ETHICS AND THE HEALTH PROFESSIONS

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

SU: PHI 593, REL 551

LMC: CCM 408/508, PHL 347

FALL 2011

INSTRUCTORS:

Robert W. Daly, M.D.
Robert J. Flower, Ph.D.
Paul Prescott, M.A.
ETHICS AND THE HEALTH PROFESSIONS

FALL 2011

Wednesdays, 4:00-7:00 p.m., Room 1507 Setnor Academic Building next to Weiskotten Hall

INSTRUCTORS:

Robert W. Daly, M.D.
Psychiatry, Bioethics and Humanities
SUNY Upstate Medical University
713 Harrison Street, Room 330
Office: 464-3104
Home: 446-6748
Fax: 464-3163
E-mail: dalyr@upstate.edu
E-mail: rdaly2@twcny.rr.com

Rebecca Garden, Ph.D.
Executive Director, CFM
SUNY Upstate Medical University
Office: 464-8451
E-mail: gardenr@upstate.edu

Paul Prescott, M.A.
Doctoral Candidate
Department of Philosophy
Syracuse University
Home: 422-0886
E-mail: papresco@syr.edu

Robert Flower, Ph.D.
Department of Philosophy
Le Moyne College
Office: 445-4499
Home: 458-6347
Fax: 445-4540
E-mail: flower@lemoyne.edu

Lois Dorschel, Coordinator, CFM
SUNY Upstate Medical University
618 Irving Ave., Ste 406
Office: 464-5404
Email: dorschel@upstate.edu

Linnette Thorp
SUNY Upstate Medical University
Library Weiskotten Hall, Room 040
Office: 464-3104
Email: thorpl@upstate.edu

Library
Weiskotten Hall
Phone: 464-7091
E-mail: libserve@upstate.edu

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

Required Readings for each seminar are noted on separate pages of this syllabus. (Readings on Blackboard 9)

DATE      SUBJECT                                      DUE DATES
Aug. 31   (Seminar 1) A. Introductions and Logistics Reflection I
          B. Discussion of Course Themes Typed, Double Spaced, 2pp.
Sept. 7*  (Seminar 2) Foundations of Ethics I
<table>
<thead>
<tr>
<th>DATE</th>
<th>SUBJECT</th>
<th>DUE DATES WRITTEN ASSIGNMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sept. 14</strong></td>
<td>(Seminar 3) Foundations of Ethics II</td>
<td>Reflection II</td>
</tr>
<tr>
<td><strong>Sept. 21</strong></td>
<td>(Seminar 4) Clinical Field I</td>
<td>Reflection III</td>
</tr>
<tr>
<td></td>
<td>Case 1</td>
<td></td>
</tr>
<tr>
<td><strong>Sept. 28</strong></td>
<td>(Seminar 5) Clinical Field II</td>
<td>Reflection IV</td>
</tr>
<tr>
<td><strong>Oct. 5</strong></td>
<td>(Seminar 6) The Professional Field I</td>
<td>** Proto-Précis of Term Paper</td>
</tr>
<tr>
<td></td>
<td>Case 2</td>
<td></td>
</tr>
<tr>
<td><strong>Oct. 12</strong></td>
<td>(Seminar 7) The Professional Field II</td>
<td>Reflection V</td>
</tr>
<tr>
<td><strong>Oct. 19</strong></td>
<td>(Seminar 8) The Organizational Field</td>
<td>Reflection VI</td>
</tr>
<tr>
<td></td>
<td>Case 3</td>
<td></td>
</tr>
<tr>
<td><strong>Oct. 26</strong></td>
<td>(Seminar 9) The Social/Political/Economic Field I</td>
<td>Reflection VII</td>
</tr>
<tr>
<td>***</td>
<td>***</td>
<td>*** Précis of Term Paper</td>
</tr>
<tr>
<td><strong>Nov. 2</strong></td>
<td>(Seminar 10) The Social/Political/Economic Field II</td>
<td>Reflection VIII</td>
</tr>
<tr>
<td><strong>Nov. 9</strong>**</td>
<td>(Seminar 11) The Global Field</td>
<td>Reflection IX</td>
</tr>
<tr>
<td></td>
<td>***</td>
<td>**** Submit draft of paper</td>
</tr>
<tr>
<td><strong>Nov. 16</strong></td>
<td>(Seminar 12) Group Project - Presentations</td>
<td></td>
</tr>
<tr>
<td><strong>Nov. 23</strong></td>
<td>NO SEMINAR</td>
<td></td>
</tr>
<tr>
<td><strong>Nov. 30</strong></td>
<td>(Seminar 13) TBA</td>
<td></td>
</tr>
<tr>
<td><strong>Dec. 7</strong>***</td>
<td>(Seminar 14) Review and Closure</td>
<td>***** Submit draft and final paper</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Turn in Course Evaluations</td>
</tr>
</tbody>
</table>

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

**  **Proto-Précis of Term Paper Due:** See requirements for details

***  **Précis of Term Paper Due:** See requirements for details

****  **Draft Version of Term Paper Due** -- typed, double-spaced; 10 to 15 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 2011

All required readings are available on Blackboard

Background Texts: These texts may be assigned and are 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. The instructors may also post required or recommended readings on Blackboard. Assignments regarding same will also be made in class in the seminars. It is, therefore, important to consult Blackboard when preparing for seminars.

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


Flower, Robert J., "VIII. The Lie: A Kantian Schematism For Immorality (The Centrality of Deceit)."

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


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

Taylor, Paul, "Ethical Relativism."

Sept. 7 - Seminar Two - Foundations of Ethics I


Flower, Robert J., "XIV. The Smile of Aphrodite: a Study In the Phenomena of 'Oughts'."

Flower, Robert J., "Metaxu Ti."

TBA

Sept. 14 - Seminar Three - Foundations of Ethics II

"Ethics - A Short Vocabulary," Syllabus.

Flower, Robert J., "Metaxu Ti."

Flower, Robert J., "XV. Dilemma."

TBA
Sept. 21 - Seminar Four - The Clinical Field I

"The Clinical Field," Background Notes, Syllabus, pg. 21 & 22.


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?"


TBA

Sept. 28 - Seminar Five - The Clinical Field II

"The Clinical Field," Background Notes, Syllabus, pg. 21 & 22.

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

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

New York State's Health Care Proxy Law


TBA

Oct. 5 - Seminar Six - The Professional Field I


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

TBA

Oct. 12 - Seminar Seven – The Professional Field II


TBA
Oct. 19 - Seminar Eight – The Organizational Field

"The Organizational Field," Background Notes, Syllabus, pp. 24 & 25,
"Organizational Ethics In Health Care - Primary vs Secondary Goods."


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

TBA

Oct. 26 - Seminar Nine – The Social/Economic/Political Field I


TBA

Nov. 2 - Seminar Ten – The Social/Political/Economic Field II


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

Reid, T. R., The Healing of America, New York: The Penguin Press, 2009, Chapt 4, or 5, or, 6, or 7, or 8; Chapt 13.

TBA

Nov. 9 - Seminar Eleven – The Global Field

Daly, Robert W., Global Health


TBA

Nov. 30 - 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 – Dates due as indicated above. Timely completion of all reflections and papers is required.

Reflections - 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. Pay particular attention to Professor Prescott's instructions regarding arguments.

Term Paper - Do not confuse a “term paper” with a “final paper.” A final paper is writing one expects to do toward the closing hours of a semester, usually as the last piece of required work to be submitted. A term paper, on the other hand, is a project with which one is engaged during most of the semester. While it is turned in at the end of the semester, it is presumed that only the “touches” of final revisions are completed just before submission. A term paper is completed throughout the semester. Three preliminary writing assignments are intended to ensure satisfactory completion of your “term paper: a proto-précis, a précis, and a draft of your term paper.

Proto-Précis and Précis (A Proto- Précis is your first effort at a Précis)

As the subject matter (topic) of your term paper must be determined early in the semester, the précis assignments facilitate the discernment of the relevance, import, and specification of your topic. A précis is similar to an abstract but is written at the outset of the project rather than at its completion.

One does not pick a topic blindly. The “eye of the mind” is attracted toward/into a subject matter. The précis affords one the opportunity to explore this attraction, to discern what it is in the subject matter that sparks one’s interest and to articulate this. The idea behind this assignment is that research is never unguided or entirely devoid of presumptions/expectations as to what will be “found”/determined. Once again, it is the purpose of the précis to afford you the opportunity to think through and come to terms with the intuitions driving your work.

The précis is meant to afford you a model of thinking about your work, a model for keeping your eye on the point of your work.

A précis is a short essay (not an outline) of no more than three, typed manuscript pages, and should include the following:

--an articulation of the subject matter of the research;
--an articulation of the issue embedded within this subject;
--a brief account of the dominant positions/concerns that define the issue as an issue;
--a brief description of the stance taken by you in your paper
REQUIREMENTS (continued):

Central to the précis-assignment is the challenge of clarifying the theme/subject matter. Therefore, one should make every effort in the writing of the précis to become clear as to what the issue is, and how, in philosophical terms, it is constituted. What makes the issue tick? Why is the issue one of significance for persons concerned with health care? What insight, thesis, or point relative to the issue do you intend to convey in your term paper? Failure to generate a satisfactory précis will require the writing of another, and presumably, satisfactory précis.

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.

Term 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.

Reference Librarians in the library at Weiskotten Hall at UHU can also be very helpful in the identification of texts relevant to your research.
METAXU TI
A model of/for the "logical space" of ethical discourse.

Invocation of the Divine

J-X (modern)
(divine Skyhook)
- Absolute Authority
- Divine will as ground of "ought" (commandments)
- "Thy will Be Done..."
- Reverence

The Greek gods
("Philosophical Divinity")
- Pure thought
- Pure reason
- Wisdom
- Answers

Radicalization
Some become God

Deontological: Kant
- Autonomy (Freedom)
- Right of self determination
- The covenant
- Universal conditions of contract
- Duty to the law
- Constitutionalism

Radicalization:
-Tyranny of whim
-Done as one pleases

Humankind logos
To save the phenomenon of:
- Ethical/moral agency
- The question of meaning
- The question of justification
- Human dignity (the respect worthy)
- The possibility of a mistake
- "Phronesis"
- Rational animality

Aristological: Aristotle
(utilitarianism: "mill")
- The Best
- The noble "n" beautiful
- The good life
- Happiness
- Excellence
- Aristocracy

Emotivism (modern)
- Non-cognitivism
- Subjective relativism
- "My will be done"
- Democracy

(Greek)
- Beasts
- Protagoreanism

Nihilism/Besiality
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?
NOTES

Aug. 31 - Seminar One – A. Introductions and Logistics
B. Discussion of Course Themes
NOTES

Sept. 7 - Seminar Two – Foundations of Ethics I
NOTES

Sept. 14 - Seminar Three – Foundations of Ethics II
NOTES

Sept. 21 - Seminar Four – Clinical Field I
NOTES

Sept. 28 - Seminar Five – Clinical Field II
NOTES

Oct. 5 - Seminar Six – The Professional Field I
NOTES

Oct. 12 - Seminar Seven – The Professional Field II
NOTES

Oct. 19 - Seminar Eight – The Organizational Field
NOTES

Oct. 26 - Seminar Nine – The Social/Political/Economic Field I
NOTES

Nov. 2 - Seminar Ten – The Social/Political/Economic Field II
NOTES

Nov. 9 - Seminar Eleven – The Global Field
NOTES

Nov. 16 - Seminar Twelve – Group Project – Presentations
NOTES

Nov. 30 - Seminar Thirteen – TBA