as almost my foundation building philosophers, recognizing that I had come up through the whole route of being a professional and trying to make sense of what ethics means in practice. Working from there, I made a decision to follow a more principle-based approach in ethics that seemed to make a lot of sense to nurses. I focused on patients' rights and ethical principles combined. In the early eighties as I finished my own Masters thesis that was about ethical and legal issues in health care and nursing. I was mainly studying under legal scholars at the University of Alberta as there were no profs actively involved in the study of healthcare ethics (except for Madame Justice Ellen Picard) or even philosophy of healthcare at that time. .*

Continuing on with professional traditions, how has that influenced your thinking?

*Let me discuss that professional route because certainly in my nursing education, which was a five-year Baccalaureate "sandwich" type of program, we had next to nothing in terms of formalized ethics education. All we had was linked to faculty and nursing staff who served as role models. If the role model showed us something about ethics, we often saw a negative picture and sometimes a very positive example. I do remember the course called "Professional Adjustments" which was mainly about professional etiquette and a Code of Ethics was mentioned. When I go back now and understand more about the development of Codes of Ethics in North America and the world in general, I realize how recent that was. The ICN Code, which is the Code Canada adopted, had only been developed in 1953. I was studying between 1958 and 1963, so probably some of my profs weren't even that clear about the depth of this meaning in such a Code. So what I think we mainly got was more the etiquette required of a nurse, for example, expectations of us if we moved into a new community, things we should observe, etc. We were taught that our loyalty lay somewhere between our patient and the organization and, when in doubt, to choose the organization. We recited the Florence Nightingale Pledge at our*

*capping ceremony. It includes statements about “with loyalty will I aid the physician”, and about purity and faithfulness, and the implicit ethical virtues.*

*I would say that for years, including in the book I wrote on Patients’ Rights, Ethical and Legal Issues, I was not a strong supporter of what Codes of Ethics could do. I was sceptical, but realized we had to have something like a code since it was important to being a profession. If we satisfied the four main criteria of professionalism, that set us in the right direction. When I became involved with the CNA and Sister Simone Roach’s work in developing that first Code of Ethics for Canada, I began to see that Code as advocating for a caring philosophy. I think it was a Code ahead of its time. I think if it had been brought forward five years ago, it would have been a real winner, but as you know, it was “bounced out.” I was involved in reviewing it, was pretty happy with it, and then was quite dismayed about what happened to it. Then the CNA brought in a more secular group to work on the Code of 1985. I think that Code was okay, and I think it had some problems. But it also had a much stronger philosophy that came out of the ICN Code, i.e. that our first responsibility is to our patient. To utilize that Code, to think through the philosophical base underpinning these statements has been a very important thread in how I think about the foundation of our work and what we ought to do.*

Do you want to make a comment at this point as to the influence of virtue ethics as a theory on your understanding and how you follow it?

*Well, I suppose that I grew up with virtue ethics. That came from a very strong commitment to Christianity from my childhood, from my parents. When I came to understand more about virtue ethics I thought, this really feels like the right thing. Yet, looking at what was happening with my class of 82 people who were in this middle part of the sandwich program, I began to see too that the Florence Nightingale Pledge had quite a lot of meaning for us, especially the thing about faithfulness and wisdom and that kind of thing, and the loyalty thing was not particularly bothersome at that time. As I got to learn more about virtue ethics it*



*really did have a great deal of meaning for me, and it still does. When I was chairing the Legislation Committee of the Alberta Association of Registered Nurses around the early eighties (when we were making changes to the Nursing Profession Act -- formerly called the Registered Nurses Act of Alberta), I also got to see how virtue ethics had been translated into the "character" of the nurse. This was considered a very important criteria for entering the profession when that Act was framed in the early 1900s. We had a lot of discussion in our committee about what it would mean if we let that go, i.e. if we agreed to remove the nurse being a person of "good character" from the Act. We eventually were persuaded by the registrar of the Association and by legal staff of the difficulty in enforcing the criteria of "good character" in granting nurse applicants their registration. Therefore, we had to agree to have it removed.*

*But I still think that we lost something in that removal, because what we lost was that virtue ethics piece. Most schools of nursing then ceased to require letters of reference from people who could attest to character. We no longer did interviews or even required people to write that much about why they would want to become a nurse. That also has been something of a disservice, to not select the "right people" to enter the profession. I know we have to be careful, of course, in who the "right people" might be to avoid discrimination, but we need to know applicant's motivation. I have to say I was really struck with this at the end of the eighties when I was still in Edmonton and I was part of a panel of interviewers to interview and screen medical students at U. of A. They wanted people from outside medicine to interview the new class and I met people through those interviews who I thought, "That is just who you want as a doctor". Yet marks at U of A were deemed to be far more important than virtue or character or motivation and what was important. Over and over again somebody who had done an International Baccalaureate Program and then came to first year university to basically repeat some of the courses done in the IB program to boost their University GPA, was a winner over others with a lower GPA but who seemed a better fit in becoming a physician. Most of the "winners" were not similar the average bedside doctors and so I think even there that the whole idea of virtue*

*and character really got lost. We do need scientists in medicine. But then, I think we should be clearer about the two types of people we need and make sure the scientists don't get in the way of good medical practice. It seems to me that there has been a whole thread through my life that stays with me about the importance of virtue ethics and not leaving that. It has stayed part of the Codes of Ethics for Nursing. And certainly Sister Roach's earlier code was also about virtue ethics.*

Thank you. With that as our backdrop, let's move into the the application to education. You have had senior roles in education, so let's discuss how you refer to that foundation and how you move that forward.

*And, how I would teach it then or how I think about it and therefore try to teach it to students?*

For example, what key ingredients do you ensure are moved forward, and how does that translate into the actual curriculum and then the actual teaching of it?

*I should just go back one step because something that profoundly influenced my development in moving forward in ethics were the week long seminars that the Hastings Centre used to bring to Canada elsewhere. I attended one at the Westminster Institute in London, Ontario. It was there I heard Dan Callahan, Willard Gaylin, Eric Cassel, some of these really amazing people. David Roy spoke at that too as did Bernard Dickens and George Annas, so we had sort of a legal ethical group. That particular seminar would have been in 1980, maybe 1979. I attended another one of those in Colorado. I have used the Hastings Centre "road shows" to build what I was lacking in this focus on ethics and those folks profoundly influenced my direction then and now. What I always wanted to hold on to was the primacy of the person in care and how important that was. I remember sitting at that meeting talking to a philosopher from the US and I was debating what to do to try to use what I learned in my Masters thesis work. I wondered whether I should now move to a more theoretical approach or just how to best use that background. He urged me to hold on to the rights approach, in part because it was a little more (and I found this) understandable to people.*

*There was a receptivity in that particular period of time with civil rights, and that then moved into principles. He urged me not to jump too far into theoretical or great philosophical approaches but to try through the principled and rights approaches to bring in philosophers like Kant and others who had influenced my thinking. So that's what I tried to do for some time, i.e. to hold on to that approach and to use examples in the text about what that would mean if it was translated into nurse-patient relationships, and how that held nurses to some of those ideals.*

*When I see "covenant," what comes to mind is the work of May, who talked a lot about covenant. This really resonated for me because of the Old Testament/New Testament knowledge that I grew up with. I would note for students the value of thinking about the relationship with their patients as a covenant, e.g. "Isn't that a wonderful way to think about what kind of a relationship we have," To me, contract seemed very tinny, hollow. In the past decade I spent a several years being embarrassed that I had focused on "rights" because I thought, that's just too limited a conversation. But I remembered that when I lectured about ethics in a class of undergraduate students it seemed like it just going right over their heads, their eyes glazed over. It was as though I was getting into something that they just thought right away, "Well, I couldn't possibly know that". There was a time when philosophy and ethics seemed remote to the average person. Fortunately, we are in a different time. Now talking to students and nurse practitioners and nurses in practice, which I'm doing regularly through our research project, they do have a sense of what it's about, and there is no longer a glaze-over. Instead, it is a very quick engagement. There's still a little bit of this, "Oh I couldn't possibly know," but what we're trying to do through that participatory action research project is to say that "you do know." "You also need to pull that out from within everything that you know about what this relationship should be." I have to say that I do shy away from use of the word "covenant" with the majority of people just because it's that same reaction as people seemed to have to Sister Roche's code, "Oh my gosh, that's a religious term, it's Jewish, it's Christian, but it's not about me if I'm not in those groups." But in my heart I*

*believe that's just the best way it can be stated. It's that virtue brings a sense of the primacy of the person and it's the sense that you do go the extra mile because that's what is important to do in ethics, you're not just fulfilling a little job description.*

Thank you. That can then lead into your understanding of the moral imagery, how you understand that professional moral language. I am interested to understand whether you actually feel that that language is useful today or not?

*I think it's very important language and very useful language. What still surprises me is when we put moral in front of terms now, rather than ethical. I mean terms like moral distress, moral residue, moral sensitivity and that kind of thing. I still, especially in my community, get a huge reaction from people, even within the ethics community, to say, "Oh, we can't say it that way because people will think we're talking about religion." For the most part in the things I write and in the Code of Ethics, I try not to go through the academic debate of making the distinction between moral and ethical because I understand that they come from two different routes, and that they really can mean the same thing. To me, ethical is still the broader, the external obligations. To me, moral is a little bit more about me exactly and it's very important that those two are together in the thinking, that they're a global piece.*

*But I like the term moral community because it is about "me" if you will. It is about how I participate in creating a community that is a virtuous community, one that supports people who are whistle blowers, who raise questions, who want to get us to think more widely than we do about ethical responsibilities. This involves extending those responsibilities in our minds and our practice, to the whole range of people we deal with. Also in the way we think more broadly about our responsibilities to the world community and that kind of thing. So the concept of a moral community has been something I use in my writing and teaching, in nursing management and nursing administration.*

*I emphasize that a huge goal for nurse leaders is that they be effective in developing a moral community. But staff nurses also need to see that it takes all of us to build that kind of a community. We need it so much, to allow us to practice from an ethical, competent, perspective. I think through the three research projects we've done as a group, that what really stands out over and over again is the support that can be gained from each other to behave more ethically rather than less ethically. If that support is not there, it's very difficult to be the one soldier walking alone. In our earlier research involving focus groups, one of things that really came home to us was, at the end of the group, the nurses who had volunteered their own time, stayed after shift or come in early for shift, would say, "Gee, this is really nice. This is the first time I've ever had a chance to sit down with this group and talk about ethics and I didn't know you felt that way, I didn't know you thought the same as I, I just thought I was the only one who worried about these things." So we could then see the power of extending this research to work to help people create these moral communities. That's not stated in that particular way as our research objective, but it is to provide resources and support for nurses. The project that we're doing right now with nurses over in Victoria is to help nurses develop this capacity. Our newly funded research project is designed to try to create these moral communities in the other regions in B.C. We're working with the Chief Nursing Officers on this, the CNO's, and so we're hopeful that we can help spread the findings from our study, not just through our region, but through other regions.*

Please elaborate on some of your initial thoughts in terms of supporting the leaders, whether it's formal educational, or informal through role modelling.

*I've actually just written a paper called, "Take Me to Your Leader." What that paper is about is trying to make the point that nurse leaders do need to step forward, they do need to take a big role in providing support to their nurses, and that their responsibility for ethical practice is a very, very big one in providing ethical leadership. So, how we go about doing this? Our current research is not written up yet, although some of it is translated into this leadership article. It is the*

*fact that for a while now we've been lacking nurses' ethical leadership because of cutbacks. And I fault the profession of nursing itself for allowing this to happen because there was a little period of time when it was very common to say "every nurse is a leader." And that language still goes around. That's an okay language to a point, but when you have cutbacks coming on one side and a professional group saying and championing the idea that "every nurse is a leader," well, what a good place to cut back! And so you get rid of the very people who could have enabled every nurse to be a leader, and now we have situations where there is very little clinical leadership for nurses, as often non-nurses are looking after their area and many of them do not really understand what is going on. They cannot represent the nursing voice at the senior table. That's the biggest part, they can't converse about it in an in depth way. So our whole hope in working with the leaders is to help them to think this through and respond/react to it. I would say we have some people out there who are extremely good about trying to build and provide ethical leadership, but there are others who I think have just kind of said, "Well that's nice, if I can get to it," but they don't see it as integral to everything we are and everything we do. That's the part that we want to push right into the centre of who they are and what they do. So the first part of our new three-year project will working with them on ethical leadership in action saying, "Okay, how could you start translating that within your Region? Do you want to start some projects of the sort we've been working with? How can we help you?" And what we're going to do is take these nurses who we've now worked with for three years) and they are going to be the advisors "on the ground" as knowledgeable people. For instance, on RP1 these nurses have really been struggling in practice and they keep saying to us how important our presence there has been to give them hope. Beyond the hope we give, they also need to remember that we're not going to be there forever, and we have to work together to develop sustainability for this project outcome. So we think that they will be able to help in major ways in our new project with these nurse leaders to say emphasize what nurses need managers to do, i.e. this is what nurses need in the backdrop is support from you to engage in safe, competent and ethical practice. It's the Chief*

*Nursing Officer of each region. The staff nurses are very excited about being "advisors:" it's a bottom up approach. I mean it's topsy-turvy, usually you have your advisory committee sitting on the top and in fact we do have a national advisory group that we're pulling together because we do want (if this continues to work the way it is working now) to spread the good news about what's possible. We also want to keep well grounded in the national reality. For these CNO's, their main advisory group is going to come from below, not above. I think that's where the heart of the whole thing rests.*

Now if we look at policy issues—let's expand on that in terms of the work that you're doing and the discussion that we've had—what this could mean to policy development in moving issues forward, and helping leaders to have an ethical thread in the decision making process.

*Well, in fact this new grant that I just was on the phone with the Canadian Health Services Research Foundation about. It is titled, "Ethical Leadership for Policy and Practice," so we are trying to work on both of these and to say not only do we want you to show how this can influence practice but then what's required of policy both in your region, at the agency level and at the government level to instill ethics in what we ought to look at, what we ought to respect, what we ought to put into broader based policies. So in this book that our research team is working on, "A Moral Primer," we hope to try to shift people's thinking about the how ethics is part of everyday practice and how ethics can enhance practice.*

*As I see it now, the CNOs have bought into the idea that patient safety is the big issue. A few years ago quite a few started out with quality assurance, then we changed it to continuous quality assurance, then we changed it to TQM and each time it comes out of the US. It's a product we sort of buy into and then buy into as a policy with huge implications for what doesn't happen then. So the argument we're making in terms of "patient safety" is that it's a bit of a bandwagon. That's not to say it's bad, because sometimes you jump on a bandwagon to achieve purposes that might be very much in keeping with safe care. But the trouble is*

*that when you really look at some of the literature, not all of it, but a lot of it, it's focusing on how we should purchase a whole bunch of new computers and we should get all these technical means that will show us where the errors are and where we are. Apparently there's one region over on the Lower Mainland that's going to spend about five million dollars on computers to deal with patient safety. Meanwhile, what we do know from all this other evidence that's been building in nursing research is that the biggest thing about patient safety is appropriate staffing and well educated staffing so that errors and unsafe conditions can be avoided/reduced. Errors are bound to be in the making, and near misses, but if you have well educated nurses, for example, at bedsides or in operating rooms or wherever, they often can see it and they often can see that slip, that error about to be made and avoid it. If you don't have a well educated nurse you will get a different statistic (and this has now been brought to nursing research in quantifiable ways) that indicates that an error has been made or that patient safety has been breached. When you have this person (an unregulated worker) rather than a RN, it does not just impact patient outcomes; it's the fact that errors are often made. I scanned Healthcare Papers and, as with the Baker and Norton research, the whole issue is about different people's perspectives on how we're going to find where these errors are and how we're going to measure and quantify them. I couldn't see any article in there that was addressed to what I believe is the underlying issue (i.e., staffing as a cause of error) because nobody wants to look at it.*

*We've got a "for-profit motive" here, we've got big investment of all kinds; investments in computer companies and information systems. I think, in nursing, we have to be careful as we work this through with our leaders. First of all, they are in spots that are sometimes difficult when they want to say "no." But we need to assist them in finding ways to see through the policies that are being brought into place, whether they're written or whether they're implied by wholesale adoption, to see through the goodness that might be there. We also need to try to point out to their colleagues the need to look at bandwagon before it becomes a big policy in any Region. The thing I would fault health administrators about, and*



*I always have and I always will (even though I taught them and love to spend time with them), is that they are too quick to jump on bandwagons. They are so afraid that if they're not seen to be doing "it" that they're going to be behind. I think, unfortunately, that applies to our senior nurse leaders as well and that's what often alienates them from the nursing staff.*

Let's move to the question on communitarian ethic.

*On this one, I've had a debate with Michael Yeo about what the definition of communitarian is and he has told me that I sometimes have defined it very narrowly.*

*I guess I don't actually use it since I had this little debate with Michael I guess what I do use a lot in writing and in teaching is talking more about the individual good vs. the collective good, knowing that "good" is even a hard thing to define. What is the collective good? What is the individual good? But to me it still makes sense to say that and I like the whole ethical debate that is now swinging a little bit more towards saying that we ought to pay more attention to the collective good and over this focus on the rights of the individual. We ought at least to balance it better than we do now and recognize that there is a very important role to be played in looking hard at what is best for our society, and our world, and how we contribute to that. For instance, in the 2002 Revision of the Code of Ethics for Nurses, we've tried to build some of that thinking in with a greater focus on the collective. These are things we can do to influence the collective good and you as an individual nurse can play a part in that either through the group, through the association or on your own. I guess we've tried to put it there as an opportunity, and depending where you are in the organization, an obligation of varying degrees to what you do. I don't think that's way outside what we ought to think about. So I probably have just got a thin slice of the richer meaning of the communitarian ethic and it is always something that I think, "I'll really look into that when I have time," but that's how I use it anyway.*

What I've heard you say, I believe, is that when thinking about the communitarian ethic as the common good or the collective good, you see the opportunity for the moral community or the ethical community of nurses to be always be considering it and being able to put it forward in those ways. Have I captured some of that? So what are leaders who provide direction to the profession suggesting?

*I think it's really important based upon the whole emphasis in the last 10 years maybe, to say that there is a unique nursing ethic. Andrew Jameton said it long before that. But the actual research that's now being done by others and the work that we've been able to engage in is I think really important in this whole sphere. We are now able to say that we actually do have something that's separate and nurses need to contribute to these debates so that and promote the kind of leadership that needs to happen. I think that's another reason why nurses have often, like leaders, divorced themselves from worrying about ethics because they think of it in a particular way. They think of it as being, "Oh I should have taken the class when I had the chance" or, "Gee, what are those principles again?" or, "We have this set of values in the region. I should be doing more about that," rather than thinking about, it's about me, and it's about how I relate to individuals and then how I think about the communities of people I work with and whatever I'm doing.*

Thank you for those examples. You had mentioned CNA in passing and, of course, it was for nearly a year that you were able to provide support and leadership in the area of ethics.

*That was such a terrific experience, it really was, to be able to pull together some of the things that I developed, and that were pocketed here and there, and to realize how those could be brought in to help CNA with a few things they just happened to be doing at the time. Then I learned so much too about their work in policy, and the influence of that work. Even though it seems kind of innocuous sometimes to develop a position paper and you wonder that it's on the Web and wonder even more about who reads it. Then to read through the impact of that*

*position statement and to be able to use that more and more in my own teaching has been a real gift. I also encourage others to use the same materials in teaching as a reference point, so that people will see that what we're saying, what they're saying, is coming together and creating the bigger picture.*

That suggests a practical piece in terms of education. Is incorporating a national standard into your regular teaching helpful?

*It's very, very helpful and this is sort of a side issue too, but I was just going to mention one interesting incident. After I'd come back from CNA and the Code of Ethics was released, I was talking to a group of nurses up in the Duncan area, a focus group, and I said something about, "Do you find the Code of Ethics helpful at all to you in your practice? Do you refer to it? Do you use it?" And they said to me, "Well what do you mean? We wrote it." I thought that was such a great thing to hear because there had been many consultations and I thought, isn't that great, that they feel such a part of it.*

Let's move on to the last question. Have you experienced an epiphany?

*This is a great question. I wish I had more time to really think about what an epiphany would be, because there have actually been a few. I suppose the latest one is just the outcomes of working so closely with my research team and with the staff nurses about what it means that patients are central in care. And what does it mean to have a relationship with your patients that is central. But when you actually can see what that means in today's practice and how that can be a reality, I think, wow, the power of ethics is to me the epiphany. I guess I was really startled even when I was at CNA when somebody came in to talk about Codes of Ethics as political vehicles. I guess I knew the power thing. I talked about but never put it into everyday language. Then when I started thinking about political (because we often think of political as suspect or bad), and started to see the good that it could bring about, that has made me even a bigger fan of Codes of Ethics. Added to having a code of ethics, I have also been able to see how it enables nurses to do good practice when they know they have the backing of this*

*group who is there. This power, evident through our research, is being more evident in practice now. Nurses have been able to say that this is what we can do as a group to make ethics come into the foreground here rather than have it hidden in the background. That's been wonderful, it really has, but as I go back over time and just think of the epiphany of the Hastings Centre weeks when I was able to rub shoulders with so many great people involved in ethics. At the time, I honestly didn't know how significant these individuals were or would be in my life. I was at the Hastings Centre just in the previous sabbatical I had in the Fall of 1995. I was out there for a week and in their old place, like their old house. That was so great, and I realized what a debt I owed to the Hastings Centre people to bridge me over into a lifetime as a scholar in ethics.*

From rights, primarily the rights based model?

*And bringing that in and then that's when I also went to the Kennedy Institute to figure out, could I set up something at Hastings. I wanted to take some extended time. Should it be there, should it be Kennedy, should it be Chicago? I went to all of those places. I went to Seattle and then settled on Kennedy and again I think Dr. Pellegrino was really influential in helping me regroup in a way to that centrality of the patients. So there's another re-epiphany, if you will, of just coming back home in a way to something that I thought was really important. Then just everything he's been doing lately too about speaking about managed care and all that, has been so helpful to have that one steady voice, just showing me the way to bring that through. I guess earlier in this interview I neglected to acknowledge that way back when I was working on my Masters thesis, (that really was that turning point for me in ethics) that I did have a mentor that continues to be my mentor today, Shirley Stinson, at the University of Alberta, Professor Emeritus now, who herself was very interested in ethics, had done a lot of work in professionalization, in fact she wrote a thesis out of Columbia on Deprofessionalization of Nursing which was a big thing for me in looking at what it means to professionalize. She was arguing that compared to nurses between the 1920s and '60s (and she wrote this thing in the late '60s) that we would be*

*deprofessionalizing because originally the 1920s nurse had the patient as prime (in the home usually) and then we got "all balled up" in organizations, and so that's always been a big piece for me. Now what she really does for me is just keep pushing me onward because I have never thought I could do some of these things. Even when I wanted to think about Masters studies and never really thought I could do that, she said, "Well, of course you can do that," and she has kept pushing me in whatever I'm doing and that keeps pushing the ethics too. Reminding me of what I could probably do with what I have, I think, "Isn't that great, somebody who sees in you what you can't even see yourself." I owe a great deal of debt to her. So she "epiphanied" me earlier. I've had a lot of epiphanies. That's what happens when you get older. You have lots.*

That's probably one way to capture your work, within your epiphanies?

*That's a great idea.*

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