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Diagnosis by documentary: response to commentaries

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Introduction

In presenting the situation of a health professional witnessing an instance of misdiagnosis and mistreatment in a television documentary, we hoped to stimulate discussion of the professional responsibilities of health workers in informal encounters in a rapidly changing environment comprising print, television, and more recently social media platforms. The commentaries on our paper do not disappoint in this respect, providing insightful and sometimes challenging reactions to the position we outlined in response to our original case. In our reply here, we choose to focus on two themes running through all of the commentaries: 1) the distinction between axiological and deontic perspectives invoked by Salloch, and the open-endedness of the former that we see as crucial in addressing the constantly-changing media landscape through which health workers may confront medical need; and 2) the role of institutional, structural and social factors in constraining or enabling virtuous professional practice – suggesting perhaps a further need for health workers to take action directly against structural injustices that prevent them from fulfilling their professional responsibilities.

Axiological and deontic perspectives on professional responsibility

Salloch introduces the distinction between *axiological* and *deontic* perspectives on ethics, and we find this a useful heuristic to explore the motivations behind the account we offer. Aligned with (but distinct from) the classic distinction between the 'good' and the 'right', the axiological perspective focuses on states of affairs – whether embodied in the attributes of particular individuals or communities, or distributions of certain goods – and considers which of these are better or worse; while the deontic concentrates predominantly on the categorization of human actions into duties, responsibilities, prohibitions and the like (Heyd 2016).

While Salloch suggests that we focus on the axiological at the expense of the deontic, we are in fact drawn toward the instrumental VE we present in the original paper in large part *because* of the shortcomings of deontic attempts to address the challenges of our original case in sufficient detail; we note that professional guidance and legal frameworks for practice provided little assistance, and established techniques for extrapolating from explicit guidance such as specification, casuistry, and balancing also proved unsatisfactory (Wardrope & Reuber, forthcoming, p.xx). Several commentaries provided further demonstration of the difficulties for deontic approaches to a wide range of problems arising in informal situations in medical ethics. Arnold's focus on the responsibilities of health service volunteers working in different cultures brings to the fore the moral salience of close attendance to socio-cultural difference and respect for host community norms in working in these contexts (Arnold xxxx). Eggleson's response (Eggleson xxxx), meanwhile, issues a challenge that demonstrates the urgent need for a professional ethics capable of handling the rapid expansion of social media and the array of different ways in which it may expose health workers to illness narratives. While we do not claim even to have scratched the surface of what this range of new scenarios confronting health workers may demand of them – an important subject for future work in this area – we believe that the combination of the flexibility of an agent-oriented, axiological framework such as VE, and the focus on an external, democratically accountable collective objective such as that provided by consequentialist or social contract foundations for professional responsibility, will be important tools in developing a more substantive account. Furthermore, the stricter constraints of explicit rules for conduct typical of the deontic perspective will struggle to cope with two distinct needs: for sensitive engagement with subtle but morally relevant cross-cultural or cross-platform differences on the one hand; and the expanding range of environments in which health workers may find their services called upon, on the other.

Beyond these general difficulties the deontic perspective faces in engaging with the subtleties of professional responsibilities in informal medicine, we find that the particular balance between the axiological and deontic suggested by Salloch – using the classification of such responsibilities as 'supererogatory' – confronts an additional problem. On many externalist accounts, professional responsibilities are individual contributions to coordinated actions that jointly serve to discharge a *collective* responsibility (Wardrope & Reuber p.xx). The problem for supererogation in this framework is that, for individuals working to discharge these responsibilities as part of the collective, supererogatory acts are 'not bad not to do'. Much work on collective moral responsibility draws attention to the fact that individually-innocent acts can, on aggregation, cause serious harm; ignoring the moral significance of *sets* of acts is Derek Parfit's second 'mistake in moral mathematics' (Parfit 1986), which can have notoriously high costs in confronting structural injustices like anthropogenic climate change (Sinnott-Armstrong 2005; Jamieson 2007). Supererogation – by absolving individuals of direct responsibility to act, even where there is a collective responsibility to avoid the outcomes of inaction – commits this second moral mistake. It is for this reason that we highlight the importance of non-complacency in an instrumental VE fit for healthcare professionals (Wardrope & Reuber p.xx).It acknowledges that discharging our collective responsibilities sometimes does require of individuals that they go beyond the usual obligations of their role in order to serve better the health interests of the public to which the profession is responsible. This may be particularly the case for professionals whose clinical expertise or social roles (e.g. as representative of patient advocacy group or professional organization) are particularly relevant to a given case; a subject for future work on this topic will be to explore how virtuous responses to scenarios such as ours vary amongst health workers with such variables.

While we struggle with application of supererogation as a means of balancing deontic and axiological perspectives, other commentarists highlight an alternative means by which the deontic perspective can be invoked to provide further guidance to individual health workers' deliberations within our broader axiological framework; using established norms from relevantly similar – if importantly distinct – cases as 'intuition pumps' in guiding appraisal of the morally salient features of different situations and appropriate responses to them. While we agree with other critics that casuistry glosses over the details in which the devil resides that separate problem cases from 'easier' exemplars (DeMarco and Ford 2006, 490), using a range of such similar cases as different, complementary lenses through which to view a given problem and aid deliberation can instead bring a range of different details into clearer focus. Sankary and Ford's commentary provides an able demonstration of this process at work, highlighting how further reflection on the similarities between our case and the classic 'Good Samaritan' scenario draws attention to subtleties neglected on our initial analysis. These might aid deliberation for the health worker confronted by obstacles to their initial response (Sankary and Ford xxx).

Teaching and practicing virtue in institutional contexts

In a footnote to our original paper, we raised the question of how emphasizing virtue in professional education and practice might force a reappraisal of how ethics and professionalism are traditionally taught, with a renewed emphasis on the institutional, structural, and social factors that support or constrain virtuous practice. We are very pleased to note that several of the commentaries were able to develop this theme further. In particular, both Graf and Miller's and Sankary and Ford's responses draw attention to the ways in which intrusion of market norms into the field of healthcare may erode the capacity for health workers to practise virtuously.

The claim that the expansion of market methods (such as financial competition and cash incentives) can be damaging to societal spheres not previously subject to the norms of the free market is well-established, if still controversial. For instance, Michael Sandel famously argues that the introduction of market incentives and mechanisms into areas of human social existence not previously operating on a commercial basis can be corrosive to the norms that otherwise would govern those areas, often with detrimental effects (Sandel 2012). The responses of Graf and Miller and Sankary and Ford present a salutary warning about the dangers of commercialized healthcare for both professional virtue and healthcare journalism.

The case described by Graf and Miller of a particularly egregious violation of a family's privacy at a difficult time demonstrates how commercial interests can override even well-entrenched social norms around voyeurism and respect for the dead (Graf and Miller xxxx). They correctly observe that it is not only the journalists who are to be held responsible here – increasingly-commercialised healthcare providers acquiesce to the filming of such documentaries in part hoping that the resulting footage will help to advertise their services to fresh "consumers" of healthcare. Their pessimistic conclusion that well-informed and educational health communication is unlikely to succeed as long as narrow commercial considerations dictate what is broadcast challenges health workers to reflect on whether they must act to protect their patients from the potentially corrupting influence of market forces.

A more direct demonstration of market values 'crowding out' professional morals in healthcare is provided in concerns raised by Sankary and Ford. In the UK – the context in which the present authors both work – healthcare is overwhelmingly delivered on a publicly-funded, universally-accessible basis via

the National Health Service (NHS). Within this context, other health workers are still primarily viewed as collaborators rather than competitors (despite unpopular reforms introducing market elements) and there is little incentive for 'poaching' patients from other providers. Sankary and Ford, however, highlight the reality of such practices in the US healthcare marketplace, and thus the danger of market incentives perverting the motives of doctors drawn to intervene in cases such as the one we describe. The operation of the profit motive within US healthcare, then, can make the moral landscape far more difficult for the clinician to navigate. In considering how to enable virtuous practice amongst health workers, Sankary and Ford's example highlights the importance not only of training individual health workers, but also of attending to how healthcare institutions are constructed and the role they permit their workers to play within society.

While we have focused here on marketization as a social threat to individual professional virtue, there are other, non-financial, institutional factors that can enable or constrain individual virtuous practice. For example, in discussing our example with working clinicians, several have expressed concerns that an individualistic, blame-focused response to medical error would severely hamper the effectiveness of any potential response to addressing the errors displayed in our original case. As we originally argued, the front-line workers who are the proximate causes of clinical error (such as the doctors who misdiagnosed and mistreated the patient in our scenario) are rarely the sole or most important causes of that error, and an effective response demands that we address the systematic weaknesses that propagate through different organizational levels to result in these mistakes. But where institutions are inclined to scapegoat individuals rather than reflect on their own weaknesses, health workers may be correspondingly less likely to respond to witnessed error for fear that their colleagues would be unjustly punished – or indeed that they may face retribution as some high-profile 'whistleblowers' claim to have faced. In the wake of serious failures in the standard of care at Stafford Hospital in the United Kingdom, the official Francis inquiry (Francis 2013) and many professional and civil society responses emphasized the need for a 'just culture' in healthcare institutions to protect against such failings; but many health workers feel like such a culture has yet to be realized, and that this presents a serious barrier to their virtuous practice, in formal encounters or informal ones such as our scenario.

Conclusion

In our reply we have focused on two particular themes found throughout the commentaries that we feel may be most pertinent toward developing a more substantive theory of individual and collective professional responsibilities outside the formal professional-patient relationships of the clinical context. Clearly – as Eggleson argues – this is an important topic for health workers and healthcare ethicists to address now, before we are left still further behind by new technological developments.

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