Primum non tacere
An Ethics of Speaking Up

by James Dwyer

Many medical students are fearful of voicing their concerns about ethically troubling medical practice. Yet they must speak up if they are to meet their responsibilities to patients, colleagues, and the profession of medicine.

During the last five years I have conducted ethics courses, seminars, and case conferences for medical students. I have also had many informal discussions with students at all stages of their medical training. Yet I am still surprised by how many students know and refer to the Hippocratic maxim to do no harm. Some even cite the Latin version: *Primum non nocere.* I wish, however, that more medical students would also keep in mind a Socratic maxim: *Primum non tacere.* First, do not be silent.

When I encourage students to articulate ethical issues that they face as students, they often describe situations where they must decide whether to speak up or keep quiet. The following are cases that students have described and that I have altered somewhat and then formulated from a student's perspective.

1. Spos (acronym for "subhuman piece of shit").[1] Before I entered medical school I read *House of God,* but I didn't find it very amusing. I was troubled by the attitudes the characters displayed, and I told myself that I would try to be more respectful of patients. I assumed that speaking about patients in derogatory terms was a fad that would be over by the time I began my clerkships at the hospital. That was not the case. During my first rotation my resident presented me with a new admission: "Here's your patient. He's a forty-year-old Hispanic male, a shooter, a real spos."

I wondered whether I should say anything. I didn't like that language and the attitude it displayed, but it wasn't my job to train the house staff. On the other hand, if I didn't say anything, I'd seem to accept the judgments and attitudes I want to avoid.

2. Informed Consent.[2] I always thought that informed consent was integral to the doctor-patient relationship, that it was really one aspect of good communication with patients. Yet some people view it differently, as a bureaucratic hassle imposed by people outside medicine. This difference became painfully clear during my first week in the clerkship. My resident told me to "consent" one of his patients. This was my second day. I had never met the patient and had no idea what the risks of the proposed procedure were. So I politely asked my resident about the risks, but he told me with a slight sense of annoyance that the patient will sign anything. What were my choices? I could say something to the resident. I could just get the signature. I could look up the procedure in a textbook. Or I could ask someone who might explain the procedure to me. In fact, I asked another resident who told me a bit about the procedure.

An hour later my resident saw me again and said that the team had decided to include a second procedure. He told me to simply write the second procedure onto the form and to use the same pen. I didn't want to be party to this sham, but I also didn't want to jeopardize my grade.

3. Practice Makes Perfect.[3] I understand that this hospital is a teaching hospital and that students, residents, and fellows are here to learn. The fact that we learn on patients means that some patients are subjected to additional pain, inconvenience, and physical examinations. I guess there's a kind of bargain: we learn medicine on people who are mostly poor, and they get care they might not otherwise have access to. Whether or not this arrangement is fair, I've come to accept it. But I never imagined that people would practice a procedure that wasn't medically indicated.

Late one night I was working with a resident in the labor and delivery room. The patient was in labor, and the resident decided to do a forceps delivery. I didn't see the indication. The woman didn't seem very fatigued, and there were no apparent complications. I didn't know the exact statistics, but I was sure that a forceps delivery involved some risk to the fetus. I didn't know what to do. If I asked what the indications were, the resident was sure to have some rationalization. If I told an attending physician the next day, I'd create a lot of trouble and no good would come of it. If I did nothing, I'd feel ashamed—I went into medicine to help people.

4. An Important Finding.[4] One of the patients I was following was Mr. Z, a fifty-two-year-old diabetic man with bedsores. After rounds it was my job to dress his wounds. As I was helping him turn over in bed, my hand pressed against his left side. I felt a crackling under his skin. "Like rice crispies under the skin," I remem-

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bered the lecturer telling us two years ago. I knew what that meant: crepitus, a sign of infection by a gas-producing organism. Since I was pretty sure, I told the intern about my finding. I was polite, but direct. I told him that I thought the patient had crepitus and that he should take a look.

I asked about Mr. Z when I saw the intern that afternoon. He said that Mr. Z didn't have crepitus and that we would check on him in the morning. Before I went home that evening I stopped by to see Mr. Z again. His general condition seemed worse. I pressed on his side again and felt the same crackling. I wondered whether I should speak to the intern again that evening, go talk to the senior resident, or just go home.

5. What Were We Doing?[5] One of the first patients I had in pediatrics was a two-year-old child dying of AIDS. What bothered me most about the case was what we were doing to the child. It seemed like we were always drawing blood or doing something to it. Once we did two lumbar punctures in one day!

After a while I understood the technical reasons for each test and procedure we did, but I didn't really understand the overall strategy. I wondered what all our treatment would accomplish for the child. So I spoke to my resident. I told her I was troubled by the pain we were inflicting and asked whether she thought the child would recover enough to go home. She didn't think the child would live much longer, and she too was troubled by the aggressive treatment that the attending physician ordered. The attending wanted to do everything possible and no one was going to fault him for doing too much.

I felt I should cautiously broach my concern with the attending physician, but I saw clearly that the resident was unwilling to say anything to him.

Keeping Quiet

The ethical issue I want to discuss is whether students should voice their disagreement in situations like these. I will begin by considering the view that the best course of action for students is to keep quiet.

Melvin Konner describes how, as a medical student, he came to adopt the practice of keeping quiet.[6] His first clinical rotation was an assignment in one of the units of the hospital. At the beginning of the rotation the director of the unit explained some alphabet soup: clinical reminders formulated as a series of letters or acronyms. Konner asked a question that he thought was relevant and important. The curt response convinced him that he was making a mistake. At that point he says:

> I reminded myself of some of my own alphabet soup.... *K.M.S., you jerk,* I said to myself, as loudly as I could inside my head. KEEP MOUTH SHUT. *At least until you get the lay of the land. Or until you have something indispensable to say.* (p. 55)

Just after this reminder Konner noticed that a patient who looked to be in pain had appeared in the waiting room. Although the other staff seemed not to have noticed the patient, Konner kept quiet. But after a while the thought that the patient might need attention prompted him to say something. The director chastised him for interrupting. Konner reflects:

> It was the last message I needed to get from him. *K.M.S.* was from then on not only easy but second nature to me. I faded into the woodwork in every situation. I rarely if ever spoke unless I had been directly addressed. *This is the army,* I thought. *Every time you open your mouth you create complications for yourself.* It was a rule I followed throughout the rest of my medical training; making exceptions only when I was in the presence of the unusual medical teacher who was not overbearingly arrogant, and whom I instinctively felt I could trust. (p. 57)

Thus keeping quiet became the practice that Konner tried to adhere to during the course of medical school.

On a number of occasions Konner stifled questions that he wanted to ask. Once he had a question about the way morning rounds were conducted, but he said to himself: "mine was not to reason why, and I followed faithfully and quietly, suppressing even the most seemingly pertinent questions about treatment and course of illness" (p. 93). On another occasion he wondered why a patient did not have DNR status, but he said nothing. Often he reflected on the nonphysical aspects of healing, but he kept quiet about his reflections. When a young woman with cancer died on the wards, he thought about the case:

> As much as I wanted to hear some discussion about it—even a strictly medical discussion would have been better than nothing—I had developed sense enough not to ask. My concerns, I realized, were idiosyncratic. Nobody wanted to hear about them, not even most of my fellow students. I could simplify my life best by keeping them to myself, and I certainly wanted to simplify my life. (p. 294)

Thus Konner came to believe that most of his questions were unwelcome complications.

Although the practice of keeping quiet may simplify one's life, it is morally problematic in at least two ways. When keeping quiet is adopted as a blanket policy, it covers up important differences between cases. Keeping quiet about improper care, for example, is importantly different from keeping quiet about one's beliefs about the spiritual aspects of healing. Also, when keeping quiet is proposed as a strategy for getting through medical school, it simply ignores the ethical question of whether students have some obligation to speak up. What is needed is a discussion of the ethics of speaking up.

Students' Obligations

Speaking up may subject students to various risks and repercussions. They may be graded by someone they have offended by speaking up; they may be ridiculed for asking a question or voicing their concerns; they may be seen as a lone dissenter or even a disloyal team member; they may be viewed as unprofessional for criticizing other professionals; and, if they go over someone's head, they may be seen as rats or tattletales.

These possibilities are not trivial: how students are viewed by others can affect their career prospects as well as their sense of themselves.

Since speaking up places students at some risk, this kind of engagement requires a degree of courage. A need for courage is not limited to the situations depicted at the beginning of this paper, but is common to learning and practicing medicine. Students face a risk of infection from HIV, HBV, tuberculosis, and other diseases. Yet for the most part they draw blood or do what needs to be done, in spite of the risk to themselves. Many students, however, who act courageously in the face of contagious disease hesitate to speak up. They see procedures like drawing blood as part of what a good physician has to do, but view speaking up as an individual choice that goes beyond the practice of medicine. I do not share this view. Especially now, when medicine is often practiced in large institutions with a number of people involved in the care of an individual patient, speaking up is something physicians may have to do to meet their responsibilities to patients, colleagues, and the profession of medicine.

It is up to the medical profession to set standards of care and to regulate its members. This crucial task is one of the characteristics of professional life. Neither society as a whole nor patients individually are well positioned to take over this work. Patients, especially, rarely see and know enough to set standards and to judge who falls short. Thus physicians are entrusted with a moral and legal responsibility to assess their colleagues and to report those who are incompetent or unethical.[7] But their moral commitment goes beyond a duty to establish review boards and to report flagrant cases. Patients also entrust physicians to engage their colleagues and institutions about less flagrant, more everyday matters. This engagement might often take the form of questions and discussions. Even in cases where reasonable physicians may disagree, physicians may have a duty to do just that: to voice their disagreement and to question the reasoning of others.

But just because full-fledged physicians have an obligation to speak up, it does not follow that medical students do. Students are not professionals and have much less power and authority than practicing physicians. They may therefore have fewer or different obligations. At a minimum, students are obligated to take notice of bad practices and to try to conduct themselves in a better way when they become full-fledged physicians. But is learning from bad examples enough? Might students be obligated to engage themselves in a more active way?

Students, like all human beings, have a moral obligation to prevent serious harm when they can do so at little risk or cost to themselves. We can think of this obligation as a natural duty—independent of promises, contracts, and roles.[8] There are, however, problems with appealing to a natural duty in this context. Students face many situations where the duty does not apply because the potential harm to the patient is not grave and the risks of speaking up are significant. Furthermore, since a natural duty is (by definition) an obligation that every human being has, it does not specify what obligations students have in virtue of their role as medical students.

To determine what specific obligations medical students have, it is helpful to clarify what their role is. Medical students often assume different roles during different stages of training, in different departments, at different clinics and hospitals, and with different residents and attending physicians. They act as observers, auxiliaries for residents, caregivers, counselors, patient advocates, researchers, and even teachers. Yet their primary role, function, and purpose is to learn to be good physicians. The obligations implicit in this role are the ones that need to be elaborated.

Among the skills and habits that students need to practice are those that good physicians call upon in ethically problematic situations.

It is the work of medical students to acquire the knowledge, skills, and habits that good physicians need. To acquire these skills and habits, and even this knowledge, it is not enough for students passively to observe medical practice and to note what they will do when they are full-fledged physicians. They must practice things now—take medical histories, do physical exams, start IVs, make differential diagnoses—to have the skills and habits they will need to do a good job when they are practicing physicians. Among the skills and habits that students need to practice are those that good physicians call upon in ethically problematic situations. Students must act now to develop habits they will need later.

The key concept here is the idea of habit. Any conduct as complex as the practice of medicine depends on more than abstract knowledge, viewed as a fund of facts and theories. Such conduct also depends on habits, acquired but not always conscious ways of action and perception.[9] One of the reasons that habits are important is that they are like resources or skills that can be called into use when needed. When students are faced with situations like the ones depicted at the beginning of this paper, they have an opportunity to develop habits that are important for the good practice of medicine. It might be nice if such situations never arose—just as it might be nice if there were never any cases of tuberculosis—but such situations do arise and students must learn to deal with them. If students do not engage themselves in these situations, they fail to develop and exercise the qualities of a good physician. It is not enough to observe these

situations now and to vow to act if similar situations arise after full professional status has been attained. Habits of reflection, character, and intervention need to be developed and exercised if they are to be ready-at-hand in the future.

Learning and Caring

What I have said so far may seem to overemphasize the idea of learning at the expense of the idea of caring. I can imagine someone formulating the following objection: "Keeping quiet in situations like the ones depicted is more than a failure to seize an opportunity to develop important skills. It is not a failure of learning but of caring. In fact, keeping quiet is a failure to act as a caring physician." As a way of responding to this objection, I want to explain how a failure to speak up in certain situations is a failure of learning *and* caring.

The first thing I want to say about the complex relationship between learning and caring concerns the connection between habit and character. Acquiring a habit is often more than developing an isolated skill that can be called upon when needed. The acquisition of a habit often amounts to the formation or alteration of a part of character. It is true that habits are like resources or skills that can be called into use when needed. But habits have another important feature. They act like elements of character that influence or color conduct even when they are not in overt use. Habits are not only ready-at-hand; they are always-at-work.

John Dewey notes this feature when he remarks that habits are "operative in some subdued form even when not obviously dominating activity" (p. 39). And he gives a convincing example:

> The habit of walking is expressed in what a man sees when he keeps still, even in dreams. The recognition of distances and directions of things from his place at rest is the obvious proof of this statement. The habit of locomotion is latent in the sense that it is covered up, counteracted, by a habit of seeing which is definitely at the fore. But counteraction is not suppression. . . . Everything that a man who has the habit of locomotion does and thinks he does and thinks differently on that account. (pp. 36-37)

In this way certain habits may influence conduct even when these habits are not called into direct use.

Because many habits influence perception and conduct even when they are not dominant in a particular activity, these habits amount to or are connected with traits of character. The kind of habits needed in situations like the ones depicted are not isolated skills that are separate from the character of a caring physician. Rather, there is a positive connection between these habits and the character traits of a caring physician. Yet it would be somewhat misleading to say that students need to act in those situations so that they will learn to be caring physicians. It is more accurate to say that they need to act in those situations so that they will not learn to be uncaring physicians. I'll explain why I put the matter that way.

There is, of course, a relationship between caring and learning to fulfill one's obligations and responsibilities. I want to suggest an account of this relationship in the experience of medical students. Some accounts of ethical obligation start with rational egoists and show how they acquire and come to feel that they have obligations to others. In these accounts obligations arise to fill a vacant space—a space where previously there was no felt moral concern. Whatever the merits of these accounts, as either moral theories or theories of moral development, they do not capture the place and function of specific obligations in the moral life of medical students.

For the most part, medical students are committed and feel committed to caring about and for patients. They begin their training with a felt sense of moral concern, and then they learn specific obligations and responsibilities. Instead of thinking of students as coming to have and perceive obligations where they previously felt no commitment or moral concern, it is more accurate to think of learning specific obligations as a process that directs or even limits students' diffuse sense of moral concern. What students learn is to clarify and define their obligations and responsibilities to patients and others. This learning may only be successful when there is a background of moral concern.

There are two dangers in this learning process. If responsibilities are not clarified and delineated, students' moral concern will remain diffuse and probably ineffective. It seems to demand everything and to point in no direction. The second danger is the more common one in professional training. If responsibilities are defined too narrowly, technically, or legalistically, there is a danger that moral concern and imagination will be lost.[10] The danger is that very narrowly defined responsibilities and obligations will be substituted for a sense of moral concern that was somewhat open-ended, searching, and imaginative. When the sense of moral concern is fixed on and exhausted by the technical responsibilities that have been learned, the result is a competent technician with a narrow sense of professional responsibility.

If medical students learn to keep quiet in all situations, and do so without qualms, then their sense of moral concern is exhausted by some narrow account of responsibilities and obligations. If they experience qualms but still keep quiet, then their sense of moral concern exceeds the narrow account but has not found expression at a cost that is acceptable to them. Thus it is true that the practice of always keeping quiet is a failure of caring. It is a failure in the process of learning to care, a failure that occurs either by allowing narrowly defined responsibilities to exhaust a sense of caring or by not adequately expressing a residual, open-ended sense of caring.

When and How

To further their development as caring physicians, students need to consider exactly when and how they should speak up. Although these considerations depend very much on the particular situations, there are some general factors to keep in mind. In

trying to decide whether to speak up in a particular case, students should consider the nature and certainty of their judgment, their specific role in the situation, the potential harm to patients, the probable effectiveness of speaking up, and the likely cost to themselves if they do speak up. I'll say a few words about each of these points.

Students may be unsure of their judgments in two different ways. They may not have enough experience to know with certainty whether a particular course of action is medically appropriate, or they may have doubts about their own ethical judgment in a particular situation. Yet the existence of either kind of uncertainty is not necessarily a reason for keeping quiet, since there is usually some degree of uncertainty in medicine and ethics. Students need to find the appropriate threshold of certainty for voicing their concerns. This threshold may depend on a number of the factors mentioned.

Variations in students' specific roles make an ethical difference. When students are actively engaged in patient care, they have a greater obligation to speak up about situations that involve their patients, whereas in situations they merely hear about because they are on the wards their obligation is correspondingly less. Of course, if the matter is serious enough, they should speak up even if they stand on the periphery of the situation.

Obviously, the potential harm to the patient is a very important factor. When there is a serious threat to the patient's well-being, students should speak up even if they are somewhat uncertain and somewhat on the periphery. They should speak up, for example, in cases where they make important findings, believe certain tests should be done, or think that the proposed courses of action involve serious and unjustified risks. When the potential harm to the patient is less serious and clear-cut, the decision to speak up is more difficult.

Students should also take into account the probable effectiveness of speaking up. They are not obligated to speak up when they know that doing so will accomplish nothing. Yet they need to guard against rationalizing a policy of keeping quiet by supposing that speaking up will always be ineffective. It is difficult to know in advance whether voicing a concern will be effective. I personally know of cases where speaking up has made a difference, in matters ranging from the use of derogatory language to the proposed course of surgery. Doubts about the effectiveness of speaking up should not occasion a retreat into silence but a search for the most effective way of voicing one's concerns.

When deciding whether to speak up, students may legitimately take into account the likely cost to themselves. They are not required to sacrifice their careers for some trivial matter, but neither should they keep quiet about a significant matter simply because speaking up may have some effect on their grades and careers. Obligations, by their very nature, require people to act in ways that sometimes include a cost or inconvenience to themselves.

Many students are concerned that speaking up will result in a lower grade than they deserve and that a lower grade will diminish their chances of getting into the residency program of their choice. Since the selection and self-selection of medical students tends to result in people who are exceedingly grade-conscious, it would not be surprising if many students exaggerated the role and importance of grades. There may, however, be times when speaking up will have some effect on students' grades. When an adverse effect is a real possibility, students may simply have to choose between doing what will maximize their grades and doing what fulfills their obligations in the broadest sense. In making this choice, students should try to examine their notion of a "good" residency. If a good residency is just a prestigious one, then students should recognize the importance they are assigning to prestige. But if a good residency is one that trains people to be good physicians, then students should recognize that there is something a little odd about choosing not to act as a good physician now in order to maximize their chances of later getting into a program that will train them to be good physicians.

> The practice of always keeping quiet is a failure in the process of learning to care.

The question of when students should speak up cannot be completely separated from the question of how students should speak up. In an obvious way the question of whether and when to speak up depends on what one is proposing to say and how one is going to say it. For example, students need very little cause or justification for asking about the medical indications of a particular procedure, whereas they need more cause or justification for going over a person's head.

When students have decided to speak directly to the person involved, there is still the question of how they should formulate their concerns. The phrasing and tone of what they say is more than a matter of style. Insofar as different ways of speaking up express different sensitivities, these ways are of ethical significance. Perhaps an example can illustrate this point.

Sometimes medical students notice a problem or make a diagnosis before the resident does. Students must then decide how, and how forcefully, to convey their discovery to the resident. They can even decide to play dumb: to tell the resident about some findings and tests so as to lead the resident to make the diagnosis that they have already made. Playing dumb may itself express various concerns or attitudes. Students may play dumb in order not to appear arrogant, to maintain a working relation-

ship within a hierarchical system, or to get an egotistical person to see and act on the problem. Whether playing dumb expresses a kind of servility is an issue worth considering. Although patient care should be the primary concern, issues of attitude and character are not insignificant.

Learning how best to speak up is important because many of the problems that students encounter need to be resolved by talking to people face to face. Relatively few problems can or should be dealt with in other ways: by anonymous letters, note boxes, or grievance committees. The need for face-to-face engagement is not an unfortunate fact, but an occasion for developing a certain kind of character and work environment. It is an occasion for caring students to try to voice important concerns and disagreements in a way that does not alienate the people they are working with. This is a task that requires a lot of practice. Now is the time to begin.

More Socratic

There are many reasons why students find it difficult to speak up. Some do not think it is their place or job to do so. Some are concerned about possible adverse effects on their grades, particularly when doing clerkships in specialties they hope to enter. Some fear that they will be subjected to ridicule for asking a question or expressing a concern. Some learn that it is considered improper to criticize fellow physicians. Some want to be viewed as loyal to the team, and few want to be seen as a rat or tattletale.

In spite of the reasons that make it difficult for students to speak up, I have argued that they have an obligation to do so. But by focusing on students' obligations I did not mean to excuse the people above them. Speaking up is a problem for everyone in medicine, and those with more power and authority have a greater obligation to confront the problem. They have a responsibility to speak up and a responsibility to try to change the conditions that make it so difficult for those below them to speak up.

It will not be easy to transform fearful silence into concerned conversation, but that is what needs to be done. There is a need for people to question or report the obviously bad. And in cases that are less obvious, there is a need for people to initiate discussions about what is good. For example, in one of the cases depicted at the beginning of this paper, the student and the resident had doubts about the aggressive course of treatment being given a child dying of AIDS. Perhaps the attending physician's plan of treatment was well-founded and involved the parents in a meaningful way. Perhaps not. Perhaps he was just responding to discrete technical problems. When students (and residents) fail to express their concerns in a case like this, everyone stands to lose. The patient is subjected to a course of treatment that may not be good in a broad sense. The family may suffer more. The attending physician may never examine certain assumptions. Future patients may face similar problems. And the students will fail to exercise and develop important habits of a caring physician.

I guess I am really suggesting that the practice of medicine needs to become more Socratic. Perhaps medicine could not function if everyone acted like Socrates—perhaps there would be too much discussion and too little patient care. Yet I believe that medicine could function quite well if everyone were a little more Socratic, a little more willing to raise questions about what is right and good.

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References

1. This account was suggested by Anna Barrett.
2. This account was suggested by Stacey Lane.
3. This account was suggested by Michelle Barry.
4. This account was suggested by Susan Staugaitis.
5. This account was suggested by Bartley Bryt.
6. Melvin Konner, *Becoming a Doctor* (New York: Penguin Books, 1987).
7. E. Haavi Morreim, "Am I My Brother's Warden? Responding to the Unethical or Incompetent Colleague," *Hastings Center Report* 23, no. 3 (1993): 19-27.
8. See, for example, John Rawls, *A Theory of Justice* (Cambridge, Mass.: Harvard University Press, 1971), pp. 113-15.
9. A number of philosophers have written about the nature and importance of habit. Three prominent examples are Aristotle, John Dewey, and Maurice Merleau-Ponty. Aristotle discusses habituation in Book 2 of *Nichomachean Ethics.* Dewey devotes one part of *Human Nature and Conduct* (New York: Modern Library, 1957) to a consideration of habit. Merleau-Ponty discusses habit and the habitual body in *Phenomenology of Perception.* My own remarks on habit follow Dewey.
10. In a different context, Carol Gilligan says that the problem "becomes one of limiting responsibilities without abandoning moral concern." See *In a Different Voice* (Cambridge, Mass.: Harvard University Press, 1982), p. 21.