

# **ETHICS AND THE HEALTH PROFESSIONS**

**SUNY: MED CCFM 1402, CON CCFM 402, GRAD 6402**

**SU: PHI 550, REL 551**

**LMC: CCM 408/508, PHL 347**

**FALL 2009**

## **INSTRUCTORS:**

**Robert W. Daly, M.D.  
Robert J. Flower, Ph.D.**

# ETHICS AND THE HEALTH PROFESSIONS

FALL 2009

Wednesdays, 4:00-7:00 p.m., Weiskotten Hall, Room 1508 Setnor, SUNY UMU

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**OBJECTIVES:** This course is intended to develop your philosophical understanding of the moral problems of patients, their families, members of the health professions, health care organizations, and society.

**Required Readings for each seminar are noted on separate pages of this syllabus. (Readings at Libraries, Reserve shelf, UMU and SU Bird)**

DATE	SUBJECT	DUE DATES WRITTEN ASSIGNMENTS
<b>Sept. 2</b> (Seminar 1)	A. Introductions and Logistics B. Discussion of Course Themes	
<b>Sept. 9*</b> (Seminar 2)	Foundations of Ethics I	Reflection I Typed, Double Spaced, 2pp.

DATE	SUBJECT	DUE DATES WRITTEN ASSIGNMENTS
<b>Sept. 16*</b> (Seminar 3)	Foundations of Ethics II	Reflection II
<b>Sept. 23*</b> (Seminar 4)	Clinical Field I <u>Case 1</u>	Reflection III
<b>Sept. 30*</b> (Seminar 5)	Clinical Field II	Reflection IV
<b>Oct. 7*</b> (Seminar 6)	The Professional Field I <u>Case 2</u>	Reflection V
<b>Oct. 14*</b> (Seminar 7)	The Professional Field II	Reflection VI
<b>Oct. 21*</b> (Seminar 8)	The Organizational Field <u>Case 3</u>	Reflection VII
<b>Oct. 28*</b> (Seminar 9)	Social/Political/Economic Field	Reflection VIII
<b>Nov. 4*</b> (Seminar 10)	The Global Field	Reflection IX
<b>Nov. 11**</b> (Seminar 11)	Group Project - Presentations	** Submit draft of paper
<b>Nov. 18</b> (Seminar 12)	Group Project - Presentations	
<b>Nov. 25</b>	NO SEMINAR	
<b>Dec. 2</b> (Seminar 13)	TBA	
<b>Dec. 9***</b> (Seminar 14)	Review and Closure	*** Submit draft and final paper Turn in Course Evaluations

\* *Writing Assignment* Due: "Reflection" on a case or readings -- typed, double-spaced; 2 pages

\*\* *Draft version of term paper* Due -- typed, double-spaced; 15 to 20 pages, no less than 8 references from the professional literature (not internet or other mass media) in the Bibliography

\*\*\* *Term Paper* Due -- typed, double-spaced; submit *draft version* and *final version*

## Required Readings

### Ethics and the Health Professions - Fall 2009

**Background Texts:** These texts will be assigned and referred to throughout the course. It is imperative that you review these materials carefully. Questions and comments about these texts are always appropriate in class settings and should be referred to in your written work.

Beauchamp and Childress, "Morality and Moral Justification," "Types of Ethical Theory," Principles of Biomedical Ethics.

Ricoeur, P. "The Difference between the Normal and the Pathological as a Source of Respect, Reflections on The Just, 2007.

Ross, W.D., "What Makes Right Acts Right?"

Taylor, Paul, "Ethical Relativism."

#### Sept. 9 - Seminar Two - Foundations of Ethics I

"Background Notes," Syllabus, pp. 1-5.

John Macmurray, "Agent and Subject," Chapt. 4 of The Self as Agent, 1957.

#### Sept. 16 - Seminar Three - Foundations of Ethics II

"Ethics - A Short Vocabulary," Syllabus.

Beauchamp and Childress, Principles of Biomedical Ethics, "Morality and Moral Justification." "Types of Ethical Theory." (See Background Texts)

John Macmurray, "Agent and Subject," Chapt. 4 of The Self as Agent, 1957.

#### Sept. 23 - Seminar Four - The Clinical Field I

"The Clinical Field," Background Notes, Syllabus, pg. 6.

Beauchamp, Tom L., "When Hastened Death Is Neither Killing Nor Letting Die."

Daly, Robert W., "May Physicians Cause Death?"

Quill, T.E., "Doctor, I Want to Die. Will You Help Me?"

Quill, T.E., et al., "Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide.

**Sept. 30 - Seminar Five - The Clinical Field II**

"Beauchamp, Tom L., "Informed Consent."

Fletcher, et al., "Clinical Ethics: History, Content and Resources."

New York State's Health Care Proxy Law

**Oct. 7 - Seminar Six - The Professional Field I**

"The Professional Field," Background Notes, Syllabus, pp. 7, & 8.

AMA, "Code of Ethics," ANA, "Code of Ethics."

Daly, Robert W., "Professions-Officio."

**Oct. 14 - Seminar Seven - The Professional Field II**

Committee for Physicians Health, Medical Society of the State of New York

Selected materials, Office of Professional Medical Conduct, State of New York

Spencer, Edward M., "Professional Ethics in Health Care Organizations."

**Oct. 21 - Seminar Eight - The Organizational Field**

Daly, R.W., "The Organizational Field," Background Notes, (Syllabus), pp. 9, & 10  
"Organizational Ethics In Health Care - Primary vs Secondary Goods."

American Hospital Association, "A Patient's Bill of Rights."

"Code of Ethics." University Hospital.

Chambliss, Daniel F., Beyond Caring, 1996, Chapter 4.

## **Oct. 28 - Seminar Nine - The Political - Economic Field**

"The Social Field," Background Notes, Syllabus, pp. 10, & 11.

Bodenheimer, T.S., and Grumbach, K., "Painful Versus Painless Cost Control," Chapt. 8, "Mechanisms for Controlling Costs," Chapt. 9, and "Conclusion: Tensions and Challenges," Chapt 17, of Understanding Health Policy: A Clinical Approach, Fifth Edition 2009.

Cohn, J., "What's the One Thing Big Business and the Left Have In Common?"  
<http://www.nytimes.com/2007/04/01>

Daly, R. W., "The Two Cultures of Managed Care."  
"The Two Environments of Managed Care."

Reinhardt, U.E., "Reforming the Health Care System: The Universal Dilemma." American Journal of Law & Medicine, 1993; 19: 21-36.

Weissert, Carol S. and Weissert, William G., Governing Health: The Politics of Health Policy, Introduction pp.1-12, and Conclusion pp. 385-396, 3rd ed., 2006.

## **Nov. 4 - Seminar Ten– The Global Field**

Dwyer, James, "Global Health and Justice," Bioethics, 19:56-6, 2005.

Evans, Graham, and Newnham, Jeffrey, The Penguin Dictionary of International Relations, Penguin Books, New York: 1998, see "State" (512-513), "State-centrism" (513-514), "State System" (515-517), "Westphalia, peace of (1648)", "World Health Organization" (576-577).

Kickbusch, Ilona, "The development of international health policies-accountability intact?" Social Science & Medicine 51(2000). 979-989.

## **Dec. 2 - Seminar Thirteen - TBA**

## **REQUIREMENTS:**

Attendance - Because active participation in the seminar is an essential component of this course, regular attendance is a necessity. Frequent absences will lower your final grade.

Participation - All students are expected to contribute to all group discussions. It is important that you read the assignments carefully before class and that you are prepared to discuss the cases, texts, and the issue(s) at hand. Given that this course is a seminar, failure to actively participate throughout the semester will negatively impact one's final course grade.

Group Project-Presentation - All students will be required to participate in a group project-presentation. Once divided into assigned groups, students in each group will decide upon a research topic for their project-presentation. Class presentations of these projects will take place in the appointed seminars [as indicated above]. More specific directions will be given in class.

Writing Assignments - as indicated above. Timely completion of all reflections and papers is required. Reflections must be presented in hardcopy and are due on the date indicated. Reflections presented more than one week after the due date will not be accepted.

Draft Paper - A meaningful hardcopy draft of your final paper is required by the date indicated. Failure to provide such a draft will deny access to a grade of A on the final paper.

Final Paper - Due on the date indicated above. Further guidance regarding content will be provided by the instructors.

Grades - Students will be graded on the basis of (1) the quality of participation in the seminar discussions; (2) the timely completion of short papers; (3) the quality of each student's performance in the group project-presentation; and (4) the quality of the final research paper. The standard of assessment will vary in accordance with the educational background of the individual student, though a minimum standard of philosophical competence must be met by all students.

**ADDENDUM:** Be aware that Bird Library (Syracuse University) and the Le Moyne College Library have in their reference sections a series known as The Philosopher's Index. These volumes cross-reference author and subject-matter listings of most of the articles written during any given year on subjects in philosophy. By using these listings one can find reference to the necessary journals. Both libraries have many of the important journals in the stacks.

## Case One: The Clinical Field

### THE CASE OF EDITH

Edith is a resident in the Medford Extended Care Facility, a thirty-four bed, private extended-care facility located just south of Boston. She has been living at Medford for just over five years. Edith came to Medford after a two-month stay at the Medford Hospital for injuries suffered in a single vehicle accident. The record states that Edith was thrown from her jeep as it rolled over when, apparently, Edith had failed to negotiate a fairly sharp curve on the road leading to her family's retreat in the Berkshire Mountains. She had been driving several of her friends from work to her family's retreat for the weekend when, according to the accounts given by her friends, she lost control of the vehicle. The trip had become something of a party. No one in the jeep was wearing a seat-belt and some alcohol had been consumed by Edith and her friends. The resulting injuries were extensive and severe, but none more traumatic than Edith's.

A family friend had discovered the accident and called 911. The emergency technicians reported that they had initially passed over Edith in their effort to triage the injured. She had been discovered face down in a shallow roadside creek and "showed no signs of life". However, after caring for the others the technicians decided to attempt resuscitation on Edith and succeeded in gaining and sustaining a pulse. Transported to the emergency room at Medford, Edith was ultimately admitted into the ICU. She stayed in the ICU for nearly two weeks and was then transferred to ward care where she was treated for several more weeks. During her stay at Medford Hospital, Edith received a battery of neurological exams by which it was determined that she was suffering from severe brain damage from extended asphyxia. In time it was decided, in concert with her parents, that Edith should be transferred to a long-term care facility. Her diagnosis was "persistent vegetative state," and her prospects for a "meaningful recovery" were deemed exceedingly slim.

Now, three years later, Edith is plump, pink, breathing on her own. As a result of her injuries she lies in a fetal position, her hands "cramped" into "permanent" distortion. Her mouth is open, and she drools. Her eyes do not seem to focus or track, and she appears unresponsive to painful stimuli. The most recent EEG reveals virtually no brain activity in her cerebral cortex. The most recent MRI reveals significant atrophy of her brain. All relevant tests suggest that the proper description of the patient is that she is presently in a "persistent vegetative state" and may have been since her accident. For all of this, her care is excellent and strikingly loving. Each day Edith is "awakened," bathed, fed (through a gastro-intestinal tube because of her failed gag reflex) to the loving chatter and banter of her nurses. They talk "with/to" her throughout her care. After her morning care, she is winched into a tall wicker wheelchair and wheeled into the central social room so that she can "be with her friends." A similar style of care closes her day before she "goes to sleep."

A crisis in the determination of her care has now arisen between Edith's parents, who are her legal guardians, and the medical staff who care for Edith. Approximately six weeks ago, Edith's parents had decided "enough is enough" and requested that Edith's feeding tube be removed. The attending physician, Dr. Silvia Marsh, had signed the order in her chart ("with some reluctance", she admitted later), but Edith's nurses balked and have steadfastly refused to carry out the order. They have petitioned the administration at Medford to support their refusal to carry out "such a heinous order" and to allow them to continue their care for "their beloved Edith."

As the conflict between Edith's parents and her care-givers spiraled, the situation within Medford Care began to deteriorate. The chief administrative officer of Medford, Ms. Kathleen Peterson, sought legal counsel from the firm of Branson and Branson, a Boston-based firm, retained by the home office of Universal Care, Inc. which owns Medford and for whom Ms. Peterson works. In turn, Edith's parents have retained their own lawyer, who has sat in on several meetings between Edith's parents and Ms. Peterson. In an effort to avert a "legal fracas," Dr. March has invited the several parties to an "ethics consultation". Given that Medford Care has no ethics committee or consultant, she *has asked you - the chair of the Ethics Committee and ethics consultant at Medford Hospital* - to again serve as the ethics consultant in this case.

You have already had one consultation. In attendance at this first meeting were Edith's parents, Ms. Kathleen Peterson, Dr. Marsh, and three representatives of the nursing staff responsible for the care of Edith. At your request all parties were asked to be in attendance without legal representation. Unhappily, the meeting did not go well. Edith's parents were resolute and insistent. They expressed their "dismay" at the reaction of the staff and called the resistance of the staff to their wishes on Edith's behalf "unconscionable." They see themselves as loving parents who have sacrificed a great deal to be supportive of their daughter in the hopes of some sort of "miracle." They have come to believe, however, as year follows year with no change for the better, bringing only the unremitting evidence that their daughter is, in fact, becoming more and more locked into her condition, that now is the time to bring a loving resolution to their daughter's situation. After months and months of agonizing struggle, they have come to the deeply felt, deeply convinced conclusion that this is a "form of life" absolutely incompatible with everything their daughter stood for and believed in, and that there is absolutely no question that Edith would never want to continue living in such a condition.

The nursing staff, on the other hand, asserted that they are a group of committed and loving care-givers. It is demonstrably clear that they have come to love Edith, that they take Edith to be "their charge," and that the idea of "starving this poor woman to death" is heinous. In fact, in response to all of the neurological findings that seem to support the conclusion of the parents, these persons insist that there is a real and vibrant woman "within" her distorted body and that they know that she does not want - indeed, could not want - to die and especially by such a barbaric means as starvation. They vehemently affirm that Edith's "spirit" is very much present and that they have, each in her own time and context, "connected with her" during Edith's stay. While the administration is not anxious to sustain the cost of a court battle, and is desperately afraid that Edith will become the next "Terry Schaivo," they are uncomfortable at the prospect of complying with the parents' wishes without further clarification and court authority to act. They would very much appreciate the legal force of a court order, given the volatility of the issue not only within Medford Care but also within Medford Care and the nation. The parents left the first meeting "in frustration," with Edith's mother sobbing and her father shouting angrily about the travesty of it all.

Your efforts to persuade all parties to return to a second consultation have met with success, and you have scheduled a follow-up session for early next week. As you reflect on the next meeting, these questions occur to you:

**What can I, as an ethics consultant, hope to do?**

**What is my responsibility, as an ethics consultant, in this case?**

**What steps are available to me that could facilitate a humane resolution of this dilemma?**

## Case Two: Professional Field

### The Physician/Patient Relationship: Rights and Responsibilities

*You* are the Chairperson of the Medical Society State of New York (MSSNY) Committee on Ethical Affairs. Your job is to review appeals and to decide cases pertaining to physician misconduct. These cases most commonly involve physician impairment (e.g., drug or alcohol use) but may involve questions of physician competency and practice issues. MSSNY is a State chapter of the American Medical Association. The chapter's decisions are guided by the code of conduct of the AMA.

You are now presiding over a case that involves a young physician in his second year of practice as an orthopedic surgeon. He is accused of denying care to a person known to be positive for HIV (the AIDS virus).

The patient is a forty-year-old, gay male who suffers from debilitating back problems secondary to a herniated disk. He has had all of the conservative (non-surgical) treatments available for this ailment. He has even tried chiropractic therapy and other non-traditional forms of therapy (herbal, healing touch) with no significant improvement. Although the patient was initially reluctant to consider orthopedic back surgery, he is now convinced that there is no other reasonable course left and he had opted for back surgery. He has chosen the physician in question after a careful review of the orthopedists in the area because this physician has excellent results and has been recommended by members of the patient's family.

The patient is an accountant for a prominent local company and has worked there for ten years. He has excellent health-care insurance that will cover the consultation and operative procedures.

The physician, although still early in his career, has an excellent reputation among his colleagues for his care of patients with back disorders and his practice is growing rapidly. He is clearly competent to care for the patient's back disorder and would appear to be a good choice as an orthopedic surgeon. He is very well respected among his peers and patients. He is the father of two young sons, ages 4 and 6, and he finds time to be active in the local Little League. His character and integrity have never been questioned.

The physician is in agreement that the patient requires back surgery. He refuses to treat the patient because he is concerned about transmission of the HIV virus to himself and his family because of the possibility of acquiring infection with the AIDS virus during the surgical procedure. He quotes several medical articles about the risk of HIV transmission in orthopedic practice. The risk is somewhat higher than for other physicians because of the sharp bony fragments and use of power tools during the procedure. He also quotes an article that uses a statistical model to show that, over the average lifetime of practice for an orthopedic surgeon, the risk of blood born disease transmission (HIV, hepatitis, etc.) reaches 90% if the practice encompasses a significant number of infected patients. He is worried that by taking on this patient he will open the door to a practice with many infected patients and increase his own risk of disease and his family's risk as well. He bears the patient no ill will and has given the patient the names of other orthopedists in the local area who would be willing to do the surgery. He also believes that because this is only an initial consultation, and he has not established a formal physician/patient relationship, he is under no obligation to provide continuing care for the patient. He also believes that his position is justified by the fact that this is an elective procedure and not an urgent or emergency situation.

This case had been adjudicated in a court of law and the physician's position was upheld. He is under no legal obligation to provide further care to the patient. The patient was not satisfied with this decision and is seeking a ruling against this physician from the MSSNY Committee on Ethical Affairs. He alleges unethical discriminatory practice and dereliction of duty on the part of the physician. He claims that the physician prejudicial towards HIV+ patients and that the physician is bound by a duty to treat all those who fall into his accepted realm of competence.

*You* have now heard the case and must make a decision.

**What type of information beyond what is given is necessary to give an informed ruling?**

**What ruling will you make and why?**

**If you rule against the physician, what sanctions should be imposed?**

**What option would you choose and why?**

## Case Three: The Organizational Field

### A CEO's Dilemma

*You* are the chief executive officer of a private three-hundred bed tertiary-care, not-for-profit hospital. Many of the in-patient services of the hospital are high-tech and intended for persons with grave medical problems, e.g., cancer, end-stage renal and heart disease, profound trauma. The hospital is also affiliated with a medical university and provides a full range of both undergraduate and graduate training programs for aspiring members of the health professions. There is regional competition for staff as well as patients. Contracts with managed care corporations account for forty percent of the hospital's income. It is difficult to balance the books even with donations supplied by the community.

You have just emerged from a meeting with the Chair of the Ethics Committee and the Director of the Ethics Consultation Service of the hospital. They have informed you of a set of cases in which they contend that New York State law and hospital policies "are forcing physicians and nurses to practice bad medicine." These are cases in which a competent patient believed to be terminally ill refuses, even after counseling, to consent to a Do Not Resuscitate order (DNR order) or in which a competent proxy (or surrogate), even after counseling, of an incompetent patient refuses to consent to a DNR order. Cardio-Pulmonary Resuscitation (CPR) in all these cases is deemed medically "inappropriate" or "futile," that is, if CPR is attempted it will almost certainly result in death, or, if the patient survives the procedure, will diminish the quality of their lives, and in some cases prolong dying. In most cases the patients are too ill to be moved to another hospital.

Under these circumstances, most physicians do not write a DNR order or, if they do, are told to "cancel it" by hospital administration. Physicians contend that they are being compelled to act (perform CPR) contrary to the moral principle of "do no harm," contrary to medical knowledge, and contrary to how they should exercise discretionary professional authority. They also contend that they and nurses are forced to perform sham procedures (e.g., a "slow code") to conform with the law and that such practices are "bad for medical and nursing students to witness." (While the law provides for a hospital "dispute mediation mechanism" in such cases, physicians are reluctant to use this institutional device to resolve such disputes.)

The Chair and Director have informed you that they find such practices "unethical." In these cases they discuss with staff the differences between what the law requires and what constitutes "ethically sound practice." They also report that ethics consultants in other regional hospitals hold the same views.

They then requested that the hospital take to court the next case of this sort that comes to their attention in an effort to get a ruling that protects health care professionals and patients from the "irrational judgments of patients and surrogates." Failure to do so, they claim, would be a failure of moral courage on the part of the organization. They plan to make their views and the request known to the Medical Board of the hospital.

You know that NYS law presently requires that authority not to provide CPR must come from someone other than physicians unless the patient is terminally ill, has no advance directives, no surrogate, and is incompetent to make medical decisions. Court actions of the sort that challenge the law in this way are expensive and public. You also believe that the hospital will suffer adverse publicity and lose "market share" if you accede to the request of the Chair and Director.

Your first move is to seek the advice of the hospital's lawyer. He advises you against taking legal action, not only because it is expensive and will result in adverse publicity, but because it is extremely doubtful that the hospital can win the case. You are also concerned with what the Medical Board will demand of the hospital.

**As you ponder what actions to take, what ethical considerations enter your deliberations?**

**Do your deliberations reveal any ethical conflicts?**

**If so, what are they?**

**How do you plan to justify, from an ethical point of view, what you will do in this situation?**

# **BACKGROUND NOTES**

**BACKGROUND NOTES**  
**for**  
**ETHICS and the HEALTH PROFESSIONS**

**Robert W. Daly, M.D.©**  
**Robert J. Flower, Ph.D.**

**Premises about Persons, Ethics, and Morality**

In nearly every essential way, our existence as persons is constituted by our relations with one another.

The relations that we have are not only matters of fact, but also matters of intention, because each of us, to a greater or lesser extent, has the capacity to act, to author his or her activities, to choose on the basis of knowledge what to do or to refrain from doing in relation to others and to "all the furniture of the universe."

The exercise of my capacity to act, i.e., to intend the future so as to have a "good life," depends in part on how you and others exercise your capacities for action. My freedom to try to realize my intentions depends in part on how you and others express your freedom of action. So the freedom and the future of all the members of a society (in principle, the freedom and well-being of all persons) depends on the intentions of each.

If our intentions are incompatible, if two of us cannot agree on how, through our coordinated actions, we are to determine the future, each of us can act to prevent the other from accomplishing his or her objectives, or one of us, as a matter of intention, must give way to the other, or seek to control the other and limit his exercise of freedom, impeding him as a person. If we cannot harmonize our intentions we cannot act in concert. We may not, for that reason, sustain our relationship. In some cases, we can even seek to destroy one another. Moreover, when I limit your freedom, I also limit my own, and the two or more of us cannot in freedom discover a common intention that enables us to act in concert. Conversely, if you and I and others freely discover or defer to a common set of intentions, we do thereby constitute, or more typically find ourselves constituted as a community of interdependent persons who on balance and for the most part, most of the time, act in relations with one another in ways that permit each of us to express our nature as individual persons, to achieve some satisfaction of our desires, and to accomplish our lives.

Because the freedom and well being of all depends (in principle) on the intentions of each, you and I and the others are deemed responsible to one another, indeed, to all the members of our society, for our actions. This apperception of our nature and circumstances furnishes us with a formal criterion for the "morality of our actions" and obliges us, to respect the dignity of others as human beings endowed with a capacity for action. This threshold requirement permits us to discern a correlative principle, namely, that to be "moral" the activities we intend as individual persons (or agents) in relations with others must be intentions that are commensurate with maintaining, or developing for the better, the community of agents (of which we are already members) as a condition for the continuity of our existence as persons.

"A morally right action is an action which intends community," and so the particular intentions of every person should be informed "by a general intention to maintain the community of agents." (Macmurray)  
 "Let us define 'ethical intention' as *aiming at the 'good life' with and the others, in just institutions.*"  
 (Ricoeur)

But these criteria of morality are as yet indeterminate because they are formal. They are like the hull of a boat afloat on the sea without power or direction - without a paddle, sail, or motor; without a compass; without a project or a destination; with its movements determined simply by the elements.

The conduct of persons has content aimed at securing each person's version of a good life in a manner informed by moral norms. Conduct is also informed by an innumerable sedimented norms providing us with knowledge of the dramatic design of the community - its circumstances, settings, roles; norms directing us how to perceive, feel, do, believe, admire, emulate, and become as we struggle with choices along life's way; norms for coping with doubts, anxieties, fears, and aggressions; visions of exemplars; and coveted symbols portraying the "differential work of their bearers." (Nelson)

RWD

### **Premises regarding Health and Medicine**

Human beings as living creatures, are subject to pain, injury, illness, malnutrition, deformity, degeneration, madness, and functional impairments - conditions of persons that in various ways diminish our organismic capacity to act and thus limit our freedom as agents. Moved by an awareness of these states, persons and societies everywhere esteem "health" as an intrinsic good (like beauty but unlike wealth that can be given to another), as a good in itself, and as a prerequisite for the attainment of other goods.

Because states of good health are desired, indeed are necessary for the pursuit of most of our projects, and states of ill-health are to be avoided, prevented, or, with their advent, cured if that is possible, persons everywhere engage in actions intended to maintain, restore, or otherwise improve their health. We do so privately with respect to ourselves and in informal relations with intimates. We do so formally and in relations with a host of professionalized healers and in organizations devoted to health care. The whole of society may at times express a commitment to maintaining the health of the persons who comprise it by seeking justice with respect to access to care.

We call actions intended to secure the health of persons, "medicine" - whether such acts are performed by strangers, mothers, sons, soldiers, or by members of historically emergent occupational classes such as shamans, priests, indigenous healers, physicians, nurses, or acupuncturists.

For empirical and analytic purposes, we count all practices and crafts intended to secure health as "medicine" and include practices in every time and setting, e.g., domestic households, schools, fields of battle, offices, and hospitals. We also include in our portraits of medicine accounts of the resources used in support of such practices, linkages to other features of society (e.g., law, finance, politics) that sustain and deform these practices, and the discourses that inform every effort to secure health.

If we knew all that could be known about "medicine" (which we do not) including the efforts needed to improve it and to hand down what is known to succeeding generations, we would have a complete picture of the "institution of medicine." But suffice it to say that health finds a prominent and

discreet place among the goods that human beings hope to enjoy and are among the ends to which we regularly devote our energies. The activities that count as "medicine" can, therefore, usually be distinguished from institutions designed to secure other goods such as justice, education, the exchange of commodities, entertainment, and victory.

Health *per se* is not a "moral good," as is justice. Justice and injustice are predicated on and constitutive of the moral dimensions of our relationships. States of good and bad health depend in different proportions on what is done and on what simply happens that is beyond what can be done by us. States of health are not constituted simply by our relations. We cannot praise a state of health in a moral sense but we can admire or be appalled by such a state.

Since for us health depends in part on a reflective consciousness of health, and to a variable and ever increasing extent on what we do or fail to do (follow the right diet, exercise, rest, avoid toxins, prescribe or take right drugs, perform or submit to timely surgery, etc.) to maintain or restore health, the acts we perform and the dispositions to act that we acquire in relation to securing health can be praised or blamed from a moral point of view. If you intentionally act to diminish my health (e.g., injure me) or refuse to act in some situations to secure my health (e.g., refuse to care for me because I emit a noxious odor when, as an emergency room nurse, it is your duty to provide care), you may be acting contrary to the rules generally intended to secure and safeguard the harmony of the community of which we are members. Conversely, you may be praised as morally good when you stay with me beyond the appointed hour in the service of improving my health.

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### **Premises about Bioethics and Fields of Action**

Bioethics is reflection on and the results of reflecting on moral problems and issues that arise within and about the institution of medicine. Bioethics, together with other types of reflection, also contributes to our understanding of problems and issues about the institution of medicine in relation to other institutions of society (e.g., What proportion of the public treasury should, in justice, be devoted to health care?) Ethical questions that arise in special communities found within society may also be the focus of bioethics. For example, is it morally permissible in an Amish community to keep a young member on "a breathing machine" for a week to provide him with an opportunity to recover from a brain injury?.

Because the manifestations of the institution of medicine in America are omnipresent, exceedingly complex, and take many forms, those who study bioethics need some way of ordering ethical questions about this institution. For example, one could examine the issues and problems as they arise - abortion, cloning, confidentiality, consent, just health care, truth-telling, etc. Or, study the problems in the light of a particular theory of ethics - a theory of principles, rights, goods or values, virtues, utilities - indicating how any problem would be approached using the resources of that point of view. We use another approach, one that we call "field theory."

We use this approach because we want to study moral conflicts, doubts, confusions, and dilemmas that arise in and about established, historically emergent, social practices that are, prior to any philosophically informed reflection on them, already constituted by relatively clear goals, norms for knowing, established procedures, offices and modes of authority, ideals and standards of service, and patterns of securing a moral identity. Each field also generates particular types of disputes, and forums,

literatures, and mediatorial (if not authoritative) devices for responding to wrong doing, and to conflicts and doubts regarding what is to be done in the name of "the good," or of individual or collective "right conduct."

We also use this approach because various forms of ethical discourse apply (when they do apply) to different fields of action in different ways. (See discussions of the four fields considered in this course., pp. 6-11) We also believe that ethical discourse within a field requires a unique way of weaving or composing different types of ethical reflection because practices and offices are differentially arranged to secure the particular goods (e.g., the health of the patient, the productive association of persons in organizations) by which the field is already known. This approach also encourages us to recognize the stratigraphy and dynamics of moral problems that involve multiple fields (e.g., corporate control of professional practices in health care organizations), "inter-field" issues that concern the relation of two or more fields, and "fieldless" problems that cannot readily be associated with traditional fields (e.g., the ethics of human cloning).

Three of the "fields" reflect the division of goals and of labor within the institution of medicine: the clinical field in which actions, and so the ethical problems, are concerned with the health of particular persons; the organizational field in which action and reflection is concerned with how numbers of different sorts of persons are related to one another to facilitate the provision of services; and the professional field which is concerned with the development, promulgation, and enforcement of standards of conduct, the transmission of ideals, and the generation of moral identities. Other fields within the institution, e.g., prevention, research, public health, and education, receive less attention. The fourth field we consider is the social field, the actions taken in other institutions e.g., by courts, legislative bodies, and by corporations that profoundly influence the institution of medicine. Finally, we consider global bioethics as many concerns about health reveal that we are "citizens of the world," not simply of nation-states or local communities.

Finally, there are certain themes that inform the content of and the process of arriving at all moral judgments in all fields - e.g., respect for the dignity of persons; compassion; promise-keeping; justice and law; virtue; authority; and our knowledge of nature, language, and persons.

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### **Universal Conditions of a Field - Theoretic Model of Medical Ethics**

Basic to the "field theoretic" construction of this course is the presumption that woven throughout all field-contextualized languages run (metaphorically speaking) the "artesian conduits" of universal grammars (languages/universes of discourse). One can construct the notion of a field, as we are using it here, in terms of a Wittgensteinian "grammar"; literally, a language in terms of which certain interests are rendered articulate. If one approaches the notion of a field in these terms, we also presume that there is a universal "syntax" and "vocabulary" that undergirds the language of each and every field. No matter, then, how varied these fields may be, they all share in this universal language. Whatever the field language one is speaking, the intelligibility of this linguistic context is, in part, grounded in the presence of this universal grammar.

Our interest is the study of the ethical dimensions of health care. Hence, the conceptual hue of each field in our study will be the syntax and vocabulary of value - specifically moral values. Thus, developing a facility within any one of the fields at issue in this course, requires a facility with this universal "grammar."

Philosophical ethics purports to be a medium of study whereby one can explore the universal grammar of ethics. Ours is, at least in part, a course in ethical philosophy. The project of philosophy is here twofold. First, it is to disclose the unique logic (syntax) of ethical/moral judgments (propositions): in particular, what it means to recognize the force and authority of normative assertions (e.g., that one ought to do thusly or that one ought not to do thusly). Second, it is to bring to light the semantic content of universal concepts (the vocabulary) found within this discourse: concepts such as "human dignity," "immoral," and "virtue."

A field-theoretic approach to bioethics takes it for granted that these universal and theoretical concepts come to life only within the real and practical world of human relations. Thus, for all the conceptual integrity such concepts might have, they will accrue their own special meaning or sense as they undergo the transition from theory to practice. Insofar as a field is essentially a "context of transition," field-theory recognizes that these concepts will play out differently as they are contextualized within different fields. Each will ebb and flow in relation to such contextualization. What is ethically fundamental and at the forefront in one context may recede into relative unimportance in another. Most importantly, as one field is laminated over and upon another (i.e., clinical practice as performed by health-care professionals, takes place in an organizational setting within a social, political and economic environment), opportunities for conflict arise by virtue of the manner in which the values of the different fields impinge upon one another.

Granted that there are other "universal grammars" that underwrite any "context of meaningfulness," we shall limit our attention primarily to the grammar of ethical and moral values. However, before moving on to sketch out the respective fields that will stand as the primary focus of this course, there is one further consideration of a "universal" nature that merits our attention.

This course recognizes that the process whereby the concepts of ethics come to inform the contexts of practice involves what might be called "universal mechanisms of transition." Concepts, such as human dignity, autonomy and the like, do not enter society sprung, full-grown, from the head of Zeus. They are appear in society via certain social mechanisms: mechanisms that are, in some instances, so universal and pervasive that every setting of contextualization (i.e, every field) is at least partially, constituted by these mechanisms.

We will emphasize three such universal mechanisms of translation: religion, the law, and the economy. By way of example, due process is one of the ways the law translates the principle of autonomy (and, hence, the concept of human dignity) into the fabric of American society. So too the mechanism of the free market. On this account, then, no field of ethical interest can be understood without at least an elemental appreciation of the nature of these affairs.

Consider now, some notes on the four fields that we re-search in this course.

## The Clinical Field

The clinical field refers to those many and familiar occasions when care is sought by one person, and healing practices elaborated by another. While we associate the seeking and provision of services in hospitals, clinics, and the practitioner's office, it is well to remember that the clinical field also encompasses actions and events in long-term care establishments, ambulances, households, office buildings, factories, battlefields, schools - indeed wherever and whenever ill-health presents itself and demands attention and action intended to prevent ill-health or restore and promote good health.

Questions, problems, or issues about "ethically right action" in the clinical [*< Gr. kline, bed*] field invariably concern what should be done in *these* circumstances on *this* occasion relative to the health of an actual person or small sets of persons who are believed to be in need of "medical attention" or "health-care." Thus, discussion and texts about ethics in this field are concerned with variable senses of "health," with the moral meaning of health, and with the moral propriety of actions to be taken (or avoided) to secure this good in particular cases or types of cases.

A second prominent characteristic of this field is that, in important and even unique ways, individuals are the primary decision-makers: e.g., this patient, this health care proxy, this father, nurse, or physician. Classical relationships (e.g., between the healer and the patient) as well as the decisions of such persons in the clinical situation can be morally problematic and therefore a foci of ethical reflection. Ethical questions and decisions in this field are discussed as if one or several individuals (as contrasted with the members of an organization, a community, or the whole of the society), rooted in relationships in a situation and its momentary features - many of which are unknown or indeterminable - are faced with an important, problematic, and practical moral question that must be answered, in action, here and now. In the clinical situation, professional, organizational, and general social norms may be perceived as only remotely consequential (even if they form important features of what is at issue) with respect to the ethical questions that dominate a drama that is relatively unique and unlikely to be repeated.

Ethical conflicts, doubts, confusion, and quandaries that arise in the clinical situation concern respect for persons (professionals and patients) and their right to self-determination, the quest for health and other goods, consent, authority to treat, competence of the practitioner, beneficence, non-maleficence ("Do No Harm"), promise keeping, confidentiality, safety, and compassion. In the clinical field, many of the immediately practical questions of an ethical sort are co-mingled with or informed by religious beliefs and associated ethical directives, by the vicissitudes of the personalities of those who are the parties to the situation, and by legal considerations, e.g. competence on the part of the patient to give informed consent or refusal for treatment, undertaking to treat with due care - according to a standard of care, and the law of contract. The law may be supportive, ambiguous, or in conflict with what "ethical care" is deemed to require. In the latter circumstance, the resolution of new and complex ("multi-field") ethical as well as legal problems may become the order of the day: e.g., with regard to confidentiality, when the aim of the physician and of the patient, and the aims of a prosecutor on behalf of the State require incommensurable actions.

Upon inspection, ethical issues that present themselves in the clinical field seldom stand alone. Ethical considerations that derive from other contexts of action (e.g., justice in health care) both sponsor and deform the values that animate the clinical field.

## The Professional Field

It is necessary to understand what a profession is in order to understand the ethics of a profession. Professions are a special set of historically emergent occupations. Occupations that attain some creditable claim to the status of profession provide a service intended to secure for the members of society a good that is discreet, abiding, and of import, e.g., health, justice, education, the defense of the nation. Those who provide the service intended to secure such goods take a public oath or vow or otherwise profess that they will provide such services. The services require a high degree of education, training, technical skill, and devotion to duty. In recognition of the nature of the good, and the degree of expertise entailed in the services provided, society, via tradition and law, accords to those engaged in such occupations a great deal of autonomy - regarding the nature of the service provided, in determining the standards by which those aspiring to enter the occupation are educated and credentialed, and by permitting those engaged in the occupation to form membership associations - professional societies - that enable members to decide who can become and remain a member. Members of these associations are also permitted, in limited ways, to work together to pursue their private interests as well as society's interest in maintaining or restoring health, securing justice, or to protecting the nation in times of armed conflict.

(Many occupational groups are called *professionals*, for example, professional athletes. They are not required to have a general higher education, attend schools with standard curriculums, pass certifying exams defined by other athletes, or be licensed by the State in order to enjoy the benefits and burdens of their occupation. While professional athletes are very good at what they do, their work, as entertainers and exemplars of various skills does not bear the sense of *gravitas* required of an occupation that achieves a robust sense of profession).

Professional societies traditionally claim that the services of their members and the professional society itself are constituted for the purpose of serving a particular need of the members of the whole society. They are not, in principle, constituted for the purpose of securing the self-centered interests of the members, e.g., financial compensation or status. This claim has led to cynicism on the part of many members of American society who believe, with some reason, that "professionals" in fact fail to put the interest of their clients before their own interests.

For example, the interests of the health-care professional in earning a good livelihood may conflict with the care that the patient requires. The ideal of the physician who was revered because he or she did put the patient first has been replaced in some quarters with the image of the physician as a businessman (or woman) who has only his or her financial interests in mind when conducting the practice of medicine. Neither stereotype - the disinterested physician nor the businessman - characterizes how most physicians live and work. But the moral tension between service to others and self interest on the part of professionals is one that must be recognized.<sup>1</sup>

Professions elaborate codes of ethics that govern how the members are to interact with clients and with one another. These codes attempt to insure a proper balance between service to society and the self interest of the members of a professional society. If conduct by a professional is found to be in violation of the code of the professional society to which he/she belongs, ethics committees composed of members of the professional associations decide on what action should be taken. The most severe sanction that can be inflicted by a professional society is banishment from that society. For example, a

lawyer may be "disbarred" or a physician expelled from membership in the medical society. The State may respond to misconduct by revoking one's legal authority to practice a profession.

Various occupations within the institution of medicine achieve varying degrees of professionalization, having more or less well defined purposes, codes of ethics, autonomy in determining the nature of their work, and the capacity to freely negotiate in a variety of public and private markets for their services.

An example of a code of ethics in health care is the code for physicians is promulgated by the American Medical Association.<sup>2</sup> This code is based mostly on case law. It is less an *a priori* moral document than a reaction to circumstances and social interests revealed by the findings of the courts. The circumstances of patients have occasioned some of the opinions and annotations enumerated in the code while others pertain directly to the conduct of physicians. For example, the Code refers to patient confidentiality as well as to medical advertising. The Code of Ethics of the American Nursing Association is more concerned with ethics than with law.

It is also possible that what a physician or nurse does in the name of "good clinical practice" will place him at odds with what the professional code prescribes as appropriate professional behavior. The adjudication of these conflicts sometimes leads to the revision of codes because what is deemed to be good clinical care has changed. An ancient example of this is found in one of the original codes of conduct, "The Oath of Hippocrates." That code forbade the practice of surgery. We have modified the Oath to allow what is now standard clinical practice.

The ethics of the professions are usually cast in a juridical tone.

A major contemporary conflict for members of the health-care professions arises when care, according to medical or nursing standards, does not correspond with care that is authorized for reimbursement by managed care organizations. Such organizations may be more concerned with providing dividends to shareholders than funding expensive but necessary medical care. When a managed care organization diminishes the capacity of the professional to practice as he or she thinks best, the idea that one's occupation constitutes a profession is weakened. Physicians and nurses can become employees, hired to practice as directed by a corporation. What the physician or nurse believes should be done for medical reasons may have little to do with his or her actual practice.

<sup>1</sup>Pellegrino calls upon physicians to embody the qualities of *the virtuous physician*. While not every physician can manifest all the habitual dispositions he calls for, a return to this ideal should recall wavering members of the profession of medicine back to the service of the members of society. See Edmund Pellegrino, "The Virtuous Physician and the Ethics of Medicine," in Virtue and Medicine, Earl E. Shelp, ed., D. Reidel Publishing Co., 1985, pp. 237-255.

<sup>2</sup>Code of Medical Ethics, Chicago: American Medical Association, Council on Ethical and Judicial Affairs, 1996-1997.

## The Organizational Field

Contemporary health care is often provided by and on behalf of strangers in complex organizations, i.e., hospitals and "health care systems," long-term care organizations, clinics and their component departments, divisions, units, and offices. Such organizations are responsive to the aims and practices of other organizations, as well as to the vicissitudes of the political economy and the law. But these sites are not simply contexts in which practices and policies informed by "market forces" and the State may be discerned. Nor are they simply locations where moral problems of a clinical and professional sort are identified. A health-care organization, as a "non-natural corporate person" shares (with individuals, professions, and the polity) responsibility for sustaining and developing medicine as a moral institution. Health care organizations therefore generate and express a moral order and are prone to experience moral problems. So they create Mission Statements, display a Patient Bill of Rights, promulgate codes of ethics, and sponsor ethics committees. It is therefore important to understand the nature of organizations and to consider how this knowledge contributes to our appreciation of medicine as a moral institution.

An organization (e.g., a government, commercial enterprise, hospital corporation, university, church) is composed of a more or less discernible set of natural persons related (by desire or necessity) through the performance of actions understood and ordered (commonly in a bureaucratic or technocratic manner) as sets of duties or functions believed to be required for the effective and efficient realization of a particular aim or set of aims - e.g., keeping the peace, securing justice, waging war, producing and marketing goods and services, training and educating the members of society, providing rituals expressing and inspiring the unity of persons. In optimal circumstances, positive affective ties among members are generated and sustained by a desire to achieve the common aim for which the organization is constituted. Reaching the goals of "the clients" as well as of the continuing members (if they differ from the clients) is closely related to internal ordering of the organization as well as organization's capacity to generate the external resources (financial, material, technical, spiritual, etc.) required to sustain the organization and its "mission." (Parsons)

Organizations regularly encounter problems of obtaining, arranging, and deploying resources in order to carry out their missions in changing environments. Managers are therefore legitimated by the organization to direct, control, and guide the activities of other members of the organization and of clients in the name of the organization and its purposes. These officers or officials determine and re-determine what functions need to or can be performed - in what way, in what number, how often, by whom, and by what methods of integration - so that the activities of participants in the organization achieve some form of cohesion, and perhaps coherence. Any large organization is managed for those who are ultimately responsible for its good name and activities - "the people" of the State, the owners of capital, the Board of Trustees, "the community," or "the people of God."

The exercise of authority by a hierarchy of officials within an organization tends to become "routinized" by way of "standard operating procedures." The origins of routine practices are found in charters, by-laws, contracts, policies, protocols, schedules, originating and other paradigmatic acts, and habits born of the historical accretions of previously established practices. These emergent routines create a very thick sense of what is "normal" in the affairs of organizations. Organizations are also noted for placing an emphasis on loyalty and on deference rituals in accordance with status hierarchies.

Qualities generally ascribed to natural persons are also ascribed to "organizational persons."

Organizations have ethical and legal responsibilities, make decisions, are praised and blamed from a moral point of view, and can be characterized in terms of their moral identity and moral integrity, as well as the moral meaning of their relationships with other non-natural and natural persons. The moral problems of organizations usually arise relative to the prevailing sense of routinized practices and are typically influenced by the radical tensions of organizations. These tensions include:

those arising from errors of judgment, mistakes in decisions and performances, and indifference; the misuse of authority to serve narrow professional or even private (as contrasted with organizational) interests;

the empirically discoverable differences between the goals reached and goods actually secured by the organization, and the goals and goods for which it is constituted;

a failure to recognize and re-recognize, in practice, the best or proper relationship between efforts to secure primary vs. secondary goods (e.g., the health of patients vs. the means of securing resources to sustain good health care);

in societies undergoing continual change, instability occasioned by the quest for "efficiency" based on a set of predetermined offices and standard procedures, and the quest for "effectiveness" as circumstances external to the organization require change in the organization (King); that is, a tension between the need for a predictable internal relationships so that persons can successfully cooperate, and the need to change the internal ordering of relations and duties in order to respond to the changing environment from which the organization secures its resources and to which it provides goods and services.

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## **The Social & Global Fields**

To entertain the "social field" of the ethics of health care is to appreciate that the practices of health care take place within society at large: that is, the practices of health care are fully contextualized within society as a whole. Thus, to understand any particular facet of health-care practice demands an understanding of how this contextualization transfigures the practices in question. According to this logic, a decision on the part of a health-care professional within a certain clinical setting is never a medical or moral "monad". On the contrary. The clinic is shaped not only by professional and organizational norms, but it is also influenced by who sponsors the clinic and by the conditions that define society as a whole. Consideration of health care at the state, national, and global level means understanding health care in terms of the major political/legal and economic forces that mold our national, hemispheric, and worldwide societies. Bluntly put, the medical and moral reasonability of a health-care professional's decision to request a certain battery of tests is richly dependent upon and thoroughly woven into the political and economic fabric of our society at aggregate levels. We undertake the study of the social and global fields in order to appreciate this richness of this dependency.

These fields initially require an empirical-scientific study of the large-scale forces that engender policies, as well as the manner in which these forces precipitate the problems and crises that confront us by virtue of these policies. For example, one is invited to investigate the mechanisms (political and economic) of production and distribution of health care taken as a collection of scarce goods. Or, again, it is in these fields that one investigates the aggregate costs of health care, seen, for example, as a

growing percentage of the Gross National Product. Or, one might explore alternative systems of health-care distribution as possible "mechanisms of rectification" for perceived inequities in the present systems of distribution. Finally, it would be in this field of study that one attempts to understand the political roadblocks to the implementation of such alternative systems of distribution of care within states and on a global level.

Though these fields of study are initially empirical, these studies do not take place in a conceptual or normative vacuum. Underlying any such empirical study is the territory of political economy. Roughly defined in the language of intellectual history, political economy is the theoretical investigation of the proper handshake between "the best" political/legal ordering of society and the "best" economic ordering of society: such a handshake can only be understood within the penumbra of an over-arching ethical/moral theory of what constitutes the "best." It is within such normative discourses that the factual circumstances of contemporary western (and worldwide) societies are to be assessed and adjudicated. An "economic injustice" cannot be understood without reference to such normative considerations. Therefore, study of this field will require some attention to the history of political and economic philosophy and the role these theories play in the development of contemporary health care within nation - states and globally.

As the medical-moral context of "the practitioner treating this patient here and now" is considered from the standpoint of aggregate financing of clinical care, the concepts that make the clinical situation morally significant can be among the very concepts that lead legislators, bureaucrats, and corporate managers to forge policies that prove, to a considerable extent in practice, to be toxic for the patient and the practitioner. The medical clinic of today may exist in a social environment that is often hostile to the institution of medicine, ironically due to the fact that the policy makers are moved by some of the same moral considerations as those who practice in the clinics. The logics of aggregate financing of health care are perhaps, to a greater or lesser extent, inevitably toxic to the medical-moral context of the healer-patient relationship. The toxins may arise from "the rub" of the unhappy weave of fields that are incommensurable.

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# **ETHICS - SHORT VOCABULARY**

# ETHICS - A SHORT VOCABULARY FOR STUDENTS OF MEDICINE ©

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## I. MORAL LANGUAGE

<i>Argument</i>	A connected series of statements intended to establish a proposition
<i>Authority</i>	A recognized capacity to command or influence the act of another
<i>Autonomy</i>	Self-governing, self-determining
<i>Code</i>	Explicit rules of conduct by which a person, profession, or other association governs the self or, in the case of a profession or association, the conduct of its members
<i>Competent</i>	Having the capacity to perform a type of action; qualified to perform a set of actions
<i>Consent</i>	To voluntarily agree to or comply with a proposal or request from another
<i>Culpable</i>	Blamable; liable to be found at fault and subject to sanction
<i>Deontology</i>	The study of obligations and duties
<i>Dignity</i>	The quality of intrinsic worth accorded to human beings by virtue of their being human, or by virtue of their capacity for action, or the quality of achieved worth as manifested in the excellence of a person's character
<i>Divine Command</i>	An imperative, dictum, or teaching ascribed to non-human persons, such as God, or gods
<i>Duty</i>	A requirement or obligation to conform one's conduct to a rule, principle, or the pursuit of certain goals
<i>Egoism</i>	Self-interest as the standard of morality - as in, "if in my judgment, it's good for me, it's good."
<i>Ethics</i>	The field of study concerned with the intention of "leading a good life with and for others in just institutions." (Ricoeur)
<i>Ethical Problems</i>	
<i>Conflict</i>	A serious disagreement regarding what ought to be done or not done that impedes the maintenance and development of the moral community
<i>Confusion</i>	A disordered or tumultuous state

<i>Dilemma</i>	A situation in which one must choose between or among equally demanding, but incompatible, courses of action
<i>Doubt</i>	A lack of trust concerning or uncertainty about or commitment to a moral belief, rule, or principle or about the moral wisdom of an act
<i>Predicament</i>	An unpleasant or dangerous state, situation or position
<i>Quandary</i>	A state of extreme uncertainty or perplexity
<i>Ethos</i>	How things are done in a fitting or appropriate manner
<i>Evil</i>	That which impedes the persistence, arrival, or enhancement of the good and thereby engenders pain and suffering; evils are both natural (an earthquake), moral (justice denied), and both natural and moral (the advent and persistence of some forms of ill health)
<i>Good</i>	Moral good pertains to the form or content of the relations among us that signal the maintenance and development of the community, as a condition of human dignity, e.g., justice done; <i>good</i> also has many non-moral meanings, e.g., a good eye, a good tool, a good work of art; goods are also classified as intrinsic, i.e., good for their own sake (e.g., friendship, life) or as extrinsic, i.e., goods esteemed for their place in securing another good
<i>Judgment</i>	A decision, finding, or opinion with respect to some practical matter - one that informs the aim or end, or the means of securing that end, or the moral meaning of an action
<i>Institution of Medicine</i>	The manifestation of the efforts, both theoretical and practical, of persons over time to maintain, restore, and improve the health of human beings
<i>Interest</i>	To 'have an interest' is to have a share in, a right or title to, or concern with something usually believed to be relevant to a person's well-being, advantage, good, or profit. Anything that is the object of desire is also said to be 'an interest.'
<i>Law</i>	A body of rules, enacted or customary, that a state or community regards as binding on its members
<i>Moral</i>	Having to do with the form and content of the relations intended within a community of persons that are necessary to the maintenance and development of the community, as a condition of human dignity (see also <i>Evil, Good, Right and Wrong, Virtue</i> and <i>Vice</i> )
<i>Morality</i>	Norms (authoritative standards) indicating what persons ought to do and to be so that the community of persons is maintained and improved

<i>Moral Principle</i>	That from which morality originates or is derived; a fundamental source, truth, or law
<i>Beneficence</i>	Acting for the good or well-being of others or self
<i>Care</i>	To feel concern or interest in the well-being of a person
<i>Compassion</i>	A caring and sympathetic response to someone who is suffering that induces a disposition to offer assistance in alleviating or living through that suffering
<i>Justice</i>	What is minimally due persons who are members of a society such that if it is not forthcoming, it is to be provided or required
<i>Nonmaleficence</i>	"Do no harm" to others
<i>Promise-keeping</i>	Remaining loyal or faithful to one's commitments
<i>Respect for the Dignity (or Autonomy) of Persons</i>	The disposition to treat others as self-governing, as capable of action, or as worthy of respect for their excellence of character - not merely as objects of use
<i>Prima Facie</i>	"First Face," what appears initially to be the case
<i>Relativism</i>	In ethics, the view that there are no moral rules common to human beings, that moral appraisals of conduct are simply dependent on the practices, norms, and codes of particular social groups in particular times and places
<i>Responsibility</i>	The imputation or ascription of authorship of an act or of the obligation to act to a person; the ability to respond as in "taking responsibility."
<i>Right and Wrong</i>	Terms used either to approve an act as performed in keeping with one's duty and obligation, i.e., right, or to disapprove of an act as not in conformity with one's duty and obligation, i.e., wrong
<i>Right(s)</i>	A power or prerogative belonging to one by law or nature, e.g., to speak and travel freely, to be left alone (negative rights); to be entitled to a benefit from others; to perform or not perform some act in keeping with office-holding
<i>Teleology</i>	In ethics, the study of what goals, ends, aims, objectives, or goods ought in the moral sense to be sought or pursued; some goals may be better than others, some bad or defective, others evil
<i>Utilitarianism</i>	An ethical point of view that defines the morally good in terms of the consequences of acts, e.g., a good or right act is the one that, all things considered, brings about the greatest happiness for the greatest number of persons
<i>Value</i>	The worth, goodness, or excellence ascribed to an act, virtue, person, state of affairs, or object

## II. PERSONS and ACTIONS

<i>Action</i>	Human activity in so far as it is determined by knowledge and choice; deliberate participation in existence; the elements of an act are movement, the aim or end, the means employed, the motive, the reason, the circumstances, and the consequences
<i>Intention</i>	The unity of movement and knowledge in action; what an agent in action is doing
<i>Human Agent</i>	A human being with the capacity to act; the author of conduct; one who may therefore be responsible, held accountable or culpable (at fault), or praised for his or her activity
<i>Freedom</i>	The capacity to determine the future by action (see also, The CAPACITY of PERSONS for ACTION, below)
<i>Community</i>	A group of persons whose relations are characterized by positive personal motivations to maintain and develop those relations, e.g., the relations of friends or family members
<i>Society</i>	A union of persons implying an awareness that one exists in virtue of his or her relations - both personal and impersonal - with other persons; the form and content of such relations and awareness

## III. The CAPACITY of PERSONS for ACTION

### A. The Ability to Act

<i>Character</i>	Personality evaluated with respect to moral excellence or the lack thereof; or, with respect to some other non-moral norm of evaluative judgment, e.g., a graceful character.
<i>Personality</i>	The dynamic organization of the behavioral and experiential foundations of a person's capacity for action
<i>Traits or Dispositions</i>	Recurring patterns of behavior, experience, and thought enabling a person to render many stimuli equivalent, and to initiate and guide equivalent forms of adaptive and expressive behavior  When traits are assigned moral significance, they are called <i>virtues</i> , e.g., patience, honesty, or <i>vices</i> , e.g., impatience, dishonesty.
<i>Habits</i>	Learned, recurrent responses to recurrent stimuli

## B. The Opportunity to Act

<i>Circumstance</i>	The specific state of affairs immediately surrounding and effecting an agent, e.g., As he hurried toward the taxi, he noted that the steps that evening were covered with ice.
<i>Situation</i>	A general description of the place, time, and state of affairs surrounding and more remotely affecting an agent, e.g., trying to get to a meeting in the winter in Syracuse, NY
<i>Context</i>	A more general description of the times which is somehow pertinent to acting one way or another, e.g., the economic, political, historical, legal, religious, civilizational, etc., factors that influence what is done or omitted from doing; e.g., The law of torts required that he be there on time or lose the case.
<i>Habitat</i>	The locality of life, living, and action
<i>Environment</i>	The conditions or influences under which a person lives and develops - especially as these pertain to the organismic capacity for action
<i>Polity</i>	That aspect of society expressed in the state and its laws that is concerned with maintaining, improving, and adjusting the impersonal relations of persons and with promoting the integrity and continuity of the state