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## The Ethics of Whistle Blowing

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We can begin with the good news: the vast majority of behavioral health professionals – including psychologists, social workers, psychiatrists, mental health counselors, marriage and family therapists, addictions counselors, and psychiatric nurses – are ethical and avoid profound moral lapses. That said, the unfortunate reality is that some behavioral health professionals, a nontrivial minority, misbehave or otherwise violate widely accepted ethical standards.

Scholarly literature on the subject suggests three noteworthy patterns (Coombs, 2000; Reamer, 1992, 2015; Wynia, 2010). First, some practitioners engage in unethical conduct. Prominent examples include egregious boundary violations (for example, engaging in sexual relationships with clients), entering into business relationships with clients, and falsifying documents (for example, clinical records, billing statements). Typically, in these instances misbehaving practitioners are aware that they are violating well known ethical standards. Why they do so is another matter.

Second, some behavioral health practitioners perform below minimally accepted standards due to incompetence. Examples include practitioners who are not sufficiently knowledgeable about intervention protocols and treatment techniques; make serious errors in judgment when working with clients; make serious documentation errors; and fail to keep current with important developments in the profession or comply with continuing education requirements.

Third, some practitioners manifest symptoms of impairment that are serious enough to interfere with their professional functioning and ability to assist clients. In some instances, the impairment may cause significant harm to clients.

Sometimes such misconduct, incompetence, and impairment come to the attention of

professional colleagues, who then face an ethical dilemma: Do I respond to troubling evidence, allegations, and rumors quietly and under the proverbial seal, or am I obligated to disclose what I know to people who are in positions of authority (otherwise known as blowing the whistle)? What are the limits of colleagues' privacy and confidentiality rights? How do I balance my concern about a colleague's privacy and reputation, on one hand, and, on the other, my corresponding duty to disclose wrongdoing and prevent harm?

Here are several representative examples:

- Dustin L. is a counselor at a mental health center. He worked at the agency as a caseworker for six years before completing his graduate degree and being promoted by the agency's executive director, with whom Dustin has a close professional relationship.

One day, one of the agency's caseworkers, whom Dustin supervises, asked to speak with him. The caseworker told Dustin that he had some "disturbing news" to share with him. According to the caseworker, one of his clients has just reported in a therapy session that she knows the agency's executive director. According to the client, several months earlier the executive director paid her for sex in a hotel room and shared cocaine with her. Altogether, the client said, she and the executive director have had "five or six dates." In addition, according to the caseworker, the executive director used agency funds for a personal trip and falsified service use data in the most recent quarterly report he prepared for a state agency that provides a significant percentage of the agency's funding.

Dustin is torn about how to handle the situation, particularly because he considers the executive director to be a friend.

- Jenny P. is an outreach worker at a program that serves people who struggle with homelessness and co-occurring issues (mental illness and substance use disorders). Two years ago, Jenny completed her master's degree in mental health counseling.

While she was in school, Jenny struggled with academic tasks. Her undergraduate grades were uneven; as a result, Jenny had difficulty getting accepted to graduate school and had to reapply twice before being admitted. She had difficulty in several courses, was placed on

academic probation, and graduated after barely meeting the graduate program's minimum requirements. Jenny did not pass the state's licensing exam and was taking a test preparation course before taking the exam a second time.

Over time, Jenny's job supervisor became concerned about the quality of her work. The supervisor believed that Jenny's clinical skills were barely rudimentary, she had limited insight about clients' complex mental health and substance use challenges, and her documentation skills were lacking. The supervisor was frustrated with Jenny's willingness to accept feedback.

At the same time, the supervisor liked Jenny and knew that she was desperate to keep her job. The supervisor was unsure about whether to share her concerns about Jenny's level of functioning with senior agency administrators or to continue giving her opportunities to improve.

- Maria D. is an addictions counselor at a residential program for people struggling with substance use disorders. Maria provides clients with on-one-one counseling and facilitates weekly support groups. Earlier in her life, Maria became addicted to opioids. She received in-patient and out-patient treatment and is in recovery. Three years ago, Maria completed her state's requirements for certification as a licensed chemical dependency professional.

Four months ago, Maria divorced her husband after five years of marriage. She had difficulty coping with this loss and relapsed. Maria did not disclose her relapse to her colleagues at work. However, one of her colleagues, Althea M., sensed that Maria was having a difficult time; Althea noticed that Maria was missing more days of work than usual, was often uncharacteristically agitated with clients and colleagues, and was not completing case notes on time.

Althea decided to share her concerns with Maria. Maria told Althea about her relapse and begged Althea to keep this secret. Maria tried to assure Althea that she was taking earnest steps to address her relapse and get back on track at work. Althea wondered whether she had an obligation to share her concerns about Maria with agency administrators.

## Ethical Choices

Understandably, behavioral health professionals are often reluctant to report colleagues who appear to be engaged in wrongdoing, incompetent, or impaired. Colleagues' careers can be ruined as a result, and individuals who blow the whistle can be ostracized throughout their place of employment and professional community.

At the same time, most professionals understand why sometimes blowing the whistle may be necessary. Clients' well-being and entire programs may be at risk because of a colleague's misconduct or impaired condition. In these situations, professionals have to weigh the competing reasons for and against whistle-blowing. Barry (1986) recognizes the moral dimensions of this challenge:

Truthfulness, noninjury, and fairness are the ordinary categories of obligations that employees have to third parties, but we can still ask: How are workers to reconcile obligations to employers or organizations and others? Should the employee ensure the welfare of the organization by reporting the fellow worker using drugs, or should she be loyal to the fellow worker and say nothing? Should the secretary carry out her boss's instructions, or should she tell his wife the truth? Should the accountant say nothing about the building code violations, or should she inform authorities? In each case the employee experiences divided loyalties. Resolving such conflict calls for a careful weighing of the obligations to the employer or firm, on the one hand, and of those to the third party, on the other. The process is never easy. (p. 239)

The circumstances surrounding a colleague's alleged misconduct, incompetence, and impairment are often ambiguous. The evidence of wrongdoing may be questionable, the effect of the incompetence or misconduct may not be clear, and the likelihood of correcting the problem may be slim. Decisions to blow the whistle must be approached deliberately and cautiously (Miceli, Near, & Dworkin, 2008). Before deciding to blow the whistle, professionals must carefully consider several major factors: the severity of the misconduct, incompetence, and impairment; the actual or potential harm involved; the quality of the evidence of wrongdoing; the effect of the decision on colleagues and agency and the viability of alternative, intermediate courses of action; and the motives of the whistle-blower.

Clearly, the more serious the misconduct, incompetence, and impairment, and the actual or potential harm involved, the greater the support for whistle blowing. These are judgment calls, of course, but it is important for potential whistle blowers to think carefully about whether their concerns justify such extreme measures.

Second, potential whistle-blowers should ask themselves, “How strong is the evidence of misconduct, incompetence, or impairment?” Practitioners should assign greater weight to compelling, incontrovertible evidence and exercise caution in the face of equivocal, circumstantial, and hearsay evidence. In light of the often serious consequences of whistle-blowing, practitioners should feel confident that their allegations rest on solid evidence.

Third, it is reasonable for potential whistle blowers to consider the likely impact of their actions. Will disclosure make a difference, and is the risk to the agency – for example, as a result of adverse publicity – tolerable? How likely is it that the whistle-blowing will be effective and produce meaningful reform and change? Are outside parties in a position to address the issue, or would the whistle-blowing result only in toxic publicity and bruised reputations?

Fourth, potential whistle blowers should carefully consider the extent to which they have made genuine, forthright attempts to discuss concerns with colleagues who are or appear to be involved in misconduct, incompetent, or impaired. Intermediate steps – which may involve mediation and various forms of corrective action, such as strict supervision, restitution, and continuing education – are sometimes reasonable alternatives to formal whistle-blowing.

Finally, potential whistle blowers should ask “What are my motives? Am I disclosing information to authorities about my colleague because of my genuine and sincere concern for clients and the agency, or is it a convenient opportunity for retribution—to ‘pay back’ a colleague with whom I have had some conflict?” To justify whistle-blowing, practitioners must be confident that their motives are noble, not self-serving.

## Causal Factors

Deciding whether to blow the whistle on an allegedly unethical, incompetent, or impaired colleague is one challenge. Yet another challenge – an essential one – is understanding why some

colleagues behave in ways that may warrant whistle blowing. Appreciating this context is important if professionals are to make informed whistle blowing decisions and, especially, prevent the kinds of transgressions that lead to whistle blowing.

The subject of impaired and incompetent professionals began to receive serious attention in the early 1970s. In 1972, for example, the Council on Mental Health of the American Medical Association issued a statement that said that physicians have an ethical responsibility to recognize and report impairment and incompetence among colleagues. In 1976 a group of attorneys recovering from alcoholism formed Lawyers Concerned for Lawyers to address chemical dependence in the profession, and in 1980 a group of recovering psychologists began a similar group, Psychologists Helping Psychologists (Kilburg, Kaslow, & VandenBos, 1988; Kilburg, Nathan, & Thoreson, 1986; Knutsen, 1977; Laliotis & Grayson, 1985; McCrady, 1989; Thoreson et al., 1983).

Organized efforts to address impaired, unethical, and incompetent workers began in the late 1930s and early 1940s after the emergence of Alcoholics Anonymous and in response to the need that arose during World War II to sustain a sound workforce. These early occupational alcoholism programs eventually led, in the early 1970s, to employee assistance programs, designed to address a broad range of problems experienced by workers.

More recently, strategies for dealing with professionals whose work is affected by problems such as substance use, mental illness, and emotional stress have become more prevalent. Professional associations and informal groups of practitioners are meeting to discuss the problem of impaired colleagues and to organize efforts to address the problem (Coombs, 2000; Reamer, 2015; Wynia, 2010).

The seriousness of impairment, unethical conduct, and incompetence among behavioral health professionals and the forms it takes vary. Impairment, unethical conduct, and incompetence may involve failure to provide competent care or violation of the profession's ethical standards. It may take such forms as providing flawed or inferior psychotherapy to a client, sexual involvement with a client, or failure to carry out professional duties as a result of substance use or mental illness. Lamb and colleagues (1987) have provided a comprehensive definition of impairment and incompetence among professionals: "Interference in professional functioning that is reflected in one or more of the following ways: (a) an inability and/or unwillingness to acquire and integrate

professional standards into one's repertoire of professional behavior; (b) an inability to acquire professional skills in order to reach an acceptable level of competency; and (c) an inability to control personal stress, psychological dysfunction, and/or excessive emotional reactions that interfere with professional functioning" (p. 598).

Impairment, unethical conduct, and incompetence among professionals that may warrant whistle blowing have various causes. Research suggests that stress related to employment, illness or death of family members, marital or relationship problems, financial problems, midlife crises, personal physical or mental illness, legal problems, and substance use all may lead to impairment (Bissell & Haberman, 1984; Coombs, 2000; Guy, Poelstra, & Stark, 1989; Reamer, 2015; Straussner, Senreich, & Steen, 2018; Thoreson, Miller, & Krauskopf, 1989; Zur, 2007, 2017). Stress induced by professional education and training can also lead to impairment, stemming from the close clinical supervision and scrutiny students receive, the disruption in students' personal lives caused by the demands of schoolwork and field placements, and the pressures of students' academic programs (Lamb, et al., 1987).

According to Wood and colleagues (1985), psychotherapists encounter special sources of stress that may lead to impairment because their therapeutic role often extends into the nonwork areas of their lives (such as relationships with family members and friends), the lack of reciprocity in relationships with clients (therapists are "always giving"), the often slow and erratic nature of therapeutic progress, and the triggering of therapists' own issues by therapeutic work with clients. As Kilburg, Kaslow, and VandenBos (1988) observed,

[The] stresses of daily life – family responsibilities, death of family members and friends, other severe losses, illnesses, financial difficulties, crimes of all kinds – quite naturally place mental health professionals, like other people, under pressure. However, by virtue of their training and place in society, such professionals face unique stresses. And although they have been trained extensively in how to deal with the emotional and behavioral crises of others, few are trained in how to deal with the stresses they themselves will face. . . . Mental health professionals are expected by everyone, including themselves, to be paragons. The fact that they may be unable to fill that role makes them a prime target for disillusionment, distress, and burnout. When this reaction occurs, the individual's ability to function as a professional may become impaired. (p. 723)

Some practitioners, like colleagues in other helping professions, are reluctant to seek help for personal problems. Also, some practitioners are reluctant to confront colleagues about their impairment. Some behavioral health professionals may be hesitant to acknowledge impairment within the profession because they fear how colleagues would react to confrontation and how this might affect future collegial relationships (Bernard & Jara, 1986; Guy, Poelstra, & Stark, 1989; McCrady, 1989; Prochaska & Norcross, 1983; Wood, et al., 1985). As VandenBos and Duthie (1986) have said,

The fact that more than half of us have not confronted distressed colleagues even when we have recognized and acknowledged (at least to ourselves) the existence of their problems is, in part, a reflection of the difficulty in achieving a balance between concerned intervention and intrusiveness. As professionals, we value our own right to practice without interference, as long as we function within the boundaries of our professional expertise, meet professional standards for the provision of services, and behave in an ethical manner. We generally consider such expectations when we consider approaching a distressed colleague. Deciding when and how our concern about the well-being of a colleague (and our ethical obligation) supersedes his or her right to personal privacy and professional autonomy is a ticklish matter. (p. 212)

Some practitioners may find it difficult to seek help for their own problems because they believe that they have infinite power and invulnerability, that they should be able to work out their problems themselves, an acceptable therapist is not available, seeking help from family members or friends is more appropriate, confidential information might be disclosed, proper treatment would require too much effort and cost, they have a spouse who is unwilling to participate in treatment, and therapy would not be effective (Coombs, 2000; Deutsch, 1985; Straussner, Senreich, & Steen, 2018; Thoreson, Miller, & Krauskopf, 1983).

It is important for behavioral health professionals to design ways to prevent professional misconduct and impairment, and respond to colleagues in constructive ways. They must be knowledgeable about the indicators and causes of impairment so that they can recognize problems that colleagues may be experiencing. When necessary, practitioners must also be willing to confront troubled or under-performing colleagues, offer assistance and consultation, and, if necessary as a last resort, refer the colleague to a supervisor or local regulatory or disciplinary body (such as a state

licensing board).

## Ethical Reasoning

Behavioral health professionals should approach whistle blowing decisions carefully, systematically, and with integrity. Ideally, practitioners should draw on relevant ethical standards, apply ethical theories and frameworks, and identify various legal and risk-management considerations.

Ethical standards: The codes of ethics of several prominent behavioral health professions recognize the problem of unethical behavior, incompetence, and impairment. Further, these codes acknowledge that, when warranted, practitioners must blow the whistle. For example, the National Association of Social Workers (NASW, 2017) *Code of Ethics* states:

Standard 4.05(a). Impairment. Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility.

Standard 4.05(b). Impairment. Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others.

Standard 2.08(a). Impairment of Colleagues. Social workers who have direct knowledge of a social work colleague's impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties and that interferes with practice effectiveness should consult with that colleague when feasible and assist the colleague in taking remedial action.

Standard 2.08(b). Impairment of Colleagues. Social workers who believe that a social work colleague's impairment interferes with practice effectiveness and that the colleague has not taken adequate steps to address the impairment should take action through appropriate

channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

The NASW code includes similar standards pertaining to social workers' obligations when they believe that a colleague's incompetence (standard 2.09) or unethical conduct (standard 2.10) interferes with their ability to provide services.

The American Psychological Association's (2017) code of ethics also focuses on psychologists' ethical duty when their personal challenges interfere with their competence:

Standard 2.06(a). Personal Problems and Conflicts. Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.

Standard 2.06(b). Personal Problems and Conflicts. When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties.

Standard 1.05. Reporting Ethical Violations. If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution . . . or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities.

The American Counseling Association *Code of Ethics* (2014) also addresses issues of practitioner impairment, unethical conduct, and incompetence:

Standard C.2.g. Impairment. Counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work.

Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients.

Standards 1.2.b. Reporting Ethical Violations. If an apparent violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution or is not resolved properly, counselors take further action depending on the situation. Such action may include referral to state or national committees on professional ethics, voluntary national certification bodies, state licensing boards, or appropriate institutional authorities.

Moral reasoning: In addition to examining whistle-blowing decisions through the lens of various professions' formal ethical standards, behavioral health practitioners should also filter these judgments through the lens of moral reasoning. Moral reasoning entails application of ethical theories, which have been used for centuries in the context of ethical decision making.

In the Western world, since the early 1980s, most professions have paid substantial attention to ethical issues and ethics education. A common goal in professional education and training is to introduce students and practitioners to ethical theories and principles that may help them analyze and resolve ethical dilemmas (Callahan & Bok, 1980; Reamer, 1989, 1995, 2018). These include theories and principles of what moral philosophers call metaethics, normative ethics, and practical (also called applied) ethics (Beauchamp & Childress, 2013). Briefly, metaethics concerns the meaning of ethical terms or language and the derivation of ethical principles and guidelines. Typical metaethical questions include the meaning of the terms right and wrong and good and bad. What criteria should we use to judge whether someone has engaged in unethical conduct? How should we go about formulating ethical principles to guide individuals who struggle with moral choices, for example whistle-blowing decisions?

In contrast to metaethics, which is often abstract, normative ethics tends to be of special concern to behavioral health practitioners because of its immediate relevance to practice. Normative ethics consists of attempts to apply ethical theories and principles to actual ethical dilemmas. Such guidance is especially useful when practitioners face conflicts among duties they are ordinarily

inclined to perform, for example, protecting colleagues' privacy rights and, at the same time, disclosing information pertaining to colleagues' alleged unethical conduct, incompetence, or impairment.

Theories of normative ethics are generally grouped under two main headings. Deontological theories (from the Greek *deontos*, 'of the obligatory') are those that claim that certain actions are inherently right or wrong, or good or bad, without regard for their consequences. Thus, a deontologist – the best known is Kant, the eighteenth-century German philosopher – might argue that disclosing a colleague's wrongdoing or impairment is obligatory, and thus practitioners should never hide or camouflage this information, even if it appears that disclosure might cause significant harm to the colleague's career and, possibly, to the whistle blower and employing agency. In general, deontologists uphold individuals' inherent obligation to tell the truth, keep promises, confront wrongdoing, and obey rules and laws. From this perspective, the ends do not necessarily justify the means, particularly if they require violating some important rule, right, principle, or law (Frankena, 1973; Herman, 1993; Rachels & Rachels, 2015).

The second major group of theories, teleological theories (from the Greek *teleios*, 'brought to its end or purpose'), takes a different approach to ethical choices. From this point of view, the rightness of any action – such as whistle blowing – is determined by the goodness of its *consequences*. Teleologists think it is naive to make ethical choices without weighing potential consequences. To do otherwise is to engage in what the philosopher Smart (1971) referred to as “rule worship.”

Therefore, from this perspective (sometimes known as consequentialism), the responsible strategy entails an attempt to anticipate the outcomes of whistle blowing and to weigh their relative merits (Frankena, 1973; Rachels & Rachels, 2015). Thus, a potential whistle blower should conduct a thorough analysis of the likely costs and benefits that would result from the various courses of action and then act in a manner that leads to the greatest good (or the best consequences). That is, what are the costs and benefits involved in blowing the whistle for all relevant parties?

Teleology has two major schools of thought: egoism and utilitarianism. Egoism is not typically found in behavioral health, although one can imagine some potential whistle blowers embracing it; according to this point of view, when faced with conflicting duties, people should maximize their *own*

good and enhance their self-interest. Thus, a potential whistle blower who thinks egoistically should think *primarily* about the potential consequences of such action on her or his own career and emotional well-being (for example, the emotional torment, impact on one's career and collegial relationships). As Peters and Branch (1972) have noted, "If an employee becomes a damaged good, tainted by a reputation as an organizational squealer, he may find so many doors locked that a drop in station or a change in profession will be required" (p. 280).

In contrast, utilitarianism holds that an action is right if it promotes the maximum good; historically, it has been the most popular teleological theory and has served as justification for many whistle-blowing decisions. According to the classic form of utilitarianism – as originally formulated by the English philosophers Jenny Bentham in the eighteenth century and John Stuart Mill in the nineteenth century – when faced with conflicting duties one should do that which will produce the greatest good. In principle, then, a behavioral health practitioner should engage in a calculus to determine which set of whistle-blowing consequences will produce the greatest good. Does the potential prevention of harm, and holding a colleague accountable for wrongdoing or incompetence, outweigh the possible costs to all involved?

Another important framework that is relevant to whistle blowing decisions is known as virtue theory. The biomedical ethicists Tom Beauchamp and James Childress developed the best-known framework for understanding professionals' virtues in the 1970s when the fields of biomedical ethics and professional ethics were just emerging and gaining prominence. This prominent framework continues to be central to the professional ethics field and is highly relevant to behavioral health. Beauchamp and Childress (2013) identify several core, or "focal," virtues that are critically important in the work carried out by professionals:

- **Compassion:** A trait that combines an attitude of active regard for another's welfare with an imaginative awareness and emotional response of deep sympathy, tenderness, and discomfort at another's misfortune or suffering. Compassion presupposes sympathy, has affinities with mercy, and is expressed in acts of beneficence that attempt to alleviate the misfortune or suffering of another person. Thus, behavioral health practitioners should be concerned about the potential impact of their whistle blowing decisions on the well-being of their colleague, along with the people affected by her or his behavior.
- **Discernment:** The virtue of discernment brings sensitive insight, acute judgment, and

understanding to action. Discernment involves the ability to make whistle-blowing judgments and reach decisions without being unduly influenced by extraneous considerations, fears, personal attachments, and the like.

- **Trustworthiness:** Trust is a confident belief in and reliance upon the moral character and competence of another person. Trust entails a confidence that another will make whistle-blowing decisions with the right motives and in accordance with appropriate moral norms.
- **Integrity:** Moral integrity means soundness, reliability, wholeness, and integration of moral character. In a more restricted sense, moral integrity means fidelity in adherence to moral norms. Accordingly, the virtue of integrity represents two aspects of a person's character. The first is a coherent integration of aspects of the self – emotions aspirations, knowledge, and so on – so that each complements and does not frustrate the others. The second is the character trait of being faithful to moral values and standing up in their defense when necessary. Thus whistle-blowing decisions must be made with integrity.
- **Conscientiousness:** An individual who acts conscientiously when making whistle-blowing decisions is motivated to do what is right because it is right, has tried with due diligence to determine what is right, intends to do what is right, and exerts an appropriate level of effort to do so.

These five focal virtues are linked directly to four core moral principles that, Beauchamp and Childress (2013) claim, constitute the moral foundation of professional practice: autonomy, nonmaleficence, beneficence, and justice. These moral principles clearly have broad application to, and implications for, whistle-blowing judgments:

- **Autonomy:** The concept of autonomy implies self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice. The autonomous individual (for example, a practitioner who is contemplating blowing the whistle) acts freely in accordance with a self-chosen plan. A person of diminished autonomy (for example, a severely impaired practitioner) is in some respect controlled by others or incapable of deliberating or acting on the basis of his or her desires and plans.
- **Nonmaleficence:** The principle of nonmaleficence asserts an obligation to not inflict harm on others. Typical examples include not killing, not causing pain or suffering, not incapacitating,

not causing offense, and not depriving others of the goods of life. Thus, behavioral health practitioners should not blow the whistle primarily to harm a colleague.

- **Beneficence:** The term beneficence connotes acts of mercy, kindness, and charity. Forms of beneficence also typically include altruism, love, and humanity. Beneficence refers to an action done to benefit others, as in blowing the whistle to try to prevent harm and protect vulnerable individuals.
- **Justice:** Various philosophers have used the terms fairness, desert (what is deserved), and entitlement in attempts to explicate justice. These accounts interpret justice as fair, equitable, and appropriate treatment in light of what is owed to people. Standards of justice are needed whenever people are owed benefits or burdens because of their particular properties or circumstances, such as being productive or having been harmed by another person's acts. A holder of a valid claim based in justice has a right and therefore is owed something. An injustice thus involves a wrongful act or omission that denies people benefits to which they have a right or distributes burdens unfairly. Behavioral health practitioners who contemplate blowing the whistle should be concerned about doing that which is just, in light of the rights held by the colleague about whom they are concerned (for example, due process rights and the right to privacy) and the duty to act in accord with potential victims' right to protection from harm.

Risk management: Along with these more abstruse considerations, practitioners who contemplate blowing the whistle should also consider more practical considerations, including possible legal consequences. Whistle blowers run the risk, no matter how small, that the colleague on whom the whistle is blown will deny the allegations, resent the adverse publicity and consequences, and, as a result, file a licensing board complaint and/or lawsuit against the whistle blower. Typically such lawsuits would allege what attorneys label defamation of character. That is, the aggrieved colleague might claim that the whistle blower reported false information that harmed her or his career and reputation.

Defamation occurs when individuals make false statements that injure the reputation of another party and expose him or her to public contempt, hatred, ridicule, or condemnation. Defamation can take two forms: libel and slander. Libel occurs when the communication is in written form – for example, when a whistle blower submits a written complaint that contains knowingly false

information and accusation. Slander occurs when the communication is in oral form – for example, when a practitioner blows the whistle on a colleague during a staff meeting or in meetings with an organization's administrators.

Behavioral health practitioners can be legally liable for defamation of character if they say or write something about a colleague that has three elements: the communication was untrue, the practitioner knew or should have known that the statement was untrue, and the communication caused some injury. Practitioners' defamatory statements about a colleague – for example, about their alleged misconduct, incompetence, or impairment – can cause emotional distress or financial harm or damage to the colleague's career and reputation (Reamer, 2015).

In licensing board cases, the complainant (the practitioner who claims that a colleague made false statements about her or him) only has to show that the respondent (the whistle blower) violated licensing board standards pertaining to ethical conduct. Many licensing boards adopt their profession's national code of ethics, in whole or in part. These codes require practitioners to treat colleagues with respect and prohibit practitioners from making false statements. For example, the NASW Code of Ethics states "Social workers should avoid unwarranted negative criticism of colleagues in verbal, written, and electronic communications with clients or with other professionals" (standard 2.01[b]) and "Social workers should not participate in, condone, or be associated with dishonesty, fraud, or deception" (standard 4.04). Prominent codes of ethics in the other behavioral health professions include comparable standards.

In contrast, in lawsuits that alleged defamation of character, plaintiffs (the aggrieved practitioner who is challenging the whistle blowing) typically claim that the defendant (the whistle blower) was negligent and engaged in malpractice. In general, malpractice occurs when evidence exists that (1) at the time of the alleged malpractice a duty existed between the practitioner and the party who filed the lawsuit (for example, a behavioral health practitioner owed a duty to the colleague to treat her or him with respect); (2) the practitioner was derelict in that duty, either through an action that occurred or through an omission (allegedly, the whistle blower made false accusations or reported false information); (3) the plaintiff suffered some harm or injury (the whistle blowing harmed the plaintiff's reputation and career); and (4) the harm or injury was directly and proximately caused by the whistle blower's dereliction of duty (making false accusations and reporting false information). Breaches of duty are typically known as violations of the profession's

standard of care, that is, conduct that is consistent with the way a reasonably prudent practitioner, with the same level of education or training, should have acted in the same or similar circumstances (Reamer, 2015). Legal judgments against whistle blowers can be costly (in the form of money damages and emotional anguish).

## Conclusion

Whistle blowing decisions should be approached systematically and with integrity, applying state-of-the-art ethical decision-making protocols and considering diverse practical consequences. They are not easy decisions. As Fleishman and Payne (1980) have argued, “There may be other ways to do right . . . than by blowing a whistle on a friend. A direct personal confrontation may serve both public interest and personal loyalty, if the corrupt practice can be ended and adequate restitution made” (p. 43).

Some cases involving misconduct are so serious, however, that the only alternative is to blow the whistle. From a deontological perspective some forms of misconduct, incompetence, and impairment are inherently wrong and must be disclosed, regardless of the consequences to the individuals or agencies involved.

The prospect of whistle-blowing is disconcerting for most behavioral health practitioners. Unethical and incompetent behavior, and the whistle-blowing that sometimes accompanies it, can cause significant problems for both colleagues and whistle blowers. That said, practitioners have an obligation to confront misconduct, incompetence, and impairment responsibly. As Fleishman and Payne (1980) concluded with regard to whistle-blowing in the political arena, “The moral problems caused by other people’s sins are an old story. When one discovers the corruption of a friend or political ally, personal or political loyalties may conflict with legal duty or devotion to the public interest. The high value of loyalty in politics may make the conflict a wrenching one, but on principled grounds the sacrifice of law or public interest to loyalty in such a case can hardly be justified” (p. 43).

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