DEREGULATING HEALTH CARE ETHICS EDUCATION: A CURRICULUM PROPOSAL

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Abstract

Ethics education is an important component of health care management education. However, this article argues that the focus in many health care management ethics courses is misplaced, as the stress is on the need for dealing with increasing control of organization actions, corporate compliance, and issues related to laws and regulations such as the False Claims Act, qui tam, and whistle blowing. This article suggests that we need a "deregulated" approach to address the problem of fraud, waste and abuse in the practice of health care management, and should also incorporate this approach into health care management ethics education. A deregulated ethics curriculum for health care management ethics education, using a modified Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) accreditation process informed by virtue ethics as a case example, is proposed and discussed.

Introduction

Ethics education is an important component in the curricula of many university degree programs, particularly those programs specializing in health care management. In fact, a review of nationally accredited health care management programs reveals that at least seventy percent address the substantive areas of ethics, laws, or regulation (AUPHA, 2002). The need is critical for discussion and examination of ethical issues in the health care systems in many countries. For example, the U.S. Medicare program alone lost $ 20 billion dollars in 1997 just due to fraud upon the system (HCFA, 2000). However this article will argue that, in both the practice and study of health care management, the particular methods used to promote ethical behavior have been inadequate. These methods overly stress the need for dealing with increasing control of organization actions, corporate compliance, issues related to laws and regulations such as the False Claims Act and *qui tam*, and whistle blowing. After a brief discussion of a potential dilemma facing any ethics course instructor, the article will discuss the context and significance of fraud, waste and abuse in the U.S. health care system, highlighting the dysfunction caused by the current practices promoting ethical conduct. Next, the article will present and discuss the concept of a "deregulated" approach to promoting ethical

behavior in both the study and practice of health care management. Lastly, a vehicle for developing this alternative ethical perspective in both study and practice of health care management, through a modified Joint Commission on the Accreditation of Healthcare Organizations JCAHO accreditation process, is offered.

Teaching Ethics or Moral Indoctrination: A Potential Dilemma

There is always a danger when addressing a specific approach to ethical behavior in the context of course or curriculum development for professional programs such as health care management that accusations of moral indoctrination will be leveled. Denhardt (1991) succinctly described the dilemmas faced by instructors when designing ethics courses and the following section paraphrases her argument. An acute problem exists for such instructors in terms of moral indoctrination. Good professional education necessarily involves a socialization process whereby new members are introduced to the values and ethical commitments of the profession. It is generally the role of the instructor to select the topics, design the process for deliberating over these matters, and evaluate the performance of a student. In any profession experiencing ambivalence about its moral commitments, however, even the choice of topics can be problematical. The greater problems arise, though, in determining what (if anything) to present as definitive ethical commitments of the profession and how to evaluate whether students have "learned" the material. This is the arena in which questions of moral indoctrination can arise (p. 95).

One method by which to reduce the potential threat of accusations of indoctrination is to introduce any new or alternative approach to ethical study as one of several methods of analysis available to the student and manager. This would allow each individual to choose among several options or approaches. However, by offering a platter of approaches to ethical analysis or decision making for students to consider and choose for themselves, we are fairly close to the current approach that many ethics course designers utilize in university courses. The author of this article suggests that an argument could be made that the current "regulated" approach used to promote ethical behavior in health care management practice is itself a moral "indoctrination" developed and enforced by the federal government. Prescribing, regulating, sanctioning, excluding, and even imprisoning are all tactics used by the federal government to promote ethical behavior in the Medicare and Medicaid programs. Individuals and organizations participating in these health care reimbursement programs must submit to such indoctrination, or risk severe penalties. Therefore, a charge of indoctrination is really not a new one when discussing the realities of current health care management practice. In the end, however, it remains with the individual ethics instructor to decide the content and specifics of their courses, and the extent to which they can live with this potential (as opposed to actual) dilemma. As will be developed further in later sections of this article, the author argues that in the logic underlying a "deregulated"

approach to ethics education, the individual student (or manager) is empowered in a way not possible under the current enforcement approach to ethics promoted by the federal government.

The Background and Context of Fraud, Waste and Abuse in Health Care

Since the mid-1990s, the federal government increasingly relied on whistle blowing as a method to control fraud, waste and abuse in the Medicare and Medicaid programs. Although not the result of a single, specific policy decision, several factors combined to create the situation. First, in 1986, an amendment to the Federal False Claims Act made the filing of whistleblower suits much easier. Second, in 1995 in an effort to combat fraud, waste and abuse in both Medicare and Medicaid, the U.S. Department of Health and Human Services (HHS) in cooperation with the U.S. Department of Justice (DOJ) implemented a new anti-fraud, waste and abuse program called "Operation Restore Trust" or (ORT).

Elected officials and managers, who worked in the program offices of both Medicare and Medicaid programs, and even the general public, were concerned about fraud, waste and abuse for years. Medicare alone lost $20 billion in 1997 to fraud, waste and abuse. This translates to a loss of 11 cents of every Medicare dollar spent in the United States (HCFA, 2000). Although we will not know the exact dollar amount of Medicare and Medicaid funds lost to fraud, waste and abuse, a reduction of any sort in those losses will not only result in a financial savings for the taxpayers, but will provide a much needed increase in public confidence in the future integrity of the programs.

As a method to achieve these ends, whistle blowing is not without its hazards. For example, very often during the process of disclosure the individual whistleblower is placed at extreme personal and professional risk. Although the False Claims Act allows for potential financial gain for the successful whistleblower, many whistleblowers ultimately regret their decisions. Moreover, it can be demonstrated that many of the organizations targeted by whistleblowers suffer both during and long after the original allegation.

This article argues that whistle blowing is dysfunctional for both whistleblowers and their organizations. Health care organizations, whose primary mission is to care for the sick and injured in an increasingly competitive marketplace, can ill afford such a dysfunctional situation. Yet, fraud, waste and abuse in health care persist and health care managers, policy makers and educators should not ignore it. Many suggest that our health care organizations need alternative methods that do not cause disruption and dysfunction to address the problem of fraud, waste and abuse in health care. According to Fletcher, Sorrell and Silva (1998), private health care accrediting organizations (such as the Joint

Commission on the Accreditation of Healthcare Organizations, or JCAHO) can provide a viable alternative to whistle blowing, but only if the JCAHO goes beyond mere compliance with standard practices. This article argues the JCAHO accreditation process can provide an alternative to whistle blowing, but only if the JCAHO includes a strong ethical grounding in its approach to health care accreditation. As such an alternative, the JCAHO process can serve as a case example in health care ethics education. The article examines the potential for virtue ethics, as first described by Aristotle, and later developed by Lynch and Lynch (1997) as an ethical mind-set for managers in health care organizations, to provide just such an ethical grounding for the JCAHO standards. It is with such modified standards that an appropriate case example can be used in health care management ethics courses.

Health Care Fraud, the False Claims Act, and Operation Restore Trust

The term "health care fraud" is often mentioned in the same breath as the 1986 False Claims Act (31 U.S.C. Sections 3729-33). The federal government uses the False Claims Act remedy increasingly to uncover instances of fraud and abuse such as billing for ghost patients, up coding, unbundling, and billing for inadequate or unnecessary care. Since 1988, the government has recovered nearly $2 billion from health-care providers and others who cheated government health programs. In the war on health care fraud, law-enforcement agencies consider that Act to be their most powerful civil weapon (Slade, 2000).

The federal government's war on health-care fraud officially began in 1993 when then Attorney General Janet Reno announced that pursuing it would be a top priority for the Department of Justice. Through increasingly aggressive use of the False Claims Act, the government obtained huge settlements and paid sizable compensation to private individuals who brought fraud to the attention of the government. The government used the False Claims Act to investigate a wide range of health care providers, from managed care organizations, clinical laboratories, pharmaceutical companies, and chains of hospitals and nursing homes, to physician practices, home health agencies and durable medical equipment suppliers. The government also pursued the entities that assist plans and providers with health care transactions, such as billing companies, attorneys, and Medicare carriers and fiscal intermediaries.

The first very large settlement was a $111 million False Claims Act settlement with National Health Laboratories in 1992. Other large settlements were with SmithKline Beecham Clinical Laboratories for improper "bundling" of lab services ($325 million), Blue Cross and Blue Shield of Illinois for improper processing of Medicare claims ($140 million), National Medical Care for billing for

unnecessary tests ($375 million), and Beverly Enterprises, the nation's largest operator of nursing homes, for inflating the costs of treating Medicare patients ($170 million). According to many researchers and health care specialists, the government's use of the False Claims Act appears to be effective in deterring health-related frauds. For example, when the New York Times reported in 1999 that Medicare spending dropped for the first time in the history of the program, the paper noted that federal efforts to "rein in fraud" was at least partially responsible for the decline (quoted in Slade, 2000).

Commentators attribute a major factor in the government's success to the financial incentives for "whistle blowing" established by provisions in the False Claims Act that permit private persons to bring cases on behalf of the United States and to share in the government's recovery. The congress enacted the False Claims Act, also called the "Lincoln Law," the "Informer's Act," or the *qui tam* statute, during the Civil War. Qui tam is shorthand for the Latin phrase "*qui tam pro domino rege quam pro seipse*," meaning "he who as much for the king as for himself." The congress originally targeted the law at stopping dishonest suppliers to the union military at a time when the war effort made it all but impossible for the government to investigate and prosecute the fraud itself.

The modern use of the *qui tam* statute allows a private individual with knowledge of past or present fraud (a "whistleblower") on the federal government to sue for the government to recover compensatory damages, stiff civil penalties, and triple damages. The person bringing the suit is known officially as the "relator." If the suit is successful, it not only stops the dishonest conduct, but also deters similar conduct by others. In addition, it may result in the relator's receipt of a substantial share of the government's ultimate recovery–as much as 30 percent of the total (HCFA, 2000).

Since 1986, relators have filed more than 2,400 *qui tam* suits, when the statute was strengthened to make it easier and more rewarding for private citizens to sue. The federal government recovered over $2 billion as a result of the suits, of which almost $340 million was paid to relators or whistleblowers. Some examples of the potential recovery available to whistleblowers under *qui tam* include a 1998 settlement $903,899 to two individuals for reporting that Charter Behavioral Health Systems - Orlando billed Medicare for medically unnecessary psychiatric care for elderly patients with severe dementia, Alzheimer's Disease and other organic brain disorders and a $ 9.8 million award to a former employee of Olsten Health Care Corporation as settlement of his allegations that Olsten charged Medicare for unallowable sales and marketing costs (Slade, 2000).

Perhaps the best-known *qui tam* case during the 1990s was first filed in 1993 against Columbia/HCA, Healthtrust and Quorum Health Resources (all were related companies). The allegations first brought forward by a lone whistleblower, center on the illegal practice of maintaining dual cost reports for the Medicare program. This case, currently in settlement discussion with the Department of

Justice (DOJ) and the affected parties, may result in the largest *qui tam* settlement in history in the health care industry. The government may recover as much as $ 1 billion from the corporations, which could result in a payment to the original whistleblower of as much as $ 250 to $ 350 million (Taylor, 1999).

As mentioned earlier Operation Restore Trust (ORT) was initially an effort to combat health care fraud, waste, and abuse in the five states (California, Florida, New York, Texas and Illinois) with the highest Medicare expenditures. Together, these states accounted for 40 percent of the nation's Medicare and Medicaid beneficiaries. The HHS and DOJ teams focused on home health care, nursing home care, and durable medical equipment, three of the fastest growing areas in Medicare.

Three agencies within HHS -- the Office of Inspector General, the Health Care Financing Administration (HCFA), and the Administration on Aging -- were involved, as was the Department of Justice. Activities that are a part of ORT include financial audits; criminal investigations and referrals to appropriate law enforcement officials; civil and administrative sanction and recovery actions by appropriate law enforcement officials; surveys and inspections of long term care facilities by HCFA and state officials; studies and recommendations by HCFA for program adjustments to prevent fraud and reduce waste and abuse; issuance of Special Fraud Alerts to notify the public and the health care community about schemes in the provision of home health services, nursing care and medical equipment and supplies; a voluntary disclosure program; and a Fraud and Waste Report Hotline (HCFA, 2000).

ORT enforcement activities are now underway nationwide. During the past few years, the federal government focused attention on auditing physicians at teaching hospitals, resulting in large financial settlements. For example, in December 1995, the government announced a $30 million settlement with the clinical practices of the University of Pennsylvania, based on alleged errors in billing submitted to Medicare that failed to document adequately physician time spent in patient care. Other academic institutions followed with settlements and large fines, including the University of Pittsburgh, which settled for $17 million and Thomas Jefferson University Hospital, which settled for $12 million (Campen and DiLoreto, 2000). Information provided to the ORT teams by whistleblowers also initiated many of these recovery suits.

In terms of strict financial recovery, ORT and *qui tam* was successful for the cases described. However, when discussing the need to combat health care fraud, commentators too often overlook the effects on whistleblowers and the resulting organization. This article examines those effects in the next section.

Effects on Whistleblowers and Organizations

The movie "The Insider" related the tale of Dr. Jeffery Wiegand and his ethical and personal challenges as a whistleblower in the tobacco industry. As noted earlier, individuals who have accused their colleagues of fraud and abuse have also challenged the health care industry. Although the nature of each whistle blowing case varies, we have a composite portrait of health care whistleblowers themselves with their common traits. According to Mark Raspanti, an attorney in the United States specializing in whistle blowing cases, whistleblowers "tend to be people who see the world in black and white and are uncomfortable with shades of gray; they are people who do not believe in fudging." (quoted in Taylor, 1999, p. 30). Moreover, according to Raspanti, "true whistleblowers are well-informed people who are knowledgeable about their jobs and want to be team players. They are often labeled as loners, because they are private people, but they seem to be drawn to large, stable organizations." (Taylor, 1999:30).

Although no one has yet conducted a serious study of health care whistleblowers, some note a similarity to U.S. Defense Department whistleblowers of the 1980s, who were profiled in several studies (e.g., Glazer, 1989; Fitzgerald, 1989). One common trait emerging from these earlier studies, and perhaps applicable in the health care setting, is that whistleblowers seem to collide with their own personal value systems when they observe problems and their managers or colleagues who ignore those observations. Whistleblowers, according to Attorney Raspanti, are incapable of sweeping perceived wrongdoing under the rug (Taylor, 1999). Other individuals working with health care whistleblowers report similar traits. For example, Washington, D.C. Attorney Lisa Hovelson, states that most whistleblowers she met wanted the fraud they observed to stop. These whistleblowers already tried various means to try to get the activity to cease, including trying to get action from upper organization management or even the government. However, many of these whistleblowers see their attempts as fruitless, forcing an escalation to *qui tam* actions (Taylor, 1999).

According to HHS, whistleblowers have diverse careers, identities and backgrounds. Some are career employees with many years' service to their employers. Some are motivated by religious experiences, others by family pressure. However, a desire to do the right thing motivates the majority (Taylor, 1999). This last point is significant. As noted earlier in this article, successful *qui tam* suits can ultimately reward the whistleblower with a percentage of the recovered monies, as much as 30 percent of the recovery. Some noted that this potential financial windfall could ultimately motivate disgruntled workers to cry fraud and abuse where none exists. However, from a review of what hard data exist regarding this point, greed does not appear to be a dominant motivation for health care whistle blowing. For example, their organizations forced them as whistleblowers to quit their jobs or were fired outright after bringing the action. In other cases the organizations required them to move themselves and their families to distant locations in order to seek other employment or avoid retribution from coworkers. Many whistleblowers had to downsize financially. *Qui tam* suits are

often long and tortuous, with potential financial payoffs years in the future. Marriages and careers are irreparably damaged. When researchers question whistleblowers, they regard their decision to go public as a mistake they made (Taylor, 1999).

Regardless of their ultimate motivation, whistleblowers and *qui tam* have had a dramatic and not particularly positive effect on health care organizations. Their actions forced organizations to develop a new cadre of operating guidelines and procedures collectively called "compliance programs." Only a few years ago, compliance programs did not exist. Now they are ubiquitous, and health care organizations are paying $600-700 million per year to a consultant industry to advise them on the intricacies of this new area. Although still labeled as "voluntary" by the federal government, virtually all hospitals and health care organizations accepting federal funds adopted compliance programs to some degree. The strict enforcement of laws governing Medicare fraud and abuse prompted the health care industry to even adopt Federal Sentencing Guidelines as the "essential elements" of their compliance programs. Federal judges adopted the seven point sentencing guidelines originally in 1991 to determine the sentencing of criminals. According to advice provided to members of a large health care trade association, including the federal sentencing guidelines into health care corporate compliance programs can serve as a mitigating factor at time of sentencing and can reduce fines imposed (Dunevitz, 1999: 11). This information follows closely the language of the federal advisory issued at the time of the guidelines development.

The tenor and specifics contained in the language of the Federal Sentencing Guidelines now present in health care compliance programs nationwide, in and of themselves, are not the concern of this article. Also not a focus of this article is the important need for the federal government to recover, through *qui tam* and other mechanisms, monies defrauded from it. What are the foci and concern of this article are the inappropriate and ultimately dysfunctional applications of these two tactics, aided by the whistleblower, to reduce fraud and abuse in health care organizations. It is this approach that also forms the basis for health care management ethics curricula. The system, as it exists today, relies not on establishing a higher ethical standard or a more moral climate, but rather on sanctions, penalties and ultimately whistles blowing to uncover fraud and abuse after it has occurred.

The current approach requires that individual whistleblowers take extreme personal and professional risks to expose the fraud and abuse. The system then does not truly protect the whistleblower from the harm that invariably occurs. It only holds out the potential of a payoff to the individual whistleblower at some point in the future. In the next section, this article explores a potential alternative to this system by suggesting the use of the JCAHO accrediting process as the mechanism through which we can apply this alternative approach. However, the JCAHO standards, as they are currently constituted, do not meet the minimums necessary to

raise the moral and ethical climate within health care organizations. To overcome this weakness, this article suggests virtue ethics as an alternative approach to inform the JCAHO standards so that they can refocus and upgrade their organizational ethics standards to achieve a higher moral and ethical climate. These updated JCAHO standards, very familiar to the vast majority of those who work in the health care sector, can also serve as a case example to integrate into health care management ethics courses.

The JCAHO Standards and Whistleblowers

As a private, not-for-profit organization, the JCAHO accredits virtually all hospitals in the United States, separate and distinct from individual state licensure efforts and federal Medicare and Medicaid guidelines and inspections. As such, it can address the issue of ethical behavior in a major sector of the health care industry. Since 1991, the JCAHO required all health care organizations it accredits to have in place procedures and resources to deal with ethical issues arising out of patient care. These patient rights standards were followed in 1995 by the requirement that health care organizations address issues relating to organizational ethics. By organizations ethics, the JCAHO standards indicate that health care organizations conduct business relationships with patients and the public in an ethical manner. Specifically, the JCAHO states… "a hospital's behavior towards its patients and its business practices has a significant impact on the patient's experience of and response to care." (JCAHO, 1997).

As Fletcher, Sorrell and Silva (1998) noted (and the following section borrows heavily from their seminal article on the subject of whistle blowing in health care organizations), the health care community has generally commended JCAHO standards regarding patient's rights in a number of venues. Although the standards are sweeping in their scope, they do not speak directly to the role and responsibilities of professional staff members in carrying out the provisions of the standards. According to the specific language of the standards, "the hospital establishes and maintains structures to support patient's rights, and does so in a collaborative manner that involves the hospital's leaders and others." (JCAHO Standards, RI-6 as quoted in Fletcher, Sorrell and Silva, 1998). Without more detailed guidance, health care organization staff members remain unclear as to just how far they should intervene in the defense of a patient's rights. In other words, in an effort to provide health care organizations the freedom to which policies and structures are most appropriate for their own local use, the JCAHO missed an opportunity to require due process and other protection for staff members who intervene on behalf of patients under their care.

Even with the addition, in 1995, of organizational ethics standards, the JCAHO did not go far enough in ensuring an ethically responsive health care organization as the standards are too narrowly construed in terms of business practices and external relationships. According to Fletcher, Sorrell and Silva

(1998), the protection of health care organization staff members requires attention to both the general ethical climate of an organization and to its internal relationships.

As presently formulated, the JCAHO standards work reasonably well for a health care organization that is already committed to ethical behavior towards patients and staff; however the standards fail to ensure commitment to an ethical climate from health care organizations that are only seeking to fulfill the letter of the law. For example, the standards do nothing to influence the ethical climate of health care organizations (Victor and Cullen, 1997). The ethical climate of an organization is the prevailing perception of the organization as reflected in the organization's practices and procedures. Therefore, some organizations have an ethical climate that is supportive of conflict resolution, while others may encourage aggressive behavior; some are benevolent in character, while others are egotistic. If whistle blowing results from a failure of organizational ethics, then health care organizations should establish their ethical climates by identifying common values and beliefs so that staff members are able to recognize those values and beliefs and hold the organization accountable for them. Moreover, a health care organization with an articulated ethical climate and published procedures for resolving disputes might minimize the need for whistle blowing all together (Bok, 1980).

However, the present realities in health care organizations are the following: a lack of an articulated ethical climate; published procedures that are merely "compliance programs" designed around federal criminal sentencing guidelines; and a federal *qui tam* statute that encourages whistle blowing, but does not ultimately protect the whistleblower. This section of the article focuses on the one outside entity available to address the situation. The federal government has made its decision and it will use whistleblowers and the "incentives" available through *qui tam* to combat and control fraud and abuse. Health care organizations, in and of themselves, will defer to the path of least resistance: compliance with federal guidelines. Only the JCAHO accreditation process remains as a single focal point through which the health care community can mount a concerted effort to improve the ethical climate of health care organizations, and subsequently either protect the whistleblower or even mitigate the need for whistle blowing altogether. But noted here, the current JCAHO standards are inadequate if they are to meet this new challenge.

The importance of an articulated organizational ethics is captured by the analogy that identifies the ethical climate of an organization with the character of an individual and the organization ethics processes within an organization with the conscience of an individual (Spencer, Mills, Rorty and Werhane, 1999). The question for the JCAHO becomes: where is there potential guidance that would inform and refocus of the accreditation standards around individual character and connect organizational ethics processes with the conscience of an individual? Lynch and Lynch (1997) and Lynch, Omdal and Cruise (1997) discussed the potential of virtue ethics, first described by Aristotle and later informed by the

spiritual wisdom literature, as a guidepost for individuals seeking to be responsive and responsible in virtual networked organizations. The last section of the article will discuss virtue ethics and its potential to upgrade and refocus the JCAHO standards to aid both the study and practice of health care management.

Where to Look: Virtue Ethics and the JCAHO Standards

Virtue ethics are a way by which an individual can develop a moral and ethical framework through both application and practice. The following paragraphs, first articulated by Lynch and Lynch (1997), describe virtue ethics and their potential application for developing moral and ethical behaviour in individuals. Virtue ethics are based on having the moral person seek and develop an inward looking ethical view by cultivating virtuous character traits and conversely transforming or eliminating non-virtuous character traits. A good person is a moral person who acts in that way for the sake of morality itself. Rather than asking the good person to apply a rational reasoning process to moral decisions, this approach expects the good person to not only intelligently apply reason to the moral problem, but also exhibit a developed intuitive understanding of what is essentially right and wrong. The Greek philosopher Aristotle (384-322 BCE) is the individual most associated with this ethical school of thought. If you follow this ethical theory, professionals must cultivate a virtuous character within them and then exhibit that character in their everyday behaviour. An example would be the U.S. military officer that observes the concepts of 'duty, honour, and country' taught in the military academies. Each officer must bring those values into their very being and then exhibit them in their everyday work activities.

Aristotle wrote two treatises on ethics called Eudeman and Nicomachean after his first editor and pupil, Eudeman, and his son, Nicomachean. The Nichomachean Ethics was probably written when Aristotle was in his fifties or sixties. He directed his inquiry towards discovering how we can achieve our highest ideal of a fulfilled life. His answer was the virtue of the soul achieved by deliberate choice of action based on a worked out plan using his famous Golden Mean (Aristotle, 1925: v).

Aristotle viewed individuals achieving ethics not so much though intellectual reasoning but by the character of their person. He said, 'the virtue of man also will be the state of character which makes a man good and which makes him do his own work well' (Aristotle, 1925: 37). Achieving a high morality is no easy task because it requires a person to live the Golden Mean between excess and deficiency. Like the Buddha, Aristotle said we should aim at what is intermediate or the middle path in our passions and actions. The aim is to perform the right action, with the right person, to the right extent, at the right time, and in the right way. Although this is the objective, Aristotle considered achieving this goodness as rare, laudable, and noble (Aristotle, 1925: 45).

Aristotle saw two potentials for humankind. We can let our passions and desires rule us or we can be free from them by acting with our ethics and morality. He said, 'we feel anger and fear without choice, but the virtues are modes of choice or involve choice' (Aristotle, 1925: 36). The more developed our virtues the more choices we in fact have because we are able to apply a wider range of tools in making our choices. Virtues have nothing to do with passions or faculties, but rather they are a state of character. Morality is a state of mind or consciousness that each of us must develop with effort and perseverance (Aristotle, 1925: 36-7). To be moral, you must exercise your morality in your daily life like you exercise to develop your muscles. It is not something that can easily be comprehended and then applied by logic or reason. It is something that must be lived spontaneously. He said, 'without these no one would have ever a prospect of becoming good' (Aristotle, 1925: 35). Aristotle believed we can all be moral, but most of us fail because we believe that merely knowing about ethics will result in our being good. There is a wide gulf between knowing and being. He argued this self-delusion is much like the physician's patient that listens carefully to the doctor, but follows none of the advice. He says, 'As the latter will not be made well in body by such course of treatment, the former will not be made well in soul by such a course of philosophy' (Aristotle, 1925: 35).

Aristotle believed we must each create morality within ourselves. Leading a life pursuing pleasure or avoiding pain is a fundamental mistake. Morality comes from the avoidance and abstention from excess indulgences and bravely confronting life's difficulties. He said, 'it is by reason of pleasures and pain that men become bad' (Aristotle, 1925: 32). The road to morality involves life long learning beginning with early childhood education and continuing throughout our lives. He said, 'Hence we ought to have been brought up in a particular way from our very youth, as Plato says, so as both to delight in and to be pained by the things that we ought; this is the right education' (Aristotle, 1925: 32).

Unlike deontological and teleological schools of ethical thought, Aristotle saw no predictable clear moral answer that can be generalized before a situation requires a moral judgment. On the contrary he believed that, 'matters concerned with conduct and question of what is good for us have no fixity' (Aristotle, 1925: 30). He went on to say, 'the account of particular cases is yet more lacking in exactness; for they do not fall under any art or precept, but the agents themselves must in each case consider what is appropriate to the occasion'. He continued, 'matters of conduct must be given in outline and not precisely' (Aristotle, 1925: 130).

To achieve the ability to be moral requires developing the proper character. To develop the proper character requires developing virtues. To develop virtues requires creating and living with moral habits (Aristotle, 1925: 29). Aristotle said, 'so too is it with the virtues: by abstaining from pleasures we become temperate, and it is when we have become so that we are most able to abstain from them'

(Aristotle, 1925: 31). What begins as a great effort to give up in time and with effort and practice becomes quite normal and is no effort at all. He also said, 'we learn by doing them . . . states of character arise out of like activities. It makes no small difference, then, we form habits of one kind or of another from our very youth; it makes a very great difference, or rather all the difference' (Aristotle, 1925: 29). If we learn by doing as children and behaviour is the result of repeated actions, we are going to form habits anyway. Therefore, they might as well be good ones.

Each of us must develop virtue. Intellectual virtue comes from being taught. Moral virtue results from developing proper habits. Neither arises without our active intervention and participation over nature. Aristotle said, 'we first acquire the potentiality and later exhibit the activity' (Aristotle, 1925: 28). We develop virtues by practising them much like we learn the arts and music. We learn by doing them repeatedly and forming the correct habits then by exercising them like a young musician learning a new instrument. To Aristotle, the soul is where virtue exists. The body is what moves us astray from virtue (Aristotle, 1925: 26).

God was a central part of Aristotle's vision of ethics because to him proper morality was considered divine and highly prized (Aristotle, 1925: 24). Aristotle reasoned the 'best' things are to be described as blessed and happy because this was the status of God and the most god-like men (Aristotle, 1925: 23). This status could never be attained by animals, but could only be achieved by humans who properly develop their souls (Aristotle, 1925: 18 and 23).

Aristotle felt that happiness was not a state of feeling, enjoyment or pleasure, but rather it was the definition of that which is the most desirable and satisfying of life. Aristotle did not believe that God provided us with such a life, but rather we had to earn it as a result of our good actions. Our good actions were the result of our acquired virtues we developed though learning, training, and cultivation of proper habits. If we did this, he believed we acquired the most god-like blessed prize that we could achieve in the world. To Aristotle, we had to achieve virtue, which was the greatest and most noble accomplishment of all, by study and care rather than by chance (Aristotle, 1925: 18).

Human good is the activity of exhibiting excellence. To Aristotle, the good person is one who performs nobly (Aristotle, 1925: 13). We should seek good because it is desirable in and of itself and never for the sake of something else (Aristotle, 1925: 11). He said, 'The Phythagoreans seem to give a more plausible account of the good, when they place the One in the column of good' (Aristotle, 1925: 9). He argued that we should pursue the universal good in spite of how difficult it is for us to achieve (Aristotle, 1925: 7). Aristotle believed the masses of humankind are slaves to their senses and desires, which makes their lives essentially beast-like. He recognized some leed superficial lives that many call sophisticated and noble, but that are really no better than their beast-like

counterparts (Aristotle, 1925: 6). His ethics calls us to be truly noble because the potential exists within us. If successful, according to Aristotle, we would reach the universal divine good that would be the highest of any life.

The final question in this section of the article is: how can virtue ethics inform the JCAHO standards, and health care management ethics education, in a meaningful way that might reduce the need for whistle blowing or, at a minimum, offer further support for whistleblowers within health care organizations? If viewed from the three ethical perspectives mentioned earlier in this section of the article, the current JCAHO standards, specifically the section on organization ethics, are a majority of process-related (or deontological) requirements with a few minor outcome-based (or teleological) benchmarks. However, according to Aristotle, we cannot generate a clear moral answer before a moral judgement is required of us.

Moreover, according to Aristotle, we must approach matters of conduct in outline rather than in precision. For example, if the JCAHO standards were to become more teleological and attempt to specify, in detail, precisely what constitutes fraud, abuse and unethical behaviour, a line will then be drawn—a line that becomes a point up to which some individuals will step, but not cross. Other individuals will cross that line. Still other individuals will stay well back from that line to avoid even the appearance of impropriety. In other words, this is approximately the same state of affairs as exists now in health care organizations.

As another example, if the JCAHO standards remain or become even more process-focused (or deontological), the heath care community would only achieve part of Aristotle's virtues. The critical point here is that, according to Aristotle, individuals themselves must, in each case, consider what is appropriate to the occasion. What is missing in the current JCAHO standards, however, is a process focus on the individual. The JCAHO standards are organization ethics standards, not individual ethics standards. Yes, we can think of whistle blowing as a process activity. However, the ultimate instigator of this activity is an individual who steps forward to call attention to unethical activity. Aristotle calls for a focus on the individual, and the development, through habit and practice, of an individual's sense, or intuitive understanding, of what is essentially right and wrong. Although the JCAHO cannot mandate or force individuals in health care organizations to develop a more moral or ethical outlook, their standards could establish the framework whereby such development can take place, and even protect health care workers. Without such a change, the current practice of drawing lines in the sand (by the federal government) will continue, with a resulting dysfunctional organizational atmosphere that relies on whistleblowers (through *qui tam* suits) to force out into the open unethical health care organization activity, with unfortunate consequences to the whistleblowers themselves.

Conclusion

This article discussed the need for ethics education in health care management programs to refocus their current "regulated" approach to ethical behavior (focusing on the organization and emphasizing sanctions, enforcement, compliance issues and whistle blowing) to a more "deregulated" approach (focusing on the individual and emphasizing individual actions and behavior informed by virtue ethics). The article described the increasing reliance by the federal government on whistle blowing to combat fraud, waste and abuse in health care organizations. This article discussed the False Claims Act and *qui tam* suits as the vehicles by which individual whistleblowers bring actions, on behalf of the federal government, against health care organizations they suspect of engaging in illegal or unethical activities. This article listed several examples of successful *qui tam* suits and their dollar recovery amounts were listed and described the major downside risks that whistleblowers face once bringing *qui tam* suits. These downside risks are substantial, even with the possible upside financial profit available for whistleblowers after the federal government recovered under *qui tam.* This article also discussed the dysfunctions that whistle blowing can cause for health care organizations that are the target of whistleblowers.

This article explored the potential of the national voluntary accrediting body for hospitals, the JCAHO, to serve as an alternative to that promoted by the federal government for fighting fraud and abuse through the False Claims Act and *qui tam* suits. However, the article also pointed out that the current JCAHO accreditation standards, in particular the organization ethics section; do not contain an ethical grounding sufficient to address the needs of whistleblowers, nor can they mitigate the need for whistle blowing. Lastly, the article examined the potential for virtue ethics, as first described by the Greek philosopher Aristotle, to provide both a stronger ethical grounding for the JCAHO standards, and an approach that would turn the focus from organization ethics toward a focus on ethical development in the individual. It is in this reformulated approach that the JCAHO accreditation process can serve as a case example for use in a new "deregulated" approach to health care management ethics education in university programs.

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