Journal of Health Care Communications
ISSN: 2472-1654

Open Access Research Article

Doctors Can Step into the 'Rough Ground' with Con idence: Con irmed Route to Cultivate Practical Wisdom in Ethical Decision-Making for the Medical Community

Aisha Y Malik[1*], Mervyn Conroy[2], Catherine Hale[2], Chris Turner[1]

[1]*Department of Continuing Education, University of Oxford, Oxford, UK*

[2]*Department of Health and Management, University of Birmingham, Birmingham, UK*

[3]*Department of Medicine, University of Warwick, Coventry, UK*

[4]*Department of Emergency Medicine, University Hospital of Coventry and Warwickshire, Coventry, UK*

ABSTRACT

Background: Medical practitioners and academics are calling for an alternative process to following clinical guidelines that takes the particularities of the context into account. We argue that the concept of the phronesis virtue when encapsulated in a non-guideline based educational programme provides a way to navigate the complexity and variety of patient cases and arrive at ethically wise decisions. The foundational research of the resource used in the programmes, Phronesis and the Medical community (PMC), sought narratives from doctors on what making ethically wise decisions means to them. What emerged is a 'collective practical wisdom' resource in the form of a film series and app. This paper provides a thematic evaluation that indicates that when this resource is integrated into education on ethical decision-making, participants apply their learning to a phronetic approach to decision-making practice.

Methods: Two main questions were asked: 1) Do these resources in educational or Continuing Professional Development (CPD) programmes support practitioners in cultivating practical wisdom?; 2) What is the experience of educational providers and medical practitioners when using these resources to enhance ethical decision-making?

Results: The findings provide answers to those questions under two main themes: 1) Impact on practice; 2) Impact on education.

Received:	05-December-2023	**Manuscript No:**	IPJHCC-23-17863
Editor assigned:	09-December-2023	**PreQC No:**	IPJHCC-23-17863 (PQ)
Reviewed:	23-January-2024	**QC No:**	IPJHCC-23-17863
Revised:	06-January-2025	**Manuscript No:**	IPJHCC-23-17863 (R)
Published:	13-January-2025	**DOI:**	10.36648/2472-1654.10.1.63

Corresponding author: Mervyn Conroy, Department of Health and Management, University of Birmingham, Birmingham, UK; E-mail: m.conroy@bham.ac.uk

Citation: Malik AY, Conroy M, Hale C, Turner C (2025) Doctors Can Step into the 'Rough Ground' with Confidence: Confirmed Route to Cultivate Practical Wisdom in Ethical Decision-Making for the Medical Community. J Healthc Commun. 10:63.

Copyright: © 2025 Malik AY, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

© Under License of Creative Commons Attribution 4.0 License
This article is available in: https://www.primescholars.com/healthcare-communications.html

Conclusion: The implications are that the resource and associated dialogical learning approach can be employed by medical educators and practitioners with confidence that they will make a difference to practice. The wider implications are that other professions can benefit from this resource through bespoke application.

Keywords: Phronesis; Decision-making; Virtue ethics; Medical practice; Moral debating; Resources

INTRODUCTION

This paper summarises the 'Phronesis and the Medical Community (PMC) follow-on impact and engagement' study findings [1,2]. The aim was to assess the impact of the educational resources and learning approach adopted from the original PMC research project [3]. The focus here is on educational programs delivered with medical practitioners' in medical schools and post graduate CPD. It is what participants reported as the impact on their ethical decision-making practice for patients and their communities that was of most interest and in particular the 'field' where practical wisdom was being cultivated out in the 'rough ground' [4].

Background: The aim of the three-year PMC research project was to improve patient care and community well-being through gaining better understanding of ethical decision-making for the medical community [5]. The PMC project applied practice virtue ethics and phronesis based ethical decision-making theory that went beyond professional guidelines in order to be applicable to complex and multi-layered clinical decisions [6,7].

The significance of the PMC project lies in the response and contribution to calls from academic literature, practitioner community and policy bodies to provide phronesis-based ethical decision-making theory and learning that does not lead to yet another set of guidelines [3].

Ethical decision making in healthcare is under increased scrutiny due to endless media reports of healthcare scandals and its complexity has grown with demographic changes, lack of funding, staff shortages and higher public expectations. The sheer number of decision guidelines for doctors to follow has become unmanageable leading to a crisis in evidence-based medicine [8]. Calls to provide alternative ethical decision-making have grown over recent years building on Dunne's philosophical argument that exposes the limits of scientistic assumptions and Tyreman's contextually relevant assertion of the correcting role of phronesis (practical wisdom) [9]. In the former, Dunne suggests that this is a move back to the 'rough ground' of using practical experience and wisdom rather than formulas to reach decisions. Dunne's seminal contribution is a clear challenge to professional education which promotes and practices scientific objectives, outcomes and evaluations. Add to these the importance of value-based medicine so that decisions made are of value to a particular patient rather than a generic type of patient [10]. Responding to the call, the PMC research offers theory on the use of phronesis in medical decision-making, by providing an alternative as a complement to a deontological, professional guidelines approach and not as a pure replacement.

The evaluation findings in terms of impact described in that collective feedback are framed in two main areas:

- Participants used 'the resources' to cultivate their phronesis to develop an alternative approach to ethical decision-making for patients and the wider community.
- Where 'the resources' have been integrated into medical education, they have allowed students and trainees to learn from their application to ethical decision-making. It has transformed the way medical ethics is approached and taught in some medical schools, post graduate and CPD programmers.

This paper presents the impacts above in the form of the qualitative feedback received from participants. Before this, we discuss briefly both the PMC research context and the methodology used to assess the impact.

Making the right decision, both clinically and ethically, for their patients is an important part of a doctor's daily practice. The associated complexity of these decisions, operates at different levels with potential for moral distress or injury for the clinician; phenomena that are increasing in prevalence in health-care professionals [11]. Roycroft et al., argue that the more complex the decision the greater the need for sharing moral responsibility [12]. This argument aligns with the call from the general humanities literature for cultivating ethical decision-making in professional education as articulated by MacIntyre [13]. MacIntyre argues that ethical debating resources as provided in philosophy and theology have become side-lined as part of the neo-liberal effect on curricula for professional disciplines, resulting in reduced professional wisdom to that of simply following the guidelines or a sequential algorithm [14]. A return to the provision of non-prescriptive moral debating resources is therefore necessary to address multi-faceted ethical dilemmas according to MacIntyre [6]. Montgomery, Toon and Kaldjian, echo MacIntyre's argument and his practice based virtue ethics advocacy. A focus on a better understanding of the concept of phronesis (practical wisdom) in medical decision-making emerged from our PMC research [15-17].

Phronesis is a virtue for ethical decision-making which is based on accumulated practical wisdom gained through previous practice dilemmas and decisions experienced by practitioners. As an 'executive virtue' phronesis offers a way to navigate all relevant virtues for any given patient case to reach a decision on the way forward. The gap prior to the PMC research in theoretical terms was an understanding or social construction of the 'collective' practical wisdom of a community of physicians gained through their previous practice dilemmas and decisions. Therefore, the primary

research question for the PMC study was: What does it mean to medical practitioners to make ethically wise decisions for patients and their communities? Interview and observation data collected from 131 participants found that individually doctors (and medical students) conveyed many different practice virtues, which when thematically consolidated formed fifteen virtue continua that conveyed the participants' 'collective practical wisdom' and included the phronesis virtue in the executive role [3]. The virtue continua are based on Aristotle's virtue continuum concept spanning between excess and deficiency of the virtue with the 'golden mean' at the point on the continuum where the best decision lies. However, it is only when combined with phronesis that virtue is fully realised [18]. For example, the 'negotiation' virtue in the continua has an excess decision point where the doctor decides and a deficiency where the patient decides, with the mean being where the doctor negotiates/discusses with the patient (or their next of kin) on treatment plan decisions and includes their subjective perspective on what might be best for this patient. In some emergency situations where the patient lacks capacity, and/or next of kin are not available, then the tendency will be towards the excess, doctor decides pole, whereas for an adult patient who is fully compos mentis then the tendency may be towards the 'patient decides' pole, although many times the central position of negotiation/deliberation is found to the right place. As part of negotiating with the patient the doctor may have to integrate other virtues and navigate to the right place for those as well. An example is 'cultural competence' virtue which spans from only using personal values and beliefs to just going with the patient's values and beliefs. In the values deliberation the doctor may also need to employ the virtue of interpersonal/emotional intelligence and so on. It is the cultivation of the phronesis to be aware of and manage the application of an appropriately integrated set of virtues for any particular case that the resources support.

With the changing role of doctors from the sole guardians of medical knowledge to facilitators of wise medical decisions cultivating phronesis is a highly relevant endeavour for that profession [19]. We now explain how the resources were utilised in the evaluated educational programmes.

Primary Aim of the Evaluation Study

Practical wisdom (phronesis) appreciates the particularities of each case and thus a vital virtue that helps realize the moral purpose of professional care [20]. Since part of doctors' professional remit, for that matter any HCP, is to manage complex clinical and ethical decisions, the aim of the education programmers was to support and enhance the skills that are essential to complex case management.

Malloch asserts that based on their own phronesis, peer based, and dialogical learning (from reflection, debate and discussion) works best when educating professionals. That learning process was used in all the programmers we evaluated. We report participant feedback after the co-produced 'collective practical wisdom' was used as a moral debating resource to stimulate dialogical learning and change associated with their decision-making practice. The resources are based on empirical data (narratives) from the medical community, and are the first to be trialed in educational programmers in the world. They are a consolidated set of 15 ethical virtues to arrive at wise decisions. Professional actors conveyed the stories told by doctors in a film series of seven episodes to convey the 15 virtues at the poles and mean points of the continua. The resources also included character biographies and tutor facilitator notes to guide discussion. A 'wisdom wheel' application was also provided to help participants navigate their way through the 15 virtues when watching the film series and for their own use in practice decision-making. The 'app' breaks the 15 virtues down into three: Those directly relevant to the patient; those relevant to the wider context for the decision and those relevant to team and self-care.

The primary questions of this study were directed towards the education providers and practitioners at various stages of their careers:

- Does the application of these resources in professional educational or CPD programmes influence practitioners to change decision-making practice?
- What does it mean to education providers and medical practitioners to be using the resources to enhance ethical decision-making?

MATERIALS AND METHODS

The study employed Creswell's mixed methods approach to reflect the philosophical worldviews of the two communities (educators and practitioners) involved. Creswell argues that research approach should match the scholarly paradigm preferences of the communities involved. For the ontological preference of the educational and practitioner medical community of resource-users we also used a quantitative method. The quantitative surveys explore which elements of the resources that are exposed to participants have the greatest influence on their practice. Both types of data were used to test the theory that the resources in educational programmes will positively influence medical decision-making approaches for the sites and practices engaged in using them. In this paper we present the findings of just the qualitative data and the quantitative data findings are reported in which fully support the qualitative findings.

Recruitment and Data Collection

The target audience was medical schools in England and Wales, those involved in specialist education and training, in particular primary care, and those involved in CPD. A mail shot was sent to all ethics teaching leads across all medical schools in England and Wales, and contacts made *via* conferences, other events with tutors, medical directors of education as well as others who had expressed an interest. The networks (social capital) of the project steering group members and previous workshop attendees also produced enquiries. An information sheet to explain the pilot evaluation process was sent along with the evaluation sheets to all

participants. Policy groups-general medical council, health education England, royal college of GPs and royal society of medicine also requested that we run introductory sessions and workshops. An hour-long interactive introduction session was designed for the workshops.

Ten workshops, seminars/lectures were completed before the end of June 2019, and several other workshops, panel presentations and lectures were delivered by project team members, subsequently. Evaluations from all these have been included in the data as were data from initial workshops run by the three partnering universities.

Data Collection

Participants: Data were collected from the participants at the workshops and lectures. The participants belonged to the following groups:

- Medical students at UK medical schools. Original partner medical schools (Birmingham, Nottingham, Warwick) and other medical schools recruited *via* conferences, workshops and mailshot.
- Hospital speciality-based trainees *via* partner organizations and GP trainees *via* HEE programmer directors.

Senior doctors and medical consultants in hospital practice and general practice *via* a network of contacts.

- Medical ethics' tutors
- CPD providers

Participants in the initial face to face workshops were invited to a one-hour introduction to resource usage for facilitators working with participants at differing career stages from medical school onwards. These participants carried out formative and summative evaluation of the resources. Three conference workshops were also conducted RCGP, 2018; RSM, 2019 and IME 2019 and the feedback were also added to this evaluation.

Data Evaluation

Two evaluations-summative and formative were carried out. These are described below.

Formative: The resources' in the alpha form (developed initially using the findings of the PMC research) underwent a process of formative evaluation involving medical educationists, practicing clinicians and policy makers. Pawson and Tilley's approach to formative evaluation was used which started with co-defining outcomes and impacts with these participants. The evaluation, analyzed together showed that 'the resources' work well in following ways:

- Open-ended discussions facilitated by the tutor.
- Pause, reflect, and debate.
- Tutor notes, highlighting possible virtues for discussion and their interface with professional GMC code of conduct-without being too didactic.
- Adaptable to different stages of career.

The participants were involved in co-designing and developing the initial alpha series to the beta version of the resources. The beta resources were subsequently rolled out in workshops and lectures, for summative assessment to a wider audience including medical ethics' tutors, students and medical practitioners.

Summative: Kirkpatrick's model of evaluation for training programmers was used and a small number of follow-up interviews were also conducted. Kirkpatrick's evaluation model has four levels and those levels are listed below with the purpose of each in this context:

Level 1: Reaction

To explore the reaction to the resources and gather some baseline data.

To gauge the uptake of resources by different Medical Schools and CPD providers.

On the day evaluation: what participants and what trainers, tutors and lecturers felt worked well and not so well?

Level 2: Learning

To explore the effectiveness of the resources in enabling debate, (both internally and with colleagues), about wise decision-making.

This was initially intended for those completing the course, or as a minimum seeing more than one episode, but was ultimately included for all participants. Reponses were captured *via* a question asking if there has been a change in the way they are speaking about, and reflecting on, their decision-making.

Level 3: Behaviour

This level sought to evaluate behavioural change *i.e.*, whether debating practical wisdom and exploring the resources has had an impact on the decision making of doctors in terms of their delivery of care to patients. What are participants doing differently as a result?. Those participants and educators who expressed a willingness to be contacted after they had completed level 1 and 2 feedback were contacted *via* email to carry out short semi–structured telephone interviews focussed on identifying any impact on their practice.

Level 4: Results

Consultation with people involved in reviewing university Research Excellence Framework (REF) Impact Case Studies (ICS) confirmed that L3 impact, changes in medical practice, is sufficient to indicate the impact of the research.

Participants were asked a series of questions, which used Likert scaling for the quantitative part and open-ended questions for the qualitative feedback. The latter were analysed thematically.

The initial questions focused on feedback on the session or course itself (whether they found the course and video materials engaging; whether they enabled debate regarding wise decision making; or whether the introductory presentation and accompanying participant notes were

helpful). It was the questions on learning, whether participants felt they now knew more about how wise decision-making can be enabled and whether they have been aware that there has been a change in the way they are speaking about and reflecting on their decision making that provided the qualitative data. This was followed by open-ended questions seeking views on how the course or materials might be improved. For educators some questions were amended to account for issues such as the use of tutor notes, learning outcomes, impact on participants and whether the educator would like to use the materials again.

RESULTS

Data Analysis

Qualitative analysis: Content analysis was used to analyses the free text response on the feedback questionnaires from 118 participants (including 20 tutors). *In vivo* 12 was used to manage the qualitative data analysis. The interviews were analyzed thematically to identify themes relating to impact on education and practice. Initially we used the theoretical framework of levels 1, 2 and 3 from Kirkpatrick to categories the data. Two members of the team, MC and AM, analyzed the data in a flexible iterative manner. Both have different academic backgrounds and so different lenses were focused on the data. This helped remove coding bias. Codes were developed individually, in a flexible iterative approach in the first round of analysis, followed by crossover analysis. Once the codes, "identifying patterns of shared meaning" were agreed then in the subsequent round both the sub-themes below were consolidated under two main impact themes and codes re-evaluated. The two main themes are:

- Practice impact
- Education impact (**Table 1**)

Qualitative findings: Sub themes: The following sub-themes were generated:

- Moral debate and discussion.
- Reflexivity.
- Educator's overall perspective.
- Introducing the topic of phronesis.
- Useful resource.
- Prescriptive approach or not.
- Delivery format.
- Career stage applicability.
- Theory and praxis.

The above sub-themes were then drawn together under two main impact themes, reflecting a synthesized analysis and are described in **Table 1** below.

Table 1: Impact themes.

1	Practice impact	Enabled medical and related healthcare professionals to change their approach to ethical decision-making for patients and the wider community by cultivating phronesis.
2	Education impact	Resources, integrated into medical education allow students and trainees to learn from the 'collective practical wisdom' for ethical decision-making.

Practice Impact: Enabled Medical and Healthcare Professionals to Change their Approach to Ethical Decision-Making by Cultivating Phronesis

Level 1 and 2 evaluation findings: Two sub-themes are:

- **Moral debate and discussion:** Most participants reported that the videos helped in discussing problematic cases. The teaching toolkit, *i.e*. the video series, was found to be interesting and very useful "as it brings up new thought processes" (I-6) that aids discussion. More experienced participants and tutors said the "clips trigger conversations around difficult situations." (DB-14), which "could be used as a trigger for debate and discussion" (DB-14) others considered "The videos could be good to introduce the contrary view to get debate". (PMC W'shop). Thus, a vast majority were of the view that these resources are useful in the real world because it helps "Discuss the ethical issues and legal limitations; Reality is collision between virtues and legal issues" (PMC W'shop). Some students agreed that the videos "…were most engaging and insightful" and generated "very good discussion point" (I-4).
- **Reflexivity:** The videos were found to be useful as a tool for reflection: "So what could have been done better, this situation was handled appropriately or there are certain things that you could have done differently" (Int.3-01). An important point raised by a workshop participant was: "Phronesis-helps to understand your own thinking uncover your own blind spots extend your moral gaze." (PMC W'shop). Some students found the concept of virtues leading to flourishing plausible, because" if I work on being virtuous in my practice I will flourish, feel I am doing well in the world." (PMC W'shop). The more experienced participants detected virtues that the simulated doctors did not possess, and it helped reflect on their own practice: "Very poor communication skills, no empathy, and lack of values… It helped me realize some of my practice mistakes that I make subconsciously." (DB- 2).

More is better: Some participants critiqued by stating that although the videos covered important issues, the "Course materials could be improved by adding more scenarios"

(SN-02) recommending that more examples with different levels of staff" (I-4), or "the videos could be made longer to cover more diverse scenarios." (CT-02).

Level 3 evaluation findings: To gauge the changes that may have occurred in doctors/participants' decision-making, or thinking about decisions, some of those who attended the workshops/training days or otherwise viewed the videos in their own time, were subsequently interviewed.

One of first reflections that were reported is that the films and reflections helped participants better engage with patients and/or their relatives to enter a discussion regarding treatment plans: "It's made me more consultative I try to get the perspective of the patient and their relatives, get them involved in the decision-making process. I think that it has made a difference. I hear their perspective and concerns, so it has helped me" (Int1-01).

The same doctor also realized that although rules and guidelines are important, a balance needs to be struck between what the guidelines require and what the patient wants and elaborated upon this: Stick to the rules/the medical guidelines strictly, or on the other hand, these are the patient's views and we bend the rules, so the advice to people is to seek to balance in between there was a particular instance a woman with Deep Vein Thrombosis where we did some tests and we were waiting for results and she wanted to go home to attend to her kids at home, I tried to persuade her to stay, eventually we reached an agreement, ok, you can go home and as soon as we get the results I will put a call through to you and you can come back to us and she was happy with the decision" (Int1-01), whereas in the past : " I would have insisted that she had to wait for the results." (Int1.-01).

This exploration also helped in making junior doctors understand the importance of shared decision-making and respecting patient autonomy: And helping the patients to co-create the best decision for them, rather than the one that feels safest from a purely biomedical perspective." (Int.3-02).

The videos used in these sessions helped reinforce good practices. The ensuing discussions helped to critically evaluate the decision made as to why this particular decision was a good decision. One participant, a mentor who is involved in training junior doctors, reported how they now consciously explore different facets of a situation before coming to a decision that works well for this patient: "Where that has been really useful for me and I have used this, is in explicitly being able to talk to the junior doctors who come to me for advice about why the thing that I think is right, has come to be, and then to show them the different ways that I am thinking about the same problem." (Int.3-02.).

The way Int.3-02 does it now is to encourage junior doctors to be more person-centered rather than being just "legally right". Narrating an episode where trainees might make a cautious decision to avoid criticism, Int.3-02 explores all aspects of that decision to decide what is right for this patient: "It has maybe changed the way I look at it. I am much more explicit about taking into account various aspects of the decision-making process. We might have a patient who, they (trainees) come and see me, and they think the right thing for this patient is to be admitted. And, I look at that same patient and the same story, and I think about them, and I realize that I am looking through a whole bunch of lenses that they aren't privy to. 'This is what the evidence is, and this is what feels safe to me'. And, by feels safe to me, I think they sometimes mean it feels like they are not going to be criticized for this choice, rather than what is necessarily the safest thing for the patient. And, we get that when you start to tease it out." (Int. 3-02).

It was also said that viewing these video series adds to decision-making repertoire, helping unlock varied aspects of wisdom. For instance, by critically evaluating and exploring different facets of a situation and coming to a decision, and then analyzing the decision made by: "Understanding it from their evidence-based perspective. But also adding other evidence into it, like for example the evidence of harm that hospitals cause just by being hospitals, just by admitting patients, the opportunity cost that comes in when we bring patients into hospital and start to investigate them in ways where they are maybe having one or two tests a day but they are stuck in hospital and they don't actually necessarily need to be there, they could be at home." (Int.3-02).

Discussing these materials, another GP trainer commented on these materials, resonating with practitioners: "Quite massively actually I think this is a nice way of being able to sort of have a structure to it, because we've always just stuck to the four ethical domains, going through case- based type things. This is a much better way of extending it to the virtues and thinking a bit more broadly about it." (Int.01-03).

"The challenge around ethics is, if somebody goes on training, and you see how much they've taken on of the training when they're actually in the battlefield" (Int.2-01).

Talking about the applicability of virtue ethics in varied cultures/contexts, this (Int2-01) doctor also commented that:

"Yeah, that's right, and I think it's counter-intuitive that you can't teach virtue ethics… It virtues chimes exactly with a variety of cultures." (Int.2-01).

Education Impact: Resources Integrated into Medical Education Allows Students and Trainees to Learn from 'Collective Practical Wisdom' for Ethical Decision-Making

Educator's overall perspective: Tutor participants said that the issues portrayed in these videos were realistic, as the scenarios depicted were reported to be typical of what is usually encountered ethically in primary and secondary care settings as a doctor: "Clips present realistic scenarios that are encountered in practice and elicit several interesting discussion points that can be used in a teaching session." (DB -6).

The GP practice clip was especially useful, as "an example of an important topic- that sometimes doctors don't want to say things in front of family members and different religions (and)

cultural needs to be considered when assessing patients." (DB-11).

Video simulations that depict reality are a useful means of making trainees aware, because one learns "over the years" and "general medical school and general practice training doesn't prepare you for the real world." (Int1-02).

Another said: "What is depicted in those videos is scenarios that doctors face on a regular basis, and so for somebody who's not used to these scenarios, having (seeing) those videos will help when….such a situation arises..." (Int.3-01).

Another thought that the incidents depicted in the videos were good for students/doctors as reflective tools and their own experiences may also come out in discussions and so be helpful to the group learning.

Introducing the Topic of Phronesis

Undergraduate medical students' viewpoint was that the concept of phronesis needs to be made clear-to provide context with practical examples as to how it is relevant to medical decision making,. Thus, "a lecture on what virtues ethics are, and what phronesis is" (RM-BT-01), would be better.

Other experienced doctors (RSM-1) and tutors (Int.1-03) also agreed that some background reading/knowledge is necessary, as well as some context, for it would help clarify the virtues and their meanings: "this has to be placed in the context of "ethical" models and students taught that there is no "right" or "wrong"." (RK04).

"I teach my trainees about the four ancient virtues that the Greeks talked about anyway about temperance and honesty and courage and justice. So, that is always one of the tutorials we have, about what makes a good doctor and how doctors need to use philosophical knowledge with them to help themselves and their patients." (Int1-02).

In response to this feedback, as part of the formative evaluation, episode 1 of the film series was modified to include an introduction to the concepts of phronesis and virtue ethics, plus a one-hour introduction session was designed at a subsequent workshop for tutors.

Usefulness of Resource

Despite the expressed need for an expanded introduction most students and tutors were of the view that the teaching resources are a useful tool for developing phronesis (and virtues). , In order to open a debate about the various ethical decisions that could be made in the clinical context given the particularities of each case, this resource would help.

According to most participants these resources are: "Superb as a teaching tool with realistic, familiar examples." (PMC-W'shop); "very good tool." (DB- 2) to "excellent idea and project looking forward to seeing more". (DB-8).

The videos are a good way of delivering 'reality' which mere reading of an ethical dilemma and clinical scenario may not, according to a participant:

"Beauty of videos are that it shows professionals are human." (PMC W'shop), showing both professional and clinical problems: "Concrete facts will never be the full picture." (PMC W'shop). Tutors reiterated the usefulness of the resource and RM-BT-01 wrote that for the next academic year for undergraduate medical students they will be allocating an hour for viewing the videos and ensuing discussion.

It was also recommended that: "It is a very useful resource and should have a wider reach to mostly health workers. It will help in patients getting a better healthcare." (FoF w'shop -07).

Other participants too found some aspects of the videos useful as very good tools for conveying virtues, such as respecting patients' values and beliefs. Scenes relating to specific issues were considered good for generating discussion. For example, one participant "liked the medical certificate scenario as a teaching tool." and also "could be a useful discussion." (PMC W'shop). "Communication was central in both videos. This includes communication with colleagues and with patients. Verbal, listening and non-verbal communication, good use of emotional intelligence in episode 6". (DB-7).

Some participants thought that some parts of the video clips could be used to help doctors develop resilience. One participant stated: "use film to ask, 'what would be the impact on you and what could you do about it?' use it to help with resilience." (PMC-March W'shop).

It may be that the films s help in inculcating what the GMC wants in 'Tomorrows Doctors', as one participant thought that they were an: "Easy route into GMC guidance." (PMC W'shop). However, there ought to be a caveat, according to one participant, to: "Make it clear when publicized that using a virtue framework isn't the only way to teach ethics." (PMC W'shop). Another doctor advised using the videos to prepare students for OSCEs: "The students have to show some compassion and think on their feet and things, so having seen the videos, it might prepare the students better for those OSCEs." (Int3-01).

Non-Prescriptive Approach

Although there was a suggestion that "it needs to be made clear that purpose of videos was for shared involvement and decision making" (DB-15), there were those who said that less 'prescriptive' is better: "Less didactic spoken content. Less prescriptive tutorial guidance. Both will make the resource flexible and attractive; flag up potential topics from videos rather than provide learning outcomes." (PMC W'shop).

Delivery Format

The format of delivery was considered important to aid discussions generated from the videos. Thus a lecture, as stated above, followed by small group discussions around a particular virtue enacted in the video in order to get a clearer understanding of it was advocated by some participants, especially undergraduate medical students: "It would be more helpful to watch the video series in small groups and discuss

them maybe as part of a community 'day' (B2-5) or a 'workshop type format.'" (DB14).

Small group tutorials were by far the most suggested format by tutor participants for using this video teaching tool, for example one participant stated it as: "In small group tutorials with different videos used at different stages of training" (RK07). Another interviewee made similar comment: "I think it's quite a complex idea and it needs a lot more I think two hours, probably, should be the minimum for that workshop. And it should be, probably, in small groups with a lot more facilitation." (Int.1-02).

Some were of the view that the discussion on the videos could be left open and "students can draw their own conclusions, facilitated by a tutor." Though there were those who thought the "tutor notes highlight possible virtues for discussion." (PMC-Nov W'shop).

As part of the formative evaluation this feedback led to an update of the tutor notes of the beta version including the format as smaller break-out groups in debate.

Career Stage Applicability

There was no one stage that was advocated. Most participants responsible for teaching gave suggestions regarding when (and where) these resources would have the most impact. A wide range of suggestions were made (**Table 2**). One practitioner who had graduated in another country but who had come to work in the UK and NHS also had suggestions in regards to overseas medical graduates: "Course can be integrated in to the induction programmer for doctors new to the UK (international graduates)." (CT-01). **Table 2** gives the participant tutors' view on the spread of career stages that the resources could be used for. The pilots and other events did use them at all these career stages and the general consensus was that they were possible to embed into both medical education programmes and CPD programmes.

Table 2: Stages at which these resources can be useful.

Participants	Career stage
RK02	Early on in the medical course
RK01,RK03,PMC-Nov.w'shop	Year 2 MBChB
RK03	Year 3 MBChB
RK01;PMC-Nov. W'shop	Year 4 MBChB
PMC-Nov. W'shop	Year 5 MBChB
RK07	Different stages of CPD training
PMC-Nov. W'shop	Foundation Year 1 (FY1) and Year 2 (FY2) and Speciality Training Years 1-2 (ST1 and ST2) (as part of communication skills)
PMC-Nov. W'shop	Undergraduate and post graduate medical teaching
PMC-Nov. W'shop	Medical students; GP team leads; Local GP networks
CT01	Course integrated into training of foreign medical graduates
FoF 03	Post-graduate trainees
FoF 08	After medical degree
Int.1-03	Undergraduates and overseas graduates
Int.2-01	Undergraduate level

This suggests that the resources are considered applicable at any stage of a medical career by the participant tutors.

Theory and Praxis

The transition from a theoretical framework to practice in the real world was important for many of the participants: "It would be more helpful to give a very brief recap of the info, and then apply it to different clinical scenarios, since I think the translation from theory to practice is more difficult, especially with conflicting approaches." (B2-3) (**Table 3**).

Table 3: Impact themes and sub-themes.

Practice impact	Education impact
Moral debating resource	Educator's overall perspective
Reflexivity	Introducing phronesis
More is better	Usefulness of resource
	Non-Prescriptive approach
	Delivery format
	Career stage applicability
	Theory and praxis

DISCUSSION

The resources enabled medical trainees, junior doctors and qualified specialists to cultivate practically wise decision-making without being given multiple prescriptions of how it should be done.

This study evaluated the original PMC findings as educational resources applied to a range of programmes for doctors and other healthcare professions. Pilots in medical education, workshops and presentations to all levels within the career progression of a medical practitioner found that the resources when used as stimulus for moral debate positively impacted on participants' ethical decision-making.

Cribb identified delivering independent moral thinking to the situation at hand in which relevance does not trump rigor is a challenge for translational ethics. The interdisciplinary approach to data collection, analysis and the subsequent democratization of involving the end-users (medical students, practitioners and ethics tutors) to critique, endorse or reject the learning and teaching resources developed added rigour to the process. Furthermore, incorporating the views of the participants in order to transition from an 'alpha' to a 'beta' version of the resources meant that the 'beta' version is highly accessible and useable by the target group.

The findings here validate the worth of moral debating resource as argued for by MacIntyre, in order to improve ethical decision making in professional education, in this case the medical profession, using resources derived from their practice community.

MacIntyre argues for practitioner groups of any practice to use practice virtues in order for them to contribute to the well-being for wider society. The research described in Conroy, et al., drew on the diversity of participants' ethical decision-making experiences and created a robust form of 'collective practical wisdom'. This has been used by other medical practitioners as a moral debating resource to cultivate phronesis that bring the best for the patient and their community. The follow-on project summarised here in this study put the theory of using the 15 virtue continua, as a non-prescriptive moral debating resource to enhance ethical decision-making practice, to the test. Approval of the depiction of real-life ethical experiences by those at the coal-face of clinical practice grounds the argument that all technical decisions have ethics embedded within and our research brings these to the fore. Virtues/virtue ethics frameworks are applicable in varied cultural contexts by healthcare professionals, and our research evidences that 'virtues' can be used as a universal language, where moral debating resources help to cultivate phronesis and change decision making practice in the process.

This paper presents the evidence that the dissemination and application of research findings through these resources supported the cultivation phronesis, thereby enabling medical and other HCPs to change their thinking, practice and framing of ethical decision making for patients and the wider community, this evidence supports the view that practical wisdom can be acquired through reflection and deliberation [20]. Our PMC teaching and learning resources have provided the opportunity to do so explicitly. When integrated into medical education the resources allowed a safe placement to participants to learn from the 'collective practical wisdom' for ethical decision-making. The resources are designed to be used flexibly for various audience sizes and either as a series of 7 sessions or as stand-alone sessions. The resources have been designed for use in Medical Schools, for trainees and for CPD of experienced doctors. The findings show baseline information on how and in what ways the resources were used in addition to formative feedback on their value and effectiveness. Influential groups in the field such as the RCGP, RSM, GMC and HEE support the use of these resources, including policy guidance on cultivating practical wisdom and its associated virtues across the broad spectrum of healthcare professionals which will help advance patient and community well-being. Some have used them in CPD programmes (e.g. RCGP and the NHS 'Enhance' programme) for doctors and other healthcare professions. Given doctors are arguably the most trusted profession in the world, the highly positive findings from this impact case study have significant implications for other professionals and leaders that must make wise ethical decisions on a day-to-day basis.

CONCLUSION

The uptake of the resources has been demonstrated to be strong with many wanting to use the resources. Participants found them engaging and impactful in terms of their decision-making practice. Medical school educators and CPD programme leads agreed that the scenarios and ethical dilemmas posed were realistic and the material was engaging. This moral debating resource has enabled doctors and students to re-frame their notions of ethical decision making using the 'collective practical wisdom' resource. This research reiterates the importance of introducing phronesis in the formative years of medical students' ethical reasoning.

Practice Implications

Nurturing phronetic decision-making using these resources has the potential to enable doctors to develop their own practical wisdom, enabling them to cope with and improve complex ethical decision-making for individual patients.

The evaluation research creates a case to expand the inclusion of experiential and constructivist learning which uses the resources in medical schools and CPD programmes. The implication is for the design and development of curricula in medical schools, particularly in the ethics and communication domains where the evaluation indicates that these resources could play an important part, especially in small group discussions.

Policy Implications

Moving forward the plan is to establish a virtual 'community of practice' including trainers, tutors and lecturers who have used the resources to enable them to exchange ideas about how these resources can be used, and improved. A further implication is to organise where they sit within curricula and with the range of other materials and resources used in the teaching of related areas *i.e*. ethics, law, communication, etc.

Future Research Implications

This follow-on project leads the way in terms of creating a strong case to understand the different ethical perspectives of healthcare disciplines beyond the medical community; their driving purposes and how they interact in situations that require collaborative decision-making between professionals. Inter-professional working is recognized as a central component of ensuring that people and families experience more integrated care but at present there is little research regarding the virtues of inter-professional practice that lead to good decision making. This greater understanding will enable health and social care services prepare and support professionals for these new collaborative arrangements and improve outcomes for people and communities.

LIMITATIONS

We do not claim that we have been testing the 'collective practical wisdom' of the entire UK's medical workforce but n=131 amounts to the largest empirical study to date. We also do not claim that the participants' perception of tool utility is generalizable but that the intention to create a non-prescriptive moral debating resource that can be used by all doctors to enhance their ethical decision-making was realized. The PMC project achieved this, while this follow-on project evidences the impact of using the resources produced from that project.

Only one practice in the many that exist in healthcare, medical, has been explored and tested. Given the argument by MacIntyre that intra and inter-practice debate is required to refine the virtues for each practice then this leaves many more to be explored and tested in a similar way.

The final limitation is that the original research did not examine purpose or telos for the medical community to any depth, although it did feature in many of the narratives. Here it is relevant because for practice virtue ethics and a phronesis approach, according to MacIntyre and Kaldjian, debate on the virtues can only lead to an end if telos is a part of that debate. Agreeing the direction in which to pull our carts is important but this paper demonstrates that it is worth taking them over the 'rough ground' of phronesis to reach the destination.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

All methods were carried out in accordance with relevant guidelines and regulations.

This project is a follow-on to the Phronesis and the Medical Community Project (Conroy et al. BMC Med Ethics (2021) 22:16 https://doi.org/10.1186/s12910-021-00581-y),ethics approval for which was obtained from the partnering universities: University of Birmingham (Application No. ERN_15-0172 on 28th September 2015). University of Nottingham, Faculty of Medicine, and Health Sciences REC (Ref. No: L13102015 SoM Birm ERN_15- 0172) and the University of Warwick, Biomedical and Scientific REC (BRSC Ref: REGO 2015-1720)

Data were collected *via* filling in the forms and only those participants were contacted for interviews who consented to be contacted by providing their contact details. Verbal consent was obtained prior to conducting interviews.

CONSENT FOR PUBLICATION

Consent was obtained prior to conducting interviews. All data were anonymised prior to analysis.

AVAILABILITY OF DATA AND MATERIALS

The datasets generated and/or analysed during the current study are not publicly available due to IPR but are available from the corresponding author on reasonable request.

COMPETING INTERESTS

No competing interests.

FUNDING

Arts and humanities research council grant number AH/S000763/1.

AUTHORS' CONTRIBUTIONS

A.Y.M collected and analysed the data along with M.C.

A.Y.M and M.C. wrote the initial draft, subsequent revisions and the final manuscript.

C.H and C.T contributed, substantially,in writing the background, and discussion sections in subsequent drafts and the final manuscript.

All authors reviewed the final manuscript and approved it.

ACKNOWLEDGEMENTS

The authors would like to thank participants who attended the workshops, seminars and lectures and provided data for this project.

REFERENCES

1. Malloch TR (2017) Teaching virtues to business professionals. Handbook of virtue ethics in business and management. 681-689.
2. Malik A, Weir C, Conroy M, Hale C, Turner C (2020) Phronesis and the medical community: Follow-on impact and engagement project. Impact assessment of phronesis resources on ethical decision making for doctors.
3. Conroy M, Malik AY, Hale C, Weir C, Brockie A, et al. (2021) Using practical wisdom to facilitate ethical decision-making: a major empirical study of phronesis in the decision narratives of doctors. BMC Med Ethics. 22:1-3.
4. Dunne J (1993) Back to the rough ground:'Phronesis' and 'techne'in modern philosophy and in Aristotle.
5. Conroy M, Biggerstaff D, Brockie A, Hale C, Knox R, et al. (2018) Phronesis in medical decision making: medical leadership, virtue ethics and practical wisdom.
6. MacIntyre A (2007) After virtue: A study in moral theory. University of Notre Dame Pess.
7. MacIntyre A (2011) God, philosophy, universities: A selective history of the Catholic philosophical tradition. Rowman and Littlefield Publishers.
8. Greenhalgh T, Howick J, Maskrey N (2014) Evidence based medicine: A movement in crisis?. BMJ. 348.
9. Tyreman S (2000) Promoting critical thinking in health care: Phronesis and criticality. Med Health Care Philos. 3:117-124.
10. Fulford KW (2008) Values-based practice: A new partner to evidence-based practice and a first for psychiatry?. Mens Sana Monogr. 6(1):10.
11. Allen R, Judkins-Cohn T, deVelasco R, Forges E, Lee R, et al. (2013) Moral distress among healthcare professionals at a health system. JONAS Healthc Law Ethics Regul. 15(3):111-118.
12. Roycroft M, Wilkes D, Pattani S, Fleming S, Olsson-Brown A (2020) Limiting moral injury in healthcare professionals during the COVID-19 pandemic. Occup Med (Lond). 70(5):312-314.
13. Godlee F (2008) Understanding the role of the doctor. BMJ. 337.
14. Montgomery K (2006) How doctors think: Clinical judgment and the practice of medicine.
15. Toon P (2014) A flourishing practice?. Royal College of General Practitioners (RCGP).
16. Kaldjian LC (2014) Practicing medicine and ethics: Integrating wisdom, conscience, and goals of care. Cambridge University Press.
17. Clarke JN (1981) A multiple paradigm approach to the sociology of medicine, health and illness. Sociol Health Illness. 3(1).
18. Bontemps-Hommen MC, Baart AJ, Vosman FJ (2020) Professional workplace-learning. Can practical wisdom be learned?. Vocations and Learning. 13(3):479-501.
19. Padela AI, Malik AY, Curlin F, De Vries R (2015) [Re] considering respect for persons in a globalizing world. Dev World Bioeth. 15(2):98-106.
20. Anthony-Pillai R (2016) Medical professionalism. Med. 44(10):586-588.