ET502 Ethical Issues in Professional Life

Major Audit Report

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1.0 Executive Summary

This paper begins with an introduction of the case of Mitchell and Galle vs Winkler County Memorial hospital. Two nurses are caught, through illegal means, of whistleblowing the practices at the hospital. The definition of whistleblowing is given as are ethical aspects in relations to the case.

Traits within the hospital industry are discussed in this essay, and a comparison to the strategic planning process of Saint Luke's hospital is also made. The risks of which whistleblowers are exposed to are highlighted, and ethical issues are addressed. The fact pertained that the nurses' actions were perfectly legal, and their duty within their profession was in compliance with the ethical code. However, a technicality arose of misuse of the incumbent organization's system, and thus corporate governance failures are highlighted in brief.

The nature of whistleblower problems are covered, and the rectification means. The nature of whistleblowing within the medical industry is covered and ethical research information is presented for examination. The concept of virtue is covered and the concept of the False Claims Act is brought into question. Action alternatives are considered as are reporting protocols.

A concise ethical audit is compiled which highlights stakeholder analysis, the D.E.C.I.D.E. and P.O.L.I.C.Y. models. Areas of conflicts amongst stakeholders are highlighted as well as feasible solutions to incumbent problems within the case study analysed. An evaluation of each model is completed and discussion commentaries are included towards the end of the report.

The intention of this paper is to highlight the problems within America's whistleblowing community for health care organization's improvement. Solutions to inherent problems in the terms of action plans and policies to be implemented are covered through the latter stages of this essay.

2.0 Case Presentation

2.1 Introduction

In early April 2009, two registered nurses reported Dr Arafiles to the Texas Medical Board for improper surgical procedures and improper prescribing. Mrs Anne Mitchell and Ms Vickilyn Galle were employed at the Winkler County Memorial hospital when they filed the anonymous complaint which they believed was their duty as a patient advocate.

...

As a result of making this report, both nurses were subsequently charged with 'misuse of official information' a third degree felony that carries a sentence of 2-10 years imprisonment and up to a $10,000 fine if convicted.

...

Charges against Vickilyn Galle were later dropped without explanation. The nurses also had their positions terminated – after more than 20 years of service at the hospital.

...

Alarmingly, this was not the first complaint made about the doctor. Dr Arafiles had already been before the Texas Medical Board and in 2007 was fined and ordered to undergo a series of professional education programs by the Board. During the trial the hospital administrator Mr Stan Wiley further admitted that a number of complaints had been made against Dr Arafiles for improprieties in writing prescriptions and performing surgery despite the fact that he had no surgical privileges. It was the lack of any effective internal management of the complaints and their ongoing concern for the safety of their patients that led the nurses to report the doctor directly to the medical board.

...

While there were a number of laws to protect both nurses, (which they are now using to seek compensation for various claims of damage) there is no law to prevent prosecutors making a case on a particular issue.

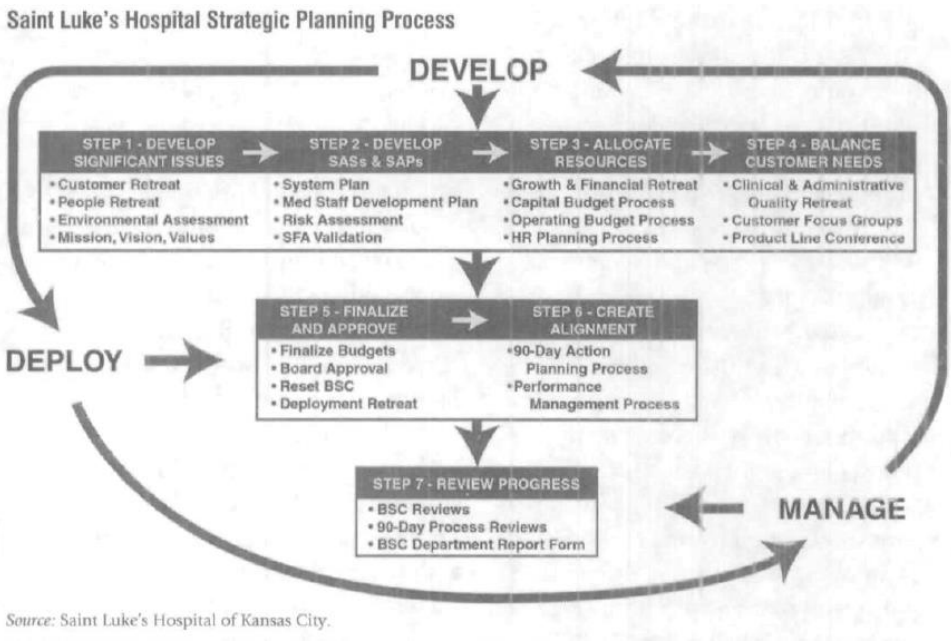
(Starr 2010, p.20)

Jackson (2005) defines whistleblowing as being a phenomenon in which a party or group take seemingly confidential matters within an organisation to bodies outside the organisation despite negative consequences that may be associated with the issue being put forward. In the case above, Mitchell and Galle were compromising the integrity of Dr Arefiles for the benefit of the patients and public – although it is argued that they did possess personal issues against the aforementioned doctor.

2.2 Brief Hospital Traits

Within the hospital industry it is well established that peer review saves hospitals the time, money, and aggravation of trial runs by sharing experiences with others in a semi-hierarchal manner (Hema, 2009). The Texas Medical Board acts as a peer reviewing authority to the Winkle County Memorial hospital in the sense that it is authorised to launch investigative procedures against all staff and issue educational training courses to mitigate any wrong comportment.

The strategic planning process of Saint Luke's hospital can be used to illustrate the decision making system and basic hierarchy within a medical institution. When adapted to a whistleblowing scenario we can observe that there are numerous steps of approval before the ethical message of the act is known throughout the medical board. The whistleblowers accusations may: represent significant issues, be related to the organisation protocols (plan), have an impact on hospital resources, directly affect customers' (patients) needs, undergo an approval and alignment process and in the end may be dismissed as a fraud by the supervising boards.



Cited in Griffith, FACHE and Pattullo 2009, p.67

The medical system, as exists, does not rely on confirming an ethical standard or a more moral environment but rather on penalties, and whistleblowing to uncover fraud

and abuse after it occurs (Cruise, 2002). Whistleblowers take extreme personal risk in exposing fraud and abuse and the system does not truly protect whistleblowers from harm (Cruise, 2002). There is, however, a potential for compensation at some later point in the future after the incident has been occurred.

2.3 Ethical Problems

The nurses' actions were completely legal, and their duty was in compliance with the ethical code of conduct of nurses, but yet the nurses faced criminal charges. This happened because Dr Arafiles filed a complaint to the Winkler County Sheriff (a friend of his) that he was being harassed (Starr, 2010). It may be deemed unethical, on the part off the Sheriff, for a counter criminal investigation to be launched, this primarily because in order to do so the nurses' rights were forgone by seizing their personal computers in order to find the letter of complaint on Mitchell's records and then ascertaining them as the culprits of the whistleblower allegations.

> "The prosecution's case was that Mitchell 'had a history of making inflammatory statements' about Dr Arafiles, and that her complaint was merely an attempt to damage his reputation. He argued that Mitchell used her position to obtain and disseminate confidential information, the patients' medical record number, which she included in the letter to the Texas Medical Board" (Starr 2010, p.20).

It was alleged that this amounted to the offence of a misuse of confidential information (Sack 2010).

2.3.1 Corporate Governance Failures

Corporate governance fails because too often plans and ethical procedures are devised and then left untouched on office shelves until a catalyst reactivates the needs to refer to them (O'Dell and Combes, 2009). The intention of ethical codes and plans is to have them constantly operating with constant reviews of what is outlined within them. At the forefront of implementation of ethics within a medical practice lies the managing director's responsibility. The role of upper management and doctors is essential for the evaluating process. A working knowledge is

essential by all incumbents and the board must be aware of the responsibilities of all within the organisation (O'Dell and Combes, 2009).

2.3.2 Related Problems

Whistleblowing is represented in the literature as an avenue of last resort (Jackson and Raftos 1997; Wilmot 2000), this cited in Jackson, 2005, p.54. Whistleblowing is a spectrum in which the worse case scenario is when all those affected experience negative consequences.

Whistleblowers often try to rectify wrong through internal channels but often are unsuccessful so they instead opt for external channels in order to be heard. "Whistleblowers raise dilemmas for nurses around issues such as patient advocacy and duty of care and can raise conflicts around organisational and professional allegiances" (Jackson 2005, p.54).

Most often all stakeholders (when nurse whistleblowing is concerned) fall in the range of; nursing affiliates, organisation linked groups, other nurses, community professions, and the whole hospital staff. McDonald and Ahern 2002 (as cited in Jackson, 2005).states that effects of whistleblowing include irritability, cynicism and isolation in the workplace

"If a worker is disturbed by malpractice he/she witness within work then there is a plausible chance that he/she will blow the whistle regardless or not if the organisation agrees with it" (de Mello, 2010).

Whistleblowing can be a difficult decision to make, especially when the accused are seniors in position. Every situation is different and requires a different response. As a society we often do not support individuals that speak out and expose situations that are considered unethical or inappropriate.

Nurses are the most honest and ethical professional group in the eyes of the public at large, and are thus faced with the challenge of continually improving their environment (Lliffe, 2002).

> "Where colleagues can talk about issues of concern with their peers and be supported; where people who raise issues of concern can be heard without fear of retribution; where unprofessional, unethical, or questionable behaviour can be dealt with in a positive manner; and, where frivolous or vexatious complaints are not supported" (Lliffe, 2002).

2.4 Ethical Research

Alerting affected bodies about poor practice or other issues of concern is wholly acceptable and desirable behaviour (Jackson, 2005). It does not necessarily involve a breach in confidentiality and using an internal or professional inspection mechanism to draw attention to internal conflicts does improve practices within for all health professionals. "On the contrary, far from being a typical and common event, whistleblowing is an extraordinary event" (Jackson 2005, p.52).

The hospital environment used to be bureaucratic as goals were achieved by rigid division of tasks, hierarchical supervision with regulations. "The tasks were so fragmented that no one was responsible or held accountable for any of the consequences of these tasks" (Ray 2006, p.440). The nurses and health care staff were instead like an amalgamation of ideologies which resulted in a culture where there were cover-ups, status quo, paternalistic control and inaction (Ray, 2006).

2.4.1 Virtues

"Virtue ethics are a way by which an individual can develop a moral and ethical framework through both application and practice" (Cruise 2002, p.14).

As a mechanism of attaining virtuous ends, whistleblowing can have severe hazards. The False Claims Act entitles for potential financial gain to any successful whistleblower, but ultimately the majority of whistleblowers regret their decisions (Cruise, 2002). Government's financial incentives for whistleblowing are limited, but the provisions in the False Claim Act permits private persons to bring forth cases to the aide of the American people (Cruise, 2002).

Aristotle (384-322 BCE) is the most associated with this ethical school of thought. Aristotle claimed that rather than asking a good person to apply a rational reasoning process to moral decisions it should be expected not only to apply intelligent reason but also exhibit a deep understanding of what is right and wrong.

2.4.2 Some Action Pointers

Mistreated employees, caused by whistleblowing actions, do posses legal avenues for redress, and often many of these laws are positioned by the very same organisations whose charges are laid against (Ettorre, 1994). There are signs that whistleblowers are generally afforded some protection from employer rebuttals (Ettorre, 1994).

In America it has been suggested, by some boards, that all organizations should seriously consider establishing whistleblower hotlines for benefits pertaining to fraud detection and affiliated (Slovin, 2006).

Suggestions for a hotline program include:

- Cultivate a vigorous whistleblower program
- Staff the hotline with trained interviewers
- Avoid the use of voice mail
- Nurture an ongoing dialogue
- Protect confidentiality (Slovin, 2006).

Additionally, what steps to take when reporting wrongdoing and what evidence is needed should be laid out for every employer to know – preferably in writing, with input from all levels (Ettorre 1994, p.22). If issues should occur mitigation procedures should be implemented timely and organisations should communicate to all workers why they took their actions in any particular way (Etorre, 1994).

3.0 ETHICAL AUDIT

(David & George, 2006)

3.1 STAKEHOLDER ANALYSIS

LIST OF STAKEHOLDERS	Briefly describe primary area of conflict
1. *MEDICAL STAFF* 2. *PATIENTS* 3. *HOSPITAL MANAGEMENT* 4. *PROFESSIONAL STAFF* 5. *BOARDS OF TRUSTEES* 6. *COMPANY DIRECTORS* 7. *SHAREHOLDERS* 8. *CREDITORS* 9. *POLICYHOLDERS* 10. *EMPLOYEES* 11. *FEDERAL GOVERNMENT* 12. *STATE GOVERNMENT* 13. *GOVERNMENT **A**GENCIES WITH DIRECT HEALTH **R**ESPONSIBILITIES (HHS DERIVATIVES, HEALTH INSURANCE*	1. Practising doctors felt protected by the system when the nurses were prosecuted. The temporary victory over whistleblowers meant, however, that doctors need exercise better caution and care with practices. 2. Patients benefited from whistleblower actions because more stringent procedures were enforced onto the system. 3. Management would undoubtedly undergo more stringent monitoring procedures. 4. Professional staff were imbued with the extra burden of culpability should anything go wrong. 5. Financial allocation of resources would need to first pass a risk assessment pending available records. 6. Company directors served in the interest of Winkler County Memorial Hospital rather than those of the patients and nursing staff. 7. Health insurance shareholders benefit from the assurance that whistleblower actions may improve the quality of service in hospital – thus affecting premiums. 8. Loaning institutions to health insurance companies are in a very minor way affected. 9. Policy holders (insurance purchasers) are only slightly affected – this indirectly.

COMPANIES) *14. THE TAX PAYER*	10. The whistleblowers' loss of their job indicated that future actions by other whistleblowers may also result in no individual benefit for such actions. Reprimand could possibly be the final cause of such actions. 11. The Texas federal government had to indirectly cover a large amount of court fees and hence place burden on the Texas Medical Board in investigative procedures (Starr, 2010). 12. The state government had to standardise rulings found in court from the 'Winkler County' case across Texas, with some jurisdiction rulings extending across America. 13. Agencies across the Medical board were affected by the rulings of court. In some cases protocol for the access and accumulation of information by internal management were modified. Statutory bodies, like the Texas Medical Board, needed to adopt better investigative and coping procedures. 14. The government had to provide for some of the costing during trials at the criminal court which were in turn a burden to the tax holders.
Definition 'The Problem'	The main problem in the Winkler County Memorial Hospital case was the way that the Winkler County Sheriff (a friend of accused Dr Arafiles) launched a criminal investigation against the two complainants and the board of directors supported such rebounding prosecution. The rebounding prosecution occurred through false grounds as there were in fact a number of laws to protect both nurses that were ignored.
Describe main areas of conflict between Stakeholders?	

The two registered nurses (whistleblowers in this case) claimed for improper surgical procedures and prescribing by Dr Arafiles. The information obtained from the nurses computers were obtained in an illegal manner but were still used in court given support from the medical institution. The main area of conflict on the stakeholder side of things is the issue of cost and time wasted in mitigating all protocol actions. The cost placed on the whistleblowers was that their actions were not seen in favour by the court in order to preserve their jobs. Patients inherently gained from the actions of whistleblowers but the medical staff, employees, and participating players did not.

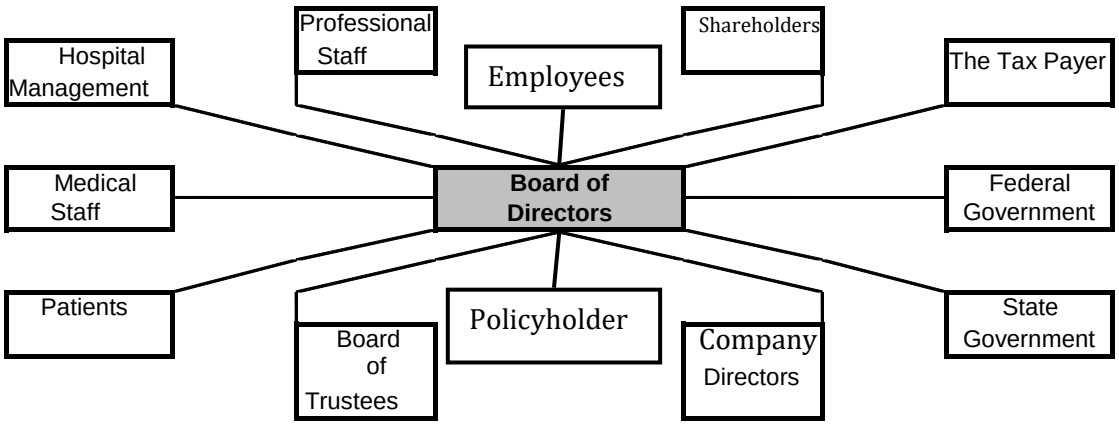
Are there areas of Common Agreement between Stakeholders?

There are areas of common agreement, these were ascertained by court to be:

- Ms Mitchel (one of the nurses) was acquitted of felony charges.
- Dr Arafiles was granted a minor leeway in the attacks against his reputation and profession. A series of professional education programs had been granted by the Board in 2007 which bore no relevance to an alleged incompetency.
- The company was mismanaged by not educating employees across the board of their rights as professionals within the medical industry.
- The Texas Medical Board should be accountable for investigative procedures.
- Compensation should be paid to the parties due as far as practicable – notably the nurses of whom are now disputing claims of damage (Starr, 2010).

3.2 DECIDE MODEL

Figure 2 – Identifying Stakeholders



D = DEFINE THE PROBLEM/S

What are the important facts of the case?
Key Facts:
1. Winkler County, Winkler County Memorial Hospital, Stan Wiley, Robert L. Roberts Jr, Scott M. Tidwell all unlawfully deprived plaintiffs Ann Mitchel and Vickilyn of their right to free speech. 2. Permanently enjoin defendants Wikler County, Winkler County Memorial Hospital, Stan Wiley, Robert L. Robert Jr, Scott M. Tidwell, Mike Fostel, their agents and those acting in concert with them; a) from maintaining an unconstitutional political patronage system; b) requiring defendants to obtain an unequal-opportunity employment policy (ie: non discriminatory hiring, promotions). 3. A monetary compensation, including back pay (minus illegal acts), should be made to plaintiffs Ann Mitchell and Vickilyn Galle. 4. Order defendants to reinstate plaintiffs in their formal positions with all incumbent benefits as before dismissal. 5. Order defendants compensate a sufficient amount for other damages to plaintiffs. 6. Issue an amount sufficient to punish defendants Rolando G. Arafiles,

Robert L. Roberts, Jr, Scott M. Tidwell, and Mike Fostel for violating plaintiffs constitutional rights. 7. Amounts of interest to plaintiffs ought to be also covered by defendants. 8. Attorney fees and costs ought to be covered by defendants. 9. Consideration for all other monetary judgement and additional relief should be made in favour of plaintiffs.
Ethical Issue:
The practices by the defendants are not in accord with good ethical and moral practice.

Who are the key stakeholders?	**Is their interest professional or personal?**
Company directors	Personal (status of org.) / professional (integrity of institute)
Creditors (minor)	Professional (financial gain)
Shareholders	Professional (financial interest) / Personal (ethical reasons for private investors)
Employees	Personal (freedom & security) / Professional (safety & assurance)
Policyholders (minor)	Personal (ethical reasons) / Professional (financial interest)
Federal government	Professional (responsibility to tax payers and for compliance)
State governments	Professional (responsibility to the law system)
Government agencies	Professional (compliance responsibility)
Medical staff	Personal (job security) / Professional (concerned with the integrity hospital)
Patients	Personal (concern for their welfare)
The tax payer	Personal (there is an interest in how hard earned money is spent by the government)
Hospital management	Professional (better procedures)

Professional staff	Personal/Professional (responsibility guidelines)
Board of trustees	Professional (complexity of system)
What particular problem demands decisions in this case?	
There is a concern by managing bodies that the outcomes from the stated trial may pose responsibility issues that need to be solved. Management handling will have to proceed smoothly so as not to impact stakeholders financially to a great degree. Arriving at ethical feasible solutions is a necessity in order to warrant integrity and stability for the system.	

E = ETHICAL REVIEW

There was a view that hospital organisations may in fact be at detriment if 'dob in our troubled doctors' views were encouraged (Starr, 2010). There is good debate for encouraging reporting of health professionals that pose a risk to patients, but there is also a need to warrant that incumbents who file those reports be protected by law from criminal, civil and disciplinary actions against them for enacting in such a manner (Starr, 2010). Whistleblowing is not about airing a grievance. It's about reporting real or perceived malpractice.

C = CONSIDER OPTIONS

1. Encourage individuals to report an incident if it is believed that an individual contravened the policies, principles, values, or the law.
2. Assist in ensuring that major malpractice or unethical behaviour is identified and handled suitably.
3. Offending whistleblowers should be given an option to resign and mitigations for their leave ought to be handled.
4. Accept malpractice, fire the culprits, and continue with operations of the hospital.
5. Outline how the hospital will handle all reported malpractices, and unethical behaviour, to all direct stakeholders.

I = INVESTIGATE OUTCOMES

OPTION – AUTONOMY (Respect for Persons), NONMALEFICENCE (Responsible Care), BENEFICENCE or JUSTICE

1. This would honour the principles of justice as it would be up to the whistleblower to enact on the decision to report any malpractice in sheer confidence that no persecution would ensue back. The main costs would come to the defendants who in turn may lose their jobs for conduct that could have alternatively be seen as ethical through a different perspective.

2. This proactive approach in 'weaselling' out malpractice within the system can be seen through the lenses of nonmaleficence. This approach may open Pandora's Box, and may be seen as detrimental to the functions of the hospital but also can be seen as great interest to the patients within the institution. Health financial institutions may see this approach as beneficial since it upholds the integrity of the clinic and hence its value.

3. This process takes the role of passive/aggressive autonomy – whistleblowers contribute to the operations of the hospital by remarking on malpractice but at the same time they are given compensation pay, choose they wish to resign, as their continual employment may cause distress within the organisation. This approach can be seen as accommodative, and

4. This principle does not fit with any of the principles (autonomy, nonmaleficence, beneficence) and in fact can be seen as the opposing of justice. It may save court mitigation fees or costs related to ascertaining the integrity of whistleblowers comments; however, it would potentially discourage any further improving of ethical standards from within.

5. This approach respects autonomy and nonmaleficence but may reject the notion of justice. The end result would be that all direct stakeholders would be clearly notified of the organisation's protocol and failure to comply could essentially just mean unlawful negligence.

D = DECIDE ON ACTION PLAN

Components of Your Plan	Means to be used	Outcome expected
Direct stakeholders must be informed of the company's stance on whistleblowing.	Meet with each group separately. The market should be informed through appropriate channels made available by the Texas Medical Board and Winkller County Memorial hospital.	A significant drop in extra work activities performed by doctors so as not be prone to unethical practices. A worker/employee outcry over what has taken place. It may de-motivate whistleblowers to some extent.
An action plan must be devised in conjunction with major stakeholders on how to deal with whistleblowers and mal-practicing staff. If stakeholders refuse to co-operate and agree on the matters then higher government state bodies must decide on a standard protocol for all organizations which must be implemented and agreed affirmatively.	Private consultation with major stakeholders. If refused, an application for legislature by a higher legal entity must be lodged to the Texas Medical Board.	Major/direct stakeholders will accept, but there may be great analytical costs in implementing such initiatives.
All offending staff must resign and be reported	In writing - to the board, through the legal system	Suspension or removal of mal-practising agents

to the law system and for the Texas Medical Board for investigation.	and to the remaining hospital executive management.	from the position and legal prosecution of the relevant individuals. If suitable then a series of professional education programs should be conducted by the Board to the individual.
All whistleblower actions should be scrutinized for legitimacy and legal coherency.	Examinations of computer files, data and informative means and investigation of fellow colleagues for verification of authenticity of claim.	A warrant that all claims are truthful, ethical, and relevant.
A code of ethics and a code of conduct must be developed. The code of conduct must address polices regarding whistleblowers, ethical conduct by employee, fellowship and teamwork within the organisation.	This must be done in consultation with an external party to the process, but with input from direct stakeholders.	A shift in culture based on strong ethical principles will slowly take place. Strong corporate governance practices will be established that will minimize malpractice and ill-conduct.
“Ethics education should become a part of employee training both for new employees and existing employees in order to raise awareness and mark a	“Ethics modules should be included in employee inductions and annual refresher courses should be required for all employees” (David & George 2006, p.12).	“A slow change in culture would take place. A strong message would also be sent from the new management that ethical behaviour is

change in priorities" (David & George 2006, p.12).		important" (David & George 2006, p.12).

E = EVALUATE RESULTS

The end results can be measured by examining final court rulings pertaining to the trial. By examining the nature of the plaintiffs (whistleblowers) we may gain a better indication of how final outcomes are achieved; who they are, "why were they motivated to risk the jobs they cared for, their privacy, and their mental outlook to tell the truth when no one else came forward to do so?" (Verschoor 2003, p.18). Recognition of issues of public safety should be thoroughly approved as it is argued that persons with expert knowledge have a 'right' to release information in their possession if it is in the public interest (Chalk 2010, p.47). The use of surveys of individual's opinions within the system may present a clear indication as to what is morally right and readily acceptable by the stakeholders.

3.3 POLICY MODEL

P **Problem Type that requires Standard Policy/Procedure**	***THE TYPE OF PROBLEM*** The inner tensions within Winkler County Memorial hospital were not a proactive aspect within the case and communication issues should have addressed well before the escalation of the case. "More attention has been given to verifying the accuracy of findings and sources of data than to exploring the issue of dissent or developing protections for the dissenter" (Chalk 2010, p.50). The whistleblower is viewed by the Medical Board, and colleagues within, as a trouble-maker or publicity-seeking dissatisfied employee (Chalk, 2010).
O **Outline Ethical Approach and**	***GENERAL POLICY STATEMENT*** 1. Medical staff, employees, and parties with influence should have an undeterred right to free speech as

Objectives to be recommended	mandated by democratic constitutional rights. It is recommended that before whistleblowing actions be taken that the directors within the afflicting institutions be first notified and the problems resolved internally before venturing into costly court procedures. The purpose of this is to encourage ethical behaviour by the Medical Board. 2. All direct stakeholders should be more involved in issues of accountability for ill actions evolving within the organisation. "Doctors are increasingly encouraged to participate in unit, hospital and general practice management, necessitating the learning of the theories and skills underpinning management" (Boggis and Davidson 2002, p.1092). 3. The ethical awareness of doctors, nurses, and employees within ought to be developed. Grace and Cohen's 2005 study (cited in David and George 2006, p.13) argues that each individual has a rational ability o choose what is right according to the moral law, and that it is by raising the awareness of ethical issues in people that skill in this field is expanded on.
L **List Standard Procedures and their Ethical Rationale**	***STANDARD POLICY GUIDELINES*** 1. The hospital board should meet with representatives of the Texas Medical Board in order to discuss legal alternatives pertaining to the treatment of their staff in questions arising in whistleblower occurrences. The aim is to avoid unnecessary legal costs that inevitably would be a detriment to the tax payer and medical board. 2. Representatives of the direct stakeholders should participate in strategic sub-committees – in the case of nursing staff this may be a union representative acting on employee's behalf. 3. The teaching of ethics must become a crucial element

	within the Health care system. Anthony Tuckett states that both the teleological theory in its utilitarian form and deontology are concerned with how a nurse ought to act (cited in Rowan and Zinaich Jr 2003, p.278). In this work it is also claimed that there is goodness within the nurse, thus by morally educating all incumbents in ethics organisation stand to gain from rational decisions being made. 4. In order to warrant ethical education across all direct stakeholders the placement of the standard hospital code of ethic should be published in whatever media feasibly available – this may include web sites, booklets, word of mouth and annual reports.
I **Identify Methods to Resolve Conflict over Policy's Implementation**	***METHODS OF CONFLICT RESOLUTION****:* 1. The legal court system remains the final decision maker when it comes to dealings of misconduct within the workplace. This does not relate to efficiency, and a more direct approach would be for the Medical Board to directly handle whistleblower problems by approaching the plaintiffs before any legal matters were undertaken and thus resolve conflict behind curtains through ethical and rational settlement. 2. In establishing a norm course of practices it is essential that superiors (doctors included) be aware of their limitations for the role they possess. Educating upper staff about proper codes of practices before mishaps occur would undoubtedly avoid much furore that may otherwise occur. An environment should be established where all staff can voice their opinions and concerns without fear of repercussions. 3. It would be argued that the appropriate committee ought to have the final say when it comes to conflict within. But as this was the initial situation in our case example

	we may see that this does not always work (ie: two nurses were fired given the medical director's decisions). It may be wise to employ a third qualified party for settlement of disputes when no ethical solution can be derived from within.
C **Check out the Effectiveness of Policy to achieve its Objectives**	***MONITORING MEASURES****:* All direct stakeholders ought to be given the option to participate in reviews of the ethics committee. Across the board employee ratings would form part of an effective audit of procedures to normalise conduct against whistleblowers. Ethical behaviour should be illustrated in annual reports and performance reviews within the hospital (David and George, 2006).
Y **Yes to Policy!** **Strategy to ensure 'ownership' by Stakeholders**	***ENDORSEMENT PROCEDURES*** The code of ethics, and hence the rulings and rights of whistleblowers, should be published in pamphlets within the hospital and the company website. Winkler County Memorial hospital does not currently possess a web site, although it would be within stakeholder's interest to establish one. Ethical training courses within the organisation would be seen as an advantage – although this has already been implemented to some extent to mal-practicing doctors such as Dr Arafiles, this by authority of the Texas Medical Board. An open learning communal culture must be established within in order to warrant future cohesion within the hospital system.

3.4 Summary and Conclusion Audit

Whistleblowing represents a dilemma for nurses, that is, it strikes at the epicentre of professional values and does pose questions in regards to the roles nurses have to communities, clients, the profession as well as themselves (Jackson, 2005). Furthermore, there ought to be processes for warranting that rights and unacceptable practices do not create public panic without unendurable conditions for nurses and personnel that may be impacted by their services (Jackson, 2005). On a major point the whistleblower needs to be ethical when approaching the media and must consider all repercussions before doing so.

Throughout this essay a number of stakeholder's were highlighted as being affected by the whistleblower actions, however only a select few were highlighted as being direct stakeholders to the incident in question. Stakeholder, decide model, policy model analyses were conducted which shed important facts about the case and resolutions to potential ethical issues.

It was generally concluded that all direct stakeholders ought to participate in determination aspects of the best code of conduct in face of ethical malpractice. The impact caused to tax payers and other minor groups are not noticeably seen at large, however, those individuals working closely within Winkle County Memorial hospital may be in a position to positively express their feelings about the issue (ie: community groups).

Ethical awareness is an aspect of key focus within the medical professional industry, and adherence to a uniform set of rules may take place given final court rulings.

The D.E.C.I.D.E. model proves to be effective in analysis because it is a decision-making model for more effective decision making, especially by health care managers. The P.O.L.I.C.Y. model is efficient in the establishment of new ethical procedures but it, by itself, will not lay out a direct action plan such as established by D.E.C.I.D.E..

4.0 POLICY RECOMMENDATIONS

Australia's current laws are designed to protect exposing imperfections in the health system. It is vital, henceforth, that policies be approached accordingly so as to act in the interest of good faith in order to be protected from any further retaliation (Starr, 2010).

Whistleblowing policies should apply when any actual or suspected incidents should occur:

- "corrupt activities
- theft, fraud or misappropriation
- significant mismanagement or waste of funds or resources
- serious harm to public health, safety or environment
- conduct or practices which are illegal or breach any law" (Ausenco, 2010).

The matter must be serious enough that it would, if proven, constitute:

- "a criminal offence
- reasonable grounds for dismissing, or otherwise terminating, the services of an employee or representative
- reasonable grounds for significant disciplinary action" (Ausenco, 2010).

The P.O.L.I.C.Y. model serves in a way to ultimately propose endorsement procedures for implementation. It may be the best way to devise codes of ethical conduct within the medical industry. If worked in conjunction with the Texas Medical board, Winkler County Memorial hospital may indeed implement effective policy guidelines.

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GLOSSARY OF TERMS

(ERC, 2009)

Code of Conduct

Can refer to a listing of required behaviors, the violation of which would result in disciplinary action. In practice, used interchangeably with Code of Ethics.

Code of Ethics

Often conveys organizational values, a commitment to standards, and communicates a set of ideals. In practice, used interchangeably with Code of Conduct.

In Section 406(c), the Sarbanes-Oxley Act defines "code of ethics" as such standards as are reasonably necessary to promote-- (1) honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships; (2) full, fair, accurate, timely, and understandable disclosure in the periodic reports required to be filed by the issuer; and(3) compliance with applicable governmental rules and regulations.

Conflict of Interest

A person has a conflict of interest when the person is in a position of trust which requires her to exercise judgment on behalf of others (people, institutions, etc.) and also has interests or obligations of the sort that might interfere with the exercise of her judgment, and which the person is morally required to either avoid or openly acknowledge.

Deontology

The science related to duty or moral obligation. In moral philosophy, deontology is the view that morality either forbids or permits actions. For example, a deontological moral theory might hold that lying is wrong, even if it produces good consequences. Deontological theories, from the Greek word deon, or duty, emphasize foundational duties or obligations. This is a kind of purest view of ethics, somewhat independent of the realities of life.

Ethical Dilemmas

Situations that require ethical judgment calls. Often, there is more than one right answer and no win-win solution in which we get everything we want.

Ethics

1. The decisions, choices, and actions (behaviors) we make that reflect and enact our values.
2. The study of what we understand to be good and right behavior and how people make those judgments. (From "What is the Difference Between Ethics, Morals and Values?", Frank Navran)
3. A set of standards of conduct that guide decisions and actions based on duties derived from core values. (From "The Ethics of Non-profit Management," Stephen D. Potts)
4. There are many definitions as to what ethics encompasses:
   * The discipline dealing with what is good and bad and with moral duty and obligation;
   * Decisions, choices, and actions we make that reflect and enact our values;
   * A set of moral principles or values;
   * A theory or system of moral values; and/or
   * A guiding philosophy.
   (From "Creating a Workable Company Code of Conduct," 2003, Ethics Resource Center)

Ethical Decision-making

Altruistic considerations What impact will this action or decision have on others or my relationship with them?

Ethical Decision-making

Idealistic considerations What is the right thing to do - as defined by the values and principles, which apply to this situation?

Ethical Decision-making

Individualistic considerations What will happen to me as a consequence of this action or decision?

Ethical Decision-making

Pragmatic considerations What are the business consequences of this action or decision?

Values

The core beliefs we hold regarding what is right and fair in terms of our actions and our interactions with others. Another way to characterize values is that they are what an individual believes to be of worth and importance to their life (valuable). (From "What is the Difference Between Ethics, Morals and Values?", Frank Navran)

Values-centered Code of Ethics Offers

A set of ethical ideals, such as integrity, trust-worthiness and responsibility, which companies want employees to adopt in their work practices.

Whistle-blower

1. A person who takes a concern (such as a concern about safety, financial fraud, or mistreatment) outside of the organization in which the abuse or suspected abuse is occurring and with which the whistle-blower is affiliated.
2. Whistleblowing is made up of four components: "(1) An individual act with the intention of making information public; (2) the information is conveyed to parties outside the organization who make it public and a part of the public record; (3) the information has to do with possible or actual nontrivial wrongdoing in an organization; (4) the person exposing the agency is not a journalist or ordinary citizen, but a member or former member of the organization." (From "Whistleblowing: When It Works -- and Why," 2003, Roberta Ann Johnson)

APPENDIX A – PARTIES IN COURT

Stakeholders directly impacted in court proceedings for plaintiff's original complaint:

- Winklery County
- Winkler County Memorial Hospital
- Stan Wiley (individual in official capacity as administrator of Winkler County Memorial Hospital)
- Robert L. Roberts, Jr (Sheriff of Winkler County)
- Dr. Rolando Arafiles, Jr. (accused doctor for malpractice)
- Scott M. Tidwell (individual in capacity as County Attorney of Winkler County)
- Mike Fostel (individual in official capacity of district Attorney of Winker County)
- Anne Mitchell and Vickilyn Galle (plaintiffs)

(Mitchell and Galle vs Winkler et al, 2010)