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Conflicting Stories of Virtue in UK Healthcare: Bringing Together

Organisational Studies and Ethics

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Conflicting Stories of Virtue in UK Healthcare: Bringing Together Organisational Studies and Ethics

Abstract

In recent years organisational theorists have been interested in the tensions faced by healthcare organisations. In this paper these tensions are examined using the virtue approach to ethics of Alasdair MacIntyre. It is argued that although MacIntyre's framework shares many concerns with organisational studies it supplements the analysis with a focus on moral content and evaluation. By providing moral evaluation of the stories told in organisations, an ethical analysis compels action on a basis that organisational studies does not. Nevertheless, it is the analysis of stories in organisation studies that provides the tools for taking action. The analysis presented here provides an example of how ethics and organisational studies can be brought together to provide a stronger analysis of organisational phenomena. Indeed, it provides support for Nielsen's position that organisational theory and ethics are co-dependent and suggests that greater attention should be paid to ethical concepts in the study of organisational phenomena.

Key words

Ethics, Healthcare, MacIntyre, Managerialism, Professionalism, Virtue

Conflicting Stories of Virtue in UK Healthcare: Bringing Together Organisational Studies and Ethics

Introduction

In recent years organisational theorists have been interested in the tensions faced by healthcare organisations. For example, Doolin (2002) examines the strategies used by healthcare professionals when faced with new 'entrepreneurial' discourse in New Zealand. Dent (1995) shows how, in UK healthcare, the tensions between professionalism and managerialism probably creates what he thinks can be labelled post-modern organisational structures. Bloor and Dawson (1994) show how professional subcultures may enter conflict with organisational cultures, which include management, in a healthcare setting. Kitchener (2002) points to similar tensions when examining how managerial innovations are perpetuated by myths in the American healthcare sector. He argues that uncritical adoption of innovations like merger leads to dysfunctional outcomes for organisations. Arndt and Bigelow (2000) show how hospitals use defensive impression management when presenting changes to organisational structures of this sort to stakeholders that include professional groups.

In this paper, the conflict between professionalism and managerialism in healthcare will be examined from a quite different perspective. Indeed, it will be argued that ethicists have also talked about the tensions discussed by organisational theorists for

some time, but in different terms, and that ethics and organisational theory may be co-dependent (Nielsen 2003). Indeed, a broader epistemology, promoted by an ethical view, allows for a different perspective on these issues (Wicks and Freeman 1998). More specifically, focusing on the virtue approach to ethics of Alasdair MacIntyre (1985, 1988, 1999), it is argued that a managerialist approach to healthcare is not just, as Kitchener (2002) believes, difficult to implement, but that it may also make unethical practice more likely.

Virtue, as a concept, has had a revival over the past 30 years, a shift that is paralleled by the "new emphasis on narrative rationality, and the conceptualization as communities of practice [that] can be interpreted as the recovery of certain Aristotelian themes" (Tsoukas and Cummings 1997: 663) in organisational studies. Those committed to modern deontological and consequentialist ethics have reacted by putting emphasis on the elements of virtue in their theories (Oakley 1996). Others have chosen to accept one or another form of virtue ethic. Indeed, it is now possible to discern many different positive accounts of Virtue Ethics from MacIntyre's (1985, 1988, 1999) neo-aristotelian approach based in Aquinas's and Thomist thought, to Foot's (2001) naturalistic account, Slote's (1996, 2001) agent based framework and Swanton's (2003) pluralistic view. These authors have mounted a convincing challenge to modern ethical theory and one that has had significant implications for what is considered to constitute ethical action.

What is common to virtue ethicists' theories is that they emphasise peoples' character. They stress how the good habits or virtues inherent in a person's character give them

the propensity to act in ways that promote good. Good is seen as the ultimate end of humans and incorporates those things that help ensure an individual's or community's well being. When people think about what to do they take into account the available facts and, using the practical wisdom given to them by the virtues, come to a decision (Whetstone 2001). People will consider the consequences of acts for their ability to think about and perform future acts (Koehn 1995), but also whether this leads to good. As Shaw (1997: 36) notes, this requires "... a balanced and coherent notion of the good". This balanced view needs to go beyond the economic and may need to incorporate environmental, social, religious and, importantly for this paper, professional based concepts of well being.

The paper starts with a discussion of MacIntyre's virtue approach and its reliance on practice, institutions, and tradition based in narratives and their associated stories. Healthcare as a profession is then discussed. How healthcare professions fit with MacIntyre's framework and their potential for practice-based virtue are examined here. From this discussion, the paper continues to suggest a predominant story of healthcare and examine the virtues that are associated with it before reviewing the challenging stories that are being put forward from outside of the tradition, stories of managerialist efficiency. Finally, approaches to resolving tension between the virtues put forward by managerialist and professional stories in the context of organisational studies are considered.

MacIntyre's Virtue Ethics and Stories of the Good

The common elements of Virtue Ethics have already been described in the introduction. However, it is important to give a more detailed account of MacIntyre's virtue ethic before it is used in the analysis of UK healthcare organisations. MacIntyre's work is used as it is a contemporary form of virtue and, as such, avoids the contextual problems that might be faced when using ancient philosophers. His work has also been the subject of sustained debate in the field of management (e.g. Beadle 2001, 2002; Beadle and Moore 2006; Brewer 1997; Dawson and Bartholomew 2003; Dobson 1997a, 1997b, 2004; Moore 2002, 2005a, 2005b; Moore and Beadle 2006), meaning that many of the issues faced when applying ethical frameworks to practical areas have already been discussed.

In the face of a range of different lists of virtues, MacIntyre (1985) notes that it is easy to wonder if the virtue approach is one that can be defended. In response, he argues that these doubts stem from a limited understanding of the virtue approach. Indeed, if it is going to be possible to make sense of the virtues they have to be understood in conjunction with the practices in which they are developed, the narrative of the tradition to which these practices belong, and the social institutions with which they exist. These elements are all needed if a person is to achieve excellence in life.

MacIntyre (1985, 1990) argues that the virtues underpin the pursuit of excellence in the practices or craft in which a person engages (Porter 2003). Excellence is reached through the mastery of the internal goods of a practice. For instance, obtaining a deep

understanding and mastery of the strategy of chess would be characteristic of mastering an internal good. External goods, including the monetary rewards and other benefits obtained indirectly because of the activity, rather than directly through the act of doing it, are pursued only to the extent that they support this mastery of internal goods. Still, to suggest that obtaining internal goods was the only objective of mastering a practice would be wrong. The point of a practice is to contribute to the good of humans, both the wider community and individuals. Practices might include medicine, architecture and natural sciences, and a range of other activities, as long as they contribute strategically to this good. In this way, good practice legitimises peoples' activities and actions in the same way that professionalism legitimises organisational decision-making (Bloor and Dawson 1994), structure and values (Doolin 2002; Kitchener 2002).

This leads to the question; what is the wider human good? What is the end that should be aimed at? This, it is argued, will depend on the narrative of the tradition of which a person is a part. What that wider end is will probably be unclear to the individual, at least initially. One of the great advantages of this virtue approach is that it makes people conscious of the tradition they inhabit and alternative traditions. And, of course, they become aware through hearing the stories associated with this narrative. Stories have a leading role in education, a concern that is not missed by organisational studies. Indeed, the role of stories in moral education works in much the same way that Abma (2003), Boyce (1995), Doolin (2002) and Phillips (1995) have shown it to work in organisations. Moreover, Morse (1999) argues strongly that

organisations have the potential to promote virtuous practice and Randels (1998) shows the role that narrative would play in doing this.

Social institutions are both supported and perpetuated by the narrative as they provide the structures through which the practices embedded in the tradition operate. In themselves they may not help people understand the human good, and they may actually divert them from that cause. Nevertheless, like external goods, they are essential to peoples' success in being virtuous. Institutions, here, are structures of social action that are based in communities or wider societies. They may not necessarily have fixed physical or social form (Barley and Tolbert 1997), but nevertheless constitute a binding power to those that recognise them. Within organisations they are likely to manifest themselves tangibly in law and the command of resources. They may also show themselves intangibly through cultural symbols, norms and arrangements (Friedland and Alford 1991) that dictate where status lies and when loyalty is appropriate, much in the same way that Mangham (2003) shows was the case in City financial institutions. To be sure, institutions play a central role in sustaining the power structures of the tradition, Friedland and Alford (1991) noting that much of organisational politics is about the ordering of institutions by different parties who seek legitimacy. Indeed, Porter (2003) shows that who has authority in a tradition, and authority's role in deciding which ideas are dominant, is important when considering a tradition's progress.

The narrative present in a tradition, in revealing the end, influences more than social institutions. The end that is adopted will also affect the concept of practical

rationality, which will, in turn, influence the way people think and the way they act. Moreover, Tsoukas and Cummings show that several organizational researchers argue for the importance of narrative rationality in management and that

Narrative thinking involves the building of a convincing story which attempts to show the coherence between the actions of the individuals involved in a particular situation and the meaning of the situation for them... Such a story will certainly contain knowledge of regularities, or scientific principles, or general values, insofar as they have been available, but will also include the details of particular contexts, local circumstances, and timely events. Knowledge that is narratively organized helps actors integrate the general and the particular. (1997: 667)

This concept of rationality will be reflected in the virtues that are adopted. MacIntyre (1988) shows how within traditions the type of practical reasoning adopted will have to fit with the tradition's understanding of what he sees as the key virtue, Justice. Of course, it will not only be Justice that will be influenced in this way. All of the virtues that surround Justice will also have to fit within this network. So, people develop the good habits and, in turn, the virtues essential to action by witnessing, imitating and learning from the people around them in organisations (Murphy 1999) or professions. In effect, they will learn from professional or organisational traditions.

The framework a particular tradition follows will have its own, maybe unique, focus. Its stories will emphasise certain aspects of the way people live as being problematic

and hence, certain ways of acting as solutions to these problems. Moreover, people will discuss those problems and not others. This means that when examining a tradition, and trying to understand it, it is important to focus not only on what it is saying, but also on what it avoids saying much in the same way as when examining organisational politics (Friedland and Alford 1991; Kitchener 2000). Only by understanding both what is and what is not discussed can people have a full appreciation of the tradition's influence on the way they live, their attitude towards virtue and the content of any approach to virtue that is adopted.

Once again, reflecting concerns similar to those considered by political science (Friedland and Alford 1991), MacIntyre (1988) also considers how different traditions compete. He starts with the proposition that people from a particular tradition will often fail to recognise the legitimacy of the point of view put forward in another tradition's stories. Two sets of circumstances might lead to this. First, the traditions may not share common concepts and therefore they will not recognise common issues. In addition, they may not have a common language of concepts and therefore, they will not be able to understand the other tradition's discourse. Put simply, people from one tradition are blind to the other tradition. The second reason relates to the standards held by those who adhere to each of the traditions. Those who adhere to competing traditions may understand common concepts and may share a common language to discuss them. Still, the traditions may hold different standards that conflict with one another and this will lead them to dispute the view contained in the other's discourse. In the short term, these disputes may leave the traditions in opposition. For example, Boyce (1995) shows how members of an organisation who

did not have direct influence on its discourse were likely to resist the challenging stories introduced by management, many of them eventually leaving when they were not successful.

In the longer term, there is more opportunity for a predominant tradition to falter or fail and other traditions to gain ascendancy. Where a tradition faces a lack of progress – in the terms of progress as it is seen in the context of the tradition – its adherents will begin to question its ability to sustain itself. This questioning is the basis of an epistemological crisis. The tradition will need to rewrite its stories by drawing on new resources so that they give the tradition a new focus and solve the crisis, or face internal dissolution. Internal dissolution may lead to encounters with rival traditions as people look for new resources or alternative traditions and, ultimately, submission or merger. Of course, the other alternative is that the tradition faces complete failure on its own terms or defeat by another tradition.

What is important in MacIntyre's (1988) argument when examining tradition, narrative and virtue is that he argues that for traditions to understand each other they must understand each other's language. They must understand not just at the level of rote learning, but as if it were their first language. This entails that they have a full appreciation of the culture, way of life and way of thinking in the other tradition. This inevitably means that, to some extent, they have to belong to the other tradition. Is it, then, not inevitable that one tradition that understands another tradition has the potential – even unknowingly – to adopt another tradition's perspectives on at least

some issues? Put another way, it seems that through language, and thereby storytelling, there is the potential to change traditions.

Healthcare - Practices, Traditions and Social Institutions

Having outlined MacIntyre's virtue approach and drawn comparisons with areas of organisational studies, it is now important to examine how healthcare organisation fits with his framework. It is argued that public healthcare in the UK mirrors MacIntyre's framework and provides a context in which virtuous practices, traditions and social institutions may already exist in the context of professional organisational structures. That this is the case can be demonstrated by reference to the professional networks that underpin the public health services in the UK. In short, the pledges made by health care professionals, the traditions associated with their professional organisations, and the professional and employing organisations themselves provide the framework in which virtue has the potential to flourish. This part of the argument will be developed in three stages. First, the link between professionalism and practice will be developed to demonstrate that healthcare roles give the basis for virtue. Second, that the professions rely on traditions when educating medical practitioners will be demonstrated. Finally, it will be shown how the medical professions rely on the resources offered by their own organisational structures and the employing organisations.

Medical Professions as Practices

It is not always easy to get agreement on what it is to be a professional. This is important as if there is no agreement on the defining characteristics of professionals it will not be possible to make the link between professions and practice. Indeed, to argue that professions are practices, in the way that MacIntyre would use the term, in that they work towards human good, it is important to have a clear idea of what a profession encompasses.

It is clear that many managers would argue that they are professionals. On the face of it this might be so, but this is in the most part a result of two trends rather than a reality. The first trend is that recent common usage of the word professional has changed so that it is used to describe things that would be better served by words like expert, efficient and effective. This is inaccurate use of the term professional. Whilst to be expert, efficient and effective might be desirable qualities in professionals they are not necessary conditions of professional status. The second trend is the drive for professional status. This trend seems to have been encouraged by certain occupations' desire for status and, to some extent, the quest for monopoly power. Occupations related to purchasing, human resource management and marketing have worked towards professional status on this basis. It is nevertheless doubtful if these occupations meet the criteria for being professions or, more importantly, are recognised as such by the populace at large.

So, what is it to be a professional? Koehn (1994: 56) draws on five frequently cited traits amongst those used to define professions, they:

- "are licensed by the state to perform an act;
- belong to an organisation of similar enfranchised agents who promulgate standards and / or ideals of behaviour and who discipline one another for breaching these standards;
- possess so-called 'esoteric' knowledge or skills not shared by other members of the community;
- exercise autonomy over their work, work which is not well understood by the larger community;
- publicly pledge themselves to render assistance to those in need and as a consequence have special responsibilities or duties not incumbent upon others who have not made this pledge."

She goes on to argue that, of the five, only the last can truly differentiate professions from other groups. It is only professionals who pledge to work for clients with the objective of a particular good, a good which, it may be added, will have a moral dimension (Bien 1998; Koehn, 1994). This leads Koehn (1994: 59) to define a professional as an "agent who freely makes a public promise to serve persons (e.g. the sick) who are distinguished by a specific desire for a particular good (e.g. health) and who have come into the presence of the professional with or on the expectation that the professional will promote that particular good".

This means that many people that are now referred to as professionals are not, in the strict sense in which the term is being used here, professionals. Whilst marketers, human resource managers or accountants may be given ‘professional’ accreditation, how many of them can convince people that they are working for a specific good, or create a clientele based in trust generated by serving generation after generation of families in a particular community? Moreover, where Bien (1998: 394) notes “virtuous character... is an essential ingredient of being a professional”, could they convince people that they consciously work towards virtuous ends?

Still, many who work in the context of healthcare do have the potential to meet this definition, whether they be scientists, medics or, indeed, managers. In working for the health of their patients, healthcare professionals are working for the good of their clientele. Healthcare professionals work for the wider good of their communities over time. When talking about nursing, Sellman (2000: 29) argues that healthcare roles cannot be engaged with “...merely as the inclination dictates, indeed nursing is the kind of practice that demands a degree of commitment...”.

Baylis (1999: 26) argues that the healthcare professional needs “to be a person of character or virtue”, and that in healthcare this requires them to develop a deep understanding of health. It is this deep understanding of health and the concomitant commitment to the community that promotes a narrative unity for healthcare professionals’ lives (Sellman 2000). It is these very aspects of true professionals that make them compatible with MacIntyre’s virtue approach and shows that they are, in fact, part of a practice.

Indeed, a true profession has a unique perspective on virtue and is a valuable source when considering what is virtuous. Oakley and Cocking (2001) argue that the medical professions have knowledge and skills that allow them to aim for ends that are strategic in nature in that they aim for specific human goods and have standards that show what to follow the good of health will look like. The professions provide the clear structures and standards that underpin their practice. Of course, these standards are communicated through the tradition and stories associated with the healthcare professions.

Medical Traditions and Education

It has already been shown how education is important to virtue ethics as a practice. Healthcare as a practice is no exception. Medics go through extensive training, the average nurse completing a three-year degree and then two years of additional training, and doctors following five years of study, residency and then specialist training. But it is not the amount of formal training that is at question here. It is the nature of that education and the education that continues throughout a medic's career. A medic's education is as much about being socialised into the tradition of medicine as it is about formal education. In Beadle's (2002) terms, medics undertake an apprenticeship. And if a person cannot get through the apprenticeship or conform to the common practices it is likely that they will not be a good (virtuous) medic.

Traditions have important implications for the way medics work because they concern issues that have very real ethical consequences.

That this is the case can be demonstrated by looking at some of the stories that are told by medics. For example, there is the story of the new doctor who cared a lot for their patients. However, the doctor became so involved that they were unable to recommend the potentially dangerous treatments that their patients really needed. Whilst this might seem like a trite and simplistic story, it raises significant moral issues about professional detachment in medicine. Likewise, Oakley and Cocking (2001) and Gauthier (2002) debate the role of professional discretion. To what extent a medic should use their own discretion will be inherent in the standards and norms of the profession. In medicine, regulations cannot account for all the situations a doctor is going to encounter, so the focus has to be on whether doctors, in exercising their discretion, meet the end of promoting health. Oakley and Cocking (2001) rightly note that there are still side constraints that need to be considered. Efficiency, justice and patient autonomy are three they mention. They argue that it is not for a doctor to ride roughshod over patients' wishes. Still, it would be right for them to use their discretion to stop the patient from embarking on a course of treatment that would be counterproductive. So, stories clearly have a very real influence on the everyday technical operation of medics by helping to indicate how the practice's standards should manifest themselves (Jones,1999).

Stories also have a significant role in educating medics and non-medics alike about the right ends of medicine. These stories set the broad parameters for what society

expects from the profession. With healthcare, it may be argued, these ends are to promote health and patient well being in a way that is characterised by compassion and care and that these form the basis for medicine's tradition of enquiry (Porter 2003). Indeed, if this is found to be the case it would be a right end in MacIntyre's view.

Medical Institutions

Having made the case that healthcare is a practice, one that is supported by traditions that promote virtues, it is important to make the final link to MacIntyre's (1985) framework for virtue and move on to examine the social institutions that support medical practice and healthcare more generally. Two sets of social institutions support medicine: the professional institutions, including the British Medical Association (BMA) and the Royal Colleges; and the employers that, in the UK, are dominated by the National Health Service (NHS).

The foundation of the professional medical associations significantly precedes the foundation of the NHS. For example, the BMA has its roots in the Provincial Medical and Surgical Association founded in 1832 by Sir Charles Hastings, and became the British Medical Association in 1856 (BMA 2003). These professional associations provide the institutional frameworks through which the medical professions are fostered. They support their members in a number of ways. In particular, they provide an independent forum for debate within the profession, lobby government on

health issues, and play a role in educating their members. These are the very activities characteristic of virtuous practice as MacIntyre describes it. Whether these institutions actually promote virtue is, of course, another thing entirely and a point on which their legitimacy may be judged (Murphy 2003). Still, it is important to recognise that the NHS, which employs most UK healthcare practitioners, is an institution that also has a significant role to play here.

The NHS was founded in 1948 in response to a variety of pressures. Before the NHS was founded medical provision was chaotic and verging on breakdown (Klein 2001). General practice was delivered through a combination of private and local authority practitioners. Some hospital provision was provided by local authorities, but more commonly by a voluntary sector that depended heavily on the contributions of their more wealthy patients. It was becoming obvious that the voluntary sector could no longer be sustained and that it would struggle to meet the challenges of the future. Moreover, there were inconsistent levels of provision across the country, some areas having wholly inadequate provision. Added to this, in many families, only those who worked had access to healthcare – through their National Insurance payments – often leaving the others with inadequate cover. These factors converged so that the voluntary sector, professional bodies, local authorities and central government all saw the need to radically alter the way healthcare was provided (Klein 2001).

The response to these challenges could have taken one of many forms. That the solution was to be a national health service reflects the ideals of some of those influential in making the decisions that led to the formation of the NHS. These are

ideals that are reflected, and supported, in the objectives and structures that, to a greater degree, still guide the organisation today. These structures have passed beyond being a mere means to the end of healthcare, and have become accepted to the extent that they are institutions (Barley and Tolbert 1997; Friedland and Alford 1991). As institutions, these structures have the potential to support the virtues that are associated with a particular view of healthcare. Indeed, now that it has been shown that healthcare organisations in the UK mirror MacIntyre's framework it is important to consider the ideals and, in turn, virtues that they promote. To do this requires consideration of the traditions that exist in the context of this framework and stories of healthcare in the UK. Although professionals, managers and patients tell many stories about UK healthcare, two that are relevant to the conflict between professionalism and managerialism have been sustained over recent years (Klein 2001).

The Predominant Story of Healthcare

So what is the predominant story that has surrounded healthcare in the UK over the past 55 years? This story is best told with reflection on the ideals that guide the professions and underpin the social institutions that support medical practice. As has already been noted, the NHS was formed in response to a number of pressures. That it was formed as it was owes much to the commitments and ideals of those involved, commitments to equality and care through professional excellence.

The inequalities that existed in the ability of people of different means to access healthcare, and the geographical inequalities in the provision of general practitioner and hospital services, were offensive to those who lobbied for changes in the healthcare system. The commitment to equal and free access to medical services is still fundamental in garnering support for the NHS. In social terms, it ranks alongside the ability to vote, and the right to trial by jury in promoting social justice. In this, it has become an integral part of the nation's psyche. Whilst the NHS has had to grapple continuously with issues of funding, the principle of equal access has won through with only minor concessions (Klein 2001).

This right of access to medical assistance is also characterised by the focus on care. At a policy level this is reflected in an approach that focuses on prevention as well as cure, an approach that encompasses education, through health campaigns and medical advisories, and vaccination programmes, in addition to tertiary care. This reflects a paternalistic approach based in beneficence. Care is also reflected at the level of practice, with medics that show a commitment to the well being of their patients. They will typically show compassion for the patients' plight and consider the widest context of their circumstances when making decisions. For example, patients who live by themselves may need different care to others and a longer period of convalescence in hospital than would be necessary if decisions were made on the basis of medical facts alone. Healthcare, rather than medicine, focuses on the wider picture, a picture that recognises a pastoral responsibility that requires a commitment to the members of the community.

Of course, to do this, medics need to build relationships with their patients. Only by developing a sustained relationship will they be able to understand the development of patient's medical conditions. Moreover, only through the development of trust based in these relationships will patients feel able to talk freely about personal issues. Sustained relationships create the conditions that support the honesty that allows doctors to make good decisions. Indeed, it is only in the context of doctor patient relationships that the practice and science of medicine show themselves. Science is, nevertheless, fundamental to the story of healthcare.

The nature of medicine calls for practitioners to show a combination of humility and courage. The sheer complexity of medicine means that the medic needs to be able to recognise the limits of their understanding and, for that matter, the limits of the profession's understanding. And this requires humility. This is not to say that people should submit to their ignorance. Rather, it is to say that, in the short term, people should be prudent, have patience and work within their limits. In the long term, science can help overcome ignorance and promote understanding of those areas of healthcare that currently leave people perplexed. Indeed, there is considerable value in close observation and exploration of disease. By developing a detailed knowledge of a disease the ground is prepared for new medical solutions. Only once this knowledge has been developed do medical practitioners need to have the courage to break new ground and make medical advances.

This complexity also raises other, more personal, issues of virtue for medics. The nature of medical decisions means that medics cannot rely on hard and fast rules.

They have to make judgements. This means, in a very real sense, that a medical practitioner's actions belong to them, they are responsible for their actions. This takes courage in that the medic needs to act where an outcome is not always certain. It also means that they have to possess the humility that limits that courage so that they will know when they need to stop, hold back and seek advice from others. Medics have to become sensitive to when action is necessary and where it is foolhardy, and this is a distinction that it is hard to make.

This story focuses on a number of virtues. At the forefront is the *propensity to care* that is supported by *compassion* and *beneficence*. *Fairness* is also dominant through the focus on equality. *Humility*, *patience* and *prudence* also have a major role in determining when it is right to act, and when it is best to seek advice first. And *courage* is important not only in the everyday making of decisions for which the medic is responsible, but also in the process of making scientific progress. Although Oakley and Cocking (2001) work with a very different conceptual basis for virtue than MacIntyre, one that rests on the idea of a regulative ideal, they argue for similar virtues. They identify six virtues, beneficence, truthfulness, trustworthiness, courage, humility and justice and give the following examples of how they would manifest themselves. Beneficence is to focus on the patient's needs. Underpinned by compassion, this limits medics from performing unnecessary actions as well compelling them to perform those that are needed. Truthfulness serves patients health as it helps them make informed decisions for themselves. Trustworthiness helps in making the open communication needed between doctor and patient possible. Courage may be important for a doctor who has to treat highly infectious or

dangerous diseases. Humility is the ability to concede when the limits of knowledge have been met. Just doctors will ensure that only morally relevant issues affect the provision of healthcare. Indeed, the mutual emphasis on beneficence, courage, humility and fairness / justice seems to point towards their status as core virtues in healthcare.

A Challenging Story of Managerial Efficiency

The predominant story of healthcare presented above is embedded in the dominant commitments of those who formed the NHS in the 1940's and 1950's. Their efficacy is supported by the fact that they have remained more or less intact despite major financial pressures and recurrent organisational restructuring. Nevertheless, society has changed dramatically in the period since the 1950's and this has generated new challenges for healthcare. Advances in medical science, whilst welcomed, have put new pressures on resources. People are also living longer and the proportion of people over the age of 65 in the UK has increased from 11% in 1951 to 16% in 2001 and the number of people over 85 increased by 29.6% between 1991 and 2001 alone (HMSO 2003). These trends have meant the demands on healthcare services have increased dramatically.

In addition, disposable incomes have increased and the customer and the market have gained ascendancy in many areas of society. In turn, this has generated new expectations in the population in general, and there has been no exception where the

expectations of healthcare are concerned (Dent 1993; Doolin 2002; Klein 2001). The tensions caused by medical innovation and changing expectations have been a continuing theme in the NHS since its inception, but since the mid 1980's governments have turned to management as a solution (Dent 1993; Klein 2001). These changes are important for the discussion here because they form the basis of a new story of healthcare, a story that emphasises managerialist efficiency. It is time to examine this story.

The challenging story of healthcare in the UK starts with management. Although management can be cast as neutral, as a set of tools or mechanisms, to use technical metaphors, in this story it is anything but neutral. Management is an agent of change and managers are people who have the courage and skill to take on the vested interests of healthcare professionals, local authorities, pharmaceutical companies and other groups and win. Winning, here, means generating efficiency. Of course, efficiency is multifaceted. Here it is about generating more output in terms of medical treatments, providing better quality care and thus allowing more people access to treatment. At the same time, it is about limiting the cost of healthcare. After all, it is not only the NHS that has a claim on government funding.

Science is the ally of efficiency. Better medical techniques help treat patients in more efficient and effective ways. The treatments are cheaper and recovery times are better meaning that fewer expensive hospital beds are needed. Science has the potential to revolutionise the way medicine is practised, but with this comes a shift in emphasis. The ideals of entrepreneurialism rather than care lead the way.

Management science also has a role to play. Advances in the manager's tool kit will enable them to design more efficient processes, manage staff more effectively and predict demand more precisely. In designing better processes, managers will reduce the time wasted by unnecessary tasks, costs associated with practices that add little value and, where it will be of benefit, transfer tasks to other organisations. These processes aim at changing the culture and attitude of staff towards one another, but also towards patients. Managers want staff to focus on the patient's service preferences as well as their medical needs.

In aiming to provide for customer preferences, managers will want to measure what is going on. Through surveys and other feedback mechanisms they will be able to find out what patients want and how well the organisation is meeting medical needs and service preferences. As they gather more information they will become better at predicting demand and developing efficient solutions to those demands. Indeed, by recasting patients as customers, managers adopt an alternative approach to providing healthcare. With this approach patient choice is an equal to medical need. What follows is a commitment to a limited market. This suits managers, as the mechanisms of the market are amenable to their measurement techniques. The shift to the market allows them to take control. If they are doing well they will be carrying out more treatments and attract more patients and be able to prove it. They will be able to demonstrate that they are providing value for money, whether through a better product, price or both.

Another point becomes clear here. Customers may be weak as individuals, but as a group in a market they have power over what is produced and how. There is, then, a role for the market in directing managers, medical providers, scientists and pharmaceutical companies. As consumers in a market, however limited, people can begin to show what they find unacceptable, acceptable and what they need or want. The implications are that consumption through the market provides a basis for social exchange in the healthcare arena. By consuming healthcare products people tell managers what they want and the healthcare sector responds by offering new innovations.

So, which virtues come to the fore with this managerialist narrative of healthcare? It seems that, as it is presented here, it demands six: *courage, managerial competence, innovativeness, responsiveness to customer, restraint, and market awareness*. *Courage* is needed in making the tough decisions that need to be made by medics, but also in working towards efficiency in the politically charged arena of healthcare. *Managerial competence* is a virtue in the sense that it supports the drive for efficiency, meaning that more patients will be treated when, as a society, it would not otherwise be possible to do so. *Innovativeness* is also a virtue in that it generates the progress that is so central to the advancement of medical practice and success in medical or scientific endeavour. The ability to innovate is necessary if the advances that medicine thrives on are going to occur. *Responsiveness to customer* is important if resources are to be directed in a way that is seen as effective by society. This responsiveness is supported by two virtues. First, the energy of the virtues discussed so far often needs to be tempered by *restraint*. The restraint spoken of here is based

in patient autonomy, that is, in the freedom of choice patients have in the healthcare market. Second, is *market awareness*. Managers with this virtue will respond to the signals communicated through patients' consumption patterns about what it is they find acceptable and unacceptable in medical provision.

Conflicting Views of Virtue in Healthcare

The striking thing about these stories is that they both exist, and are supported by people, in the NHS. That is, it is people in the NHS that tell both of these stories. They represent their constructed realities. The stories are also selectively constructed interpretations of events that those people have lived through. And here lies an important feature of stories. As Phillips (1995: 29) notes, they allow for "doubt, uncertainty, contradiction and paradox, aspects of organization that necessarily disappear under 'rigorous' analysis."

That this uncertainty and contradiction exists is not surprising where traditions are competing, and a long line of organisational theorists have argued that professionalism and managerialism compete in the context of healthcare organisations (Doolin 1995; Kitchener 2000, 2002). It is in this context that analysis of these stories takes place. The predominant story of healthcare based in the ideals of those who set up the NHS emphasises care and equality. The newer, challenging story is one that stresses virtues that have their foundations firmly in managerialist

assumptions of efficiency and systems of consumer-based capitalism that, as well as being economic, play a political role.

The claims of the managerialist story may not, on the face of it, be of concern. Why should it matter that a set of virtues is based in neo-capitalistic managerialist assumptions? It is when these assumptions are examined in the context of MacIntyre's framework that it becomes clear that it may matter. The story emphasises a world where the manager's job is to marshal resources so that they are utilised effectively.

The manager treats ends as given, as outside his scope; his concern is with technique, with effectiveness in transforming raw materials into final products, unskilled labor into skilled labor, investments into profits... [They] purport to restrict themselves to the realm in which rational agreement is possible – that is, of course from their point of view to the realm of fact, the realm of means, the realm of measurable effectiveness (MacIntyre 1985: 30).

What MacIntyre (1985) would see as problematic here is, first, that the story of managerialist efficiency focuses on a narrow range of ends. In focusing on efficiency and choice it places its attention on those things that are measurable at the expense of the less measurable, socially and community based ends of the predominant story. For example, the drive to wider access is no longer based in ideals of fairness and equality. It is now based in the ideals of efficiency.

This leads to a second but related point that, compared to the predominant story of healthcare, stories of managerial efficiency allow external goods to take precedence over internal goods. It is important to note that elements of the managerialist narrative are attractive to those who follow a virtue approach. It is important that healthcare professionals receive sufficient external rewards to live comfortable lives, healthcare institutions have the funds to sustain suitable buildings and equipment, and so on. However, where external goods are allowed to take precedence it will actively drive out the virtues (Beadle 2001, 2002).

An example of where this would be the case is where when allocating treatments healthcare professionals focus on meeting their efficiency targets rather than treating those most in need. The internal goods are subverted by the need to ensure that targets are met and external goods maintained. Efficiency comes to dominate the needs of the community. For MacIntyre (1994) any story where managerialist efficiency is dominant is likely to subvert the good of the community and is unlikely to be sustainable in to the longer term. Indeed, it is questionable if the virtues promoted by these stories can actually be virtues.

It becomes clear that, whilst it is important to generate external goods the challenging narrative promotes, the internal goods associated with the predominant narrative of healthcare need to remain to the fore. Indeed, the status of healthcare professionals as virtuous will depend on them maintaining the internal goods of their practice. If this point is accepted the question becomes how medics might promote a proper balance between internal and external goods and defend the virtues of healthcare.

Organisational Studies and Defending the Virtues of Healthcare

When defending the virtues of healthcare it is important to understand the dynamics of stories as they work in organisations, only then can they be put to work on the healthcare professional's behalf. The organisational studies literature can help here. Abma (2003) and Boyce (1995) show how people in organisations develop stories that both centre people on particular ways of doing things and introduce divergent stories when they want to challenge the status quo. Abma (2003) shows how stories focusing on palliative care reflected the values of staff in a Dutch healthcare organisation. These narratives challenged the predominant narratives and promoted change. The stories acted to educate employees into new values. Boyce (1995) shows how the telling and retelling of stories in a Christian charity helped centre the employees on the agreed objectives of the organisation. This centring not only promoted particular ideals but also gave a template for action. Only later, when management wanted changes, were new stories introduced.

In the NHS the stories of management and entrepreneurship are acting as the challengers and the retelling of these stories, if allowed to go unchecked, will lead to a shift away from care and equality. A defence, then, has to be based in stories that centre, or re-centre, the medical professional on care and equality. But saying this, in itself, has little effect. However, Bloor and Dawson's (1994) discussion of conflicting

cultures and Doolin's (2002) discussion of discourse in healthcare help identify strategies that have the potential to defend virtuous healthcare practice.

In a study of an Australian healthcare organisation Bloor and Dawson (1994) found four types of professional subculture: enhancing, dissenting, orthogonal and deferential. Whilst enhancing and deferential subcultures supported the dominant culture "...the dissenting subculture... was shown to offer the possibility for innovation and change... and the orthogonal subcultures were shown to offer the potential for redefining shared values..." (Bloor and Dawson 1994: 292). When it is considered that Bloor and Dawson (1994) argue that the codes and schemas that underpin these subcultures are learned through education and ongoing socialisation on the job, the similarities with the process of education into a tradition is striking. Indeed, it suggests that where new narratives have been introduced to the organisation, subcultures based in professional associations can be used to resist or subvert the new message. In Shaw's (1995: 855) words, a professional "...mediates the tensions between the good of the profession and that of the whole." And this leads to the next point. Whilst managers have the power to release their stories into the organisation through organisationally sponsored media, professionals have as much power to communicate their own stories. They can communicate to members of their profession through their own channels and with the wider public through the mass media. As Doolin (2002) shows, professions have an independent power base and they can use this power base to defend the narrative of care and equality.

Given that professions have this power to promote their own stories, what actions might they try to promote? Doolin (2002) shows that different groups of healthcare professionals in New Zealand met the introduction of an 'entrepreneurial' narrative, similar to the managerialist narrative introduced to the UK, in different ways. Some used the opportunities offered to strengthen and promote a new identity for their profession. In effect, they assimilated the new stories into the profession, neutralising the elements that they found threatening. Other professionals, those who worked part of their time in private practice as well as public healthcare, ignored the new narrative and worked as they always had, safe in the knowledge that they could leave public practice if they were put under excessive pressure to change. Finally, those professionals who did not see the potential for assimilation or have the ability to leave public practice, tended to resist the narrative. This suggests three strategies: to assimilate, ignore or resist the new narratives.

Assuming that healthcare professionals wish to defend the predominant narrative, it might be assumed that all three strategies would be used. So, professionals and their associations may assimilate stories of efficiency into their stories, at the same time ensuring that the ideals of equity and care are maintained. Instead of limiting face-to-face time with patients, new stories may emphasise streamlining of back office bureaucracy. Alternatively, without actively resisting stories of efficiency professionals may ignore the new stories. Against the background of national policy that emphasises efficiency, local budgets and activities may continue intact. Finally, active resistance may take place where assimilation and ignoring policies is not possible or acceptable. Through their professional bodies medics can question the

efficacy of managerialist narratives that are being introduced to healthcare by releasing stories that re-centre people on the virtues of care and equality. They can then build a social consensus around these virtues. In turn, this can be used to create political pressure for change.

Conclusions

This paper examines a topic that has received much attention in the organisational studies literature, conflict between professionalism and managerialism. It examines it from a very different perspective, that of ethics, using Alasdair MacIntyre's (1984) virtue ethics framework. Indeed, the paper leads to two clear conclusions, one that concerns which virtues might be preferred for UK healthcare and another related to the relationship between organisational studies and ethics.

It is clear that UK healthcare provides a context in which virtue has the potential to flourish. Still, the tensions between professionalism and managerialism in healthcare mean that different groups promote different stories of healthcare, two of which are examined in this paper. The first, the predominant narrative, presents what is argued to reflect the current position in healthcare, where the virtues associated with care and equality are dominant. In the second, challenging story, managerialist efficiency based in science and the markets is at the fore. Both narratives are positive and they are both about making things better. However, when examined against MacIntyre's (1985) framework for virtue the challenging story of managerialist efficiency, in

emphasising external goods, runs the risk of diverting professionals from the ends a virtuous agent would count as being worthwhile. It is the predominant story of healthcare, with its emphasis on internal goods of practice that is more likely to promote ethical action and sustain professional practice. On the basis of this ethical analysis it is this story and the virtues of care, compassion, beneficence, humility, patience, prudence, and courage that are to be preferred and defended.

Using ethical concepts and frameworks has provided an alternative perspective on the tensions between professionals and management in healthcare than might be expected in mainstream organisational studies literature. Although MacIntyre's (1985) ethical framework shares many concerns with organisational studies – both being concerned with roles, traditions, and structures – it supplements the analysis with a focus on moral content and evaluation. By providing moral evaluation, an ethical analysis compels action on a basis that organisational studies does not. It provides a basis for ethical action. But it is at this stage that ethics returns to organisational studies. It is the analysis of stories in the context of organisations that provides the tools for taking action. The analysis presented here provides an example of how ethics and organisational studies can be brought together to provide a stronger analysis of organisational phenomena. Indeed, it provides support for Nielsen's (2003) position that organisational theory and ethics are co-dependent and suggests that greater attention should be paid to ethical concepts in the study of organisational phenomena. Indeed, it seems that organisational studies and ethics would often do better working as one.

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