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Foundations in Theory

Healthcare professionals face many issues in dealing with the complexities of both patient treatment and the larger healthcare system. Addressing these issues requires a firm foundation of knowledge and skills in order to provide services that will positively affect patient treatment and organizational outcomes. Certainly, the community expects professionals to have a thorough understanding of the foundation in their professions before they can practice. In short, you are supposed to "know your stuff" if you want to be considered a professional in healthcare.

The same is true with the study of ethics. Ethics in health care is not just about doing the right thing. The issues faced often are exceedingly complex and far from black and white. In addition, society and the health professions themselves often have stringent ethics expectations. In light of these challenges, it seems logical that one must have a solid foundation in the theory and principles of ethics in order to make appropriate professional decisions. The first section of the new edition of *Health Care Ethics: Critical Issues for the 21st Century* begins with two chapters that will provide this foundation.

The foundation in ethics theory and principles provided in these chapters also will give you practical tools for analyzing ethics-related issues that you will encounter in the future. Without an ethics foundation, it would be difficult to develop plausible solutions to the thorny issues that will emerge. Thus, a foundation in theory, principles, and decision making will enhance your ability to reason through whatever problems are presented.

As you face ethics dilemmas in the future, you could ask, "What theory or theories best apply here?" or "If I take this position, what principles will I support or violate?" or "What is the price of not being ethical?" Because ethical issues are usually broader in scope than they appear, you could also think about their affect on individuals, your organization, or on the society in which you live. This type of thinking is and will continue to be necessary in the healthcare environment, where even the smallest issue may have a large impact on professionals and the institutions in which they work.

In an immediate sense, a foundation in ethics theory and principles will be useful to you as a student of this subject matter. The principles and theories explained in this section will frequently be used in subsequent chapters to examine the issues presented. In addition, at the end of each chapter questions are provided to encourage you to take your intellect beyond what you have read. Many of these questions relate directly to the application of a particular theory or principle. By answering these questions, you will enhance the depth of your understanding not only of the specific issue, but also of the application of ethical theory and/or principles.

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In Chapter 1, Dr. Summers presents a well-researched overview of the theories commonly used in healthcare ethics. He begins with a model so that you can see where ethics fits into the study of philosophy. Following that, he reviews ethics theories that might not have as much relevance to healthcare practice as other theories, including authority-based ethics, egoism, and ethical relativism. He then presents the most commonly held ethics theories that are applied in healthcare practice. These include natural law, deontology, utilitarianism, and virtue ethics. In his discussions, he uses examples to help you better understand how these theories apply to your professional practice. In fact, he refers to them as part of your *ethics toolbox.*

In Chapter 2, Dr. Summers continues his scholarly discussion of ethics by presenting the four most commonly used principles: nonmaleficence, beneficence, autonomy, and justice. Because justice is the most complex of the four, he provides additional material about the types of justice. He also provides information on how you can decide what is just. At the end of Chapter 2, Summers presents a decision-making model called the *reflective equilibrium model.* This model demonstrates the application of ethics theory and principles in the practice of making clinical and business decisions.

If you read these chapters thoroughly and think about their content, you should be well prepared to discuss the issues presented in this book in a rational way. Many of the issues presented in this text are emotional in nature, but emotional decisions might not be the best ones. Consequently, using the knowledge gleaned from these two chapters should be useful to you as a student and as a professional.

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Theory of Healthcare Ethics

Jim Summers

OVERVIEW

In this chapter, Summers presents a scholarly account of the main theories that are applied to the ethics of healthcare situations. Why bother with such a discourse? The answer is that without a foundation, you are left to make decisions without a structure to support them. You would not have the wisdom of the theorists to defend your decisions if you need to do so. In addition, you would not have a knowledge base to analyze the many issues that you will face in health care in the twenty-first century. Therefore, this chapter and the one on the principles of ethics, which follows, will serve as your ethics toolbox.

ETHICS AND HEALTH CARE

From the earliest days of philosophy in ancient Greece, people have sought to apply reason in determining the right course of action for a particular situation and in explaining why it is right. Such discourse is the topic of *normative ethics*. In the twenty-first century, issues resulting from technological advances in medicine and science will continue to provide challenges that will necessitate similar reasoning. Healthcare resource allocations will become more global and more vexing as new diseases threaten, global climate change continues apace, and ever more people around the world find their lives increasingly desperate as disease and poverty overtake them. Managers of healthcare organizations will find the resources to carry out their charge increasingly constrained by lack of money and labor shortages. A foundation in ethics theory and ethical decision-making tools can help in assessing the choices to be made in these vexing circumstances.

Knowledge of ethics can also be valuable when working with other healthcare professionals, patients and their families, and policy makers. In this sense, ethical understanding, particularly of alternative views, becomes a form of cultural competence.[1] However, this chapter is confined to a discussion of normative ethics and metaethics. By definition, *normative ethics* is the study of what is right and wrong; *metaethics* is the study of ethical concepts. Normative ethics examines ethical theories and their application to various disciplines, such as health care. In health care, ethical concepts derived from normative theories, such as autonomy, beneficence, justice, and nonmaleficence, often are used to guide decision making.[2] These concepts and principles are discussed in Chapter 2.

As one might suspect, when normative ethics seeks to determine the moral views or rules that are appropriate or correct and explain why they are correct, major disagreements in the interpretation often result. Those disagreements influence the application of views in many areas of moral

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inquiry, including health care, business, warfare, environmental protection, sports, and engineering. Figure 1–1 lists the most common normative ethical theories. Each of these theories will be considered in the text. Although no single theory has generated consensus in the ethics community, there is no cause for despair.

The best way to interpret these various ethical theories, some of which overlap, is as a toolbox. Each of these theories teaches something and provides tools that can assist with decision making. The choice of tools in the ethics toolbox depends significantly on our professional role in health care. One advantage of the toolbox approach is that you will not find it necessary to choose one ethical theory over another for all situations. You can choose the best theory for the task, according to the requirements of the role and the circumstances. Trained philosophers will find flaws with this approach, but hopefully, the practical advantages will suffice to overcome these critiques.

All of the theories presented have a value in the toolbox, although like any tool, some are more valuable than others; for example, I shall argue that virtue ethics has much more value for healthcare applications. Before explaining why this chapter has chosen to present particular theories, a quick overview is in order:

- Authority-based theories can be faith based, such as Christian, Muslim, Hindu, or Buddhist ethics. They could also be purely ideological, such as those based on the writings of Karl Marx (1818–1883) or on capitalism. Essentially, authority-based theories determine the right thing to do based on what some authority has said. The job of the ethicist is to determine what that authority would decree for the situation at hand.
- Natural law theory, as considered here, will use the tradition of St. Thomas Aquinas (1224–1274) as the starting point of interpretation. The key idea behind natural law is that nature is ordered rationally and providentially. The right thing to do is that which is in accord with the providentially ordered nature of the world. In health care, natural law theories are important, owing to the influence of the Roman Catholic Church and Aquinas as an early writer in the field of ethics. Several important debates, such as those surrounding abortion, euthanasia, and social justice, draw upon concepts with roots in natural law theory.

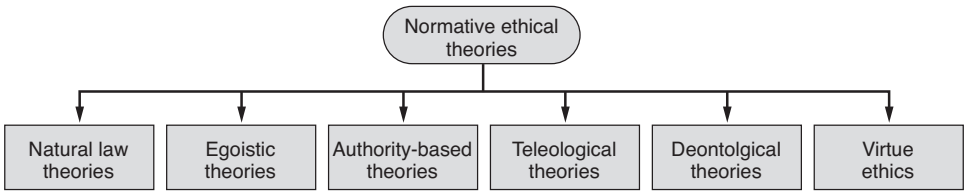

Figure 1–1 Normative ethical theories.

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- Teleological theories consider the ethics of a decision to be dependent on the consequences of the action. Thus, these theories are more commonly known as *consequentialism*. The basic idea is to maximize the good of a situation. The originators of the theory, Jeremy Bentham (1748–1832) and John Stuart Mill (1806–1873), called this maximization of good *utility*, thus this theory is most often referred to as *utilitarianism*.
- Deontological theories are usually traced to Immanuel Kant (1724–1804). The term *deon* is from the Greek and means "duty." Thus, deontology could be called the science of determining our duties. Most authors place Kant in extreme opposition to consequentialism, because he argued that the consequences themselves are not relevant in determining what is right. Thus, doing the right thing might not always lead to an increase in the good.[3]
- Virtue ethics has the longest tenure among all of these views, except for authority-based theories. Its roots can be traced to Plato (427–347 BCE) and to Aristotle (384–322 BCE). The key idea behind virtue ethics is to find the proper end for humans and then to seek that end. In this sense, people seek their perfection or excellence. Virtue ethics comes into play as people seek to live virtuous lives, developing their potential for excellence to the best of their ability. Thus, virtue ethics addresses issues any thinking person should consider, such as "What sort of person should I be?" and "How should we live together?" Virtue ethics can contribute to several of the other theories in a positive way, particularly in the understanding of professional ethics and in the training necessary to produce ethical professionals.
- Egoistic theories argue that what is right is that which maximizes a person's self-interests. Such theories are of considerable interest in contemporary society due to their relationship to capitalism. However, the ethical approach of all healthcare professions is to put the interests of the patient above the practitioners' personal interests. Even when patients are not directly involved, such as with healthcare managers, the role is described as a *fiduciary relationship*, meaning that patients can trust that their interests come before those of the practitioners. Egoistic theories are so at odds with the value systems of nearly all healthcare practitioners that it is not necessary to take them up in any depth.

Before exploring any of these ethical theory tools in depth, it is first necessary to confront the relativist argument, which denies that ethics really means anything.

ETHICAL RELATIVISM

Those who deal with ethical issues, whether in everyday life or in practice, will inevitably hear the phrase "It is all relative." Given that the purpose of this text is to help healthcare professionals deal with real-world ethical issues, it is important to determine what this phrase means and the appropriate course of action. No satisfactory ethical theory has been developed that covers every situation. In fact, philosophers are expert at finding flaws in any theory,

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thus no theory will be infallible. It is also well known that different cultures and different groups have varying opinions about what is right and wrong and how to behave in certain situations.[4]

Does the fact that people's views differ mean that any view is acceptable? This appears to be what is meant by statements such as "It is all relative." In that sense, deciding that something is right or wrong, or good or bad, has no more significance than choices of style or culinary preferences. Thus, ethical decision making and practice is a matter of aesthetics or preferences, with no foundation to ground it. This view makes a normative claim that there is no real right or wrong or good or bad.

One could equally say that there is no truth in science, because scientists disagree about the facts and nothing is ever proven, only falsified by experiment.[5] However, the intrinsic lack of final certainty in the empirical sciences does not render them simply subjective. As one commentator on the rapid changes in scientific knowledge put it, these changes reveal "the extraordinary intellectual and imaginative yields that a self-critical, self-evaluating, self-testing, experimental search for understanding can generate over time."[6] Why should we expect any better of ethics?

Sometimes the claim is made that because there are many perspectives, there cannot be a universal truth about ethics. Therefore, we are essentially on our own. A very helpful essay by Hugh LaFollettee showed a way out of these issues.[7] LaFollettee argued that the lack of an agreed-upon standard or the inability to generalize an ethical theory does not render ethical reasoning valueless. Rather, the purpose of ethical theories is to help people decide the right course of action when they are faced with troubling decisions. Some ethical theories work better in some situations than others. The theories themselves provide standards, akin to grammar and spelling rules, as to when something is properly executed using that theory.

Thus, even though ethics might not produce final answers, we are still called upon to make decisions. Ethics theories and principles are tools to help us in that necessary endeavor. The lack of absoluteness in ethical theory also does not eliminate rationality. Often, we simply must apply our rationality without knowing if we are correct. The better our understanding of ethics, the more likely it is that the decision we reach will be appropriate.

ETHICAL THEORIES

Let's begin to examine the tools in the toolbox, knowing that we are fallible, but also that we are rational, too.[8] The first tool has little application to healthcare ethics; however, it is widely believed, and therefore it must be addressed. It involves the idea of egoism in ethics.

Egoism

Egoism operates from the premise that people either should (a normative claim) seek to advance solely their own self-interests or that (psychologically)

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this is what actually people do. The normative version, *ethical egoism*, sets as its goal the benefit, pleasure, or greatest good of the self alone.[9] In modern times, the theory of ethical egoism has become popularized through the writings of Ayn Rand[10] and her theory of *objectivism*.[11] For example, Rand said, "The pursuit of his own rational self-interest and of his own happiness is the highest moral purpose of his life."[12] This is a normative statement, and a reasonable description of ethical egoism.

Although this theory has importance to the larger study of ethics, it is less important in healthcare ethics, because the healing ethic itself requires a sublimation of self-interests to those of the patient. A healthcare professional who fails to do this is essentially not a healthcare professional. No codes of ethics in the healthcare professions declare the interests of the person in the professional role to be superior to those of the patient.

> A healthcare professional who does not understand the need to sublimate his or her own interests to those of the patient or his or her role has not yet become a health professional.

Although occasionally healthcare professionals do not put the patient's best interest first, it is not a goal of the profession. Thus, we leave egoism of any form behind.

Authority-Based Ethical Theories

Most teaching of ethics ignores religion-based ethical theories, much to the chagrin of those with deep religious convictions. The use of religion-based ethics in healthcare practice should be avoided for several reasons. These include:

Which Authority Is the Correct One?

Authority-based approaches, whether based on a religion or an ideology, such as communism or capitalism, are flawed relative to the criteria needed to qualify as a normative ethical theory. Each of the authority-based approaches claims to be normative relative to everyone. Because many of these authority-based approaches conflict, there is no way to sort them out other than by an appeal to reason. There are other philosophical issues in addition to the difficulty of finding a way to agree on which of the opposing inerrant authorities is correct. For example, religious theories add an unnecessary layer of complexity to the argument and, at the same time, make defense of their claims more difficult. When faced with two competing theories that each seem to adequately explain the phenomenon, the appropriate choice is to choose the simpler explanation.

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Religions and Health Care

All religions provide explanations of the cause or the meaning of disease and suffering. Many theologies also encourage believers to take steps to remove or ameliorate causes of disease and suffering. Over the millennia, some of these religions have even formalized their positions by becoming involved with health care.

In addition, patients often have religious views that help them to understand and cope with their conditions. Understanding a person's faith can help the clinician provide health care that is more patient focused.[13] For some patients, an ethical issue arises if their faith or lack of a faith practice is neither recognized nor respected.

Beyond direct patient care, a second reason to understand the authority-based philosophies common in the healthcare environment is their affect on healthcare policy. The role of authority-based ethical positions appears to be gaining importance in the twenty-first century. To be effective working within the health policy arena, whether at the institutional, local, regional, state, federal, or international level, an understanding of the influence of the religious views of those involved in the debates and negotiations can only serve to strengthen your ability to reason with them. Proper engagement in healthcare debates or negotiations requires an understanding of the fundamental importance of health and the role of religion and philosophy in healthcare policy. In other words, it is important to understand the "common" morality of those engaged in the debate. The more diversity in beliefs and reasoning, the more important the need for understanding of what those beliefs and reasoning might be.

Religion also plays an important role in the creation of healthcare policy because religions have provided a multiplicity of philosophical answers to questions about the nature and truth of the world and how we should act in it. They explain what is considered right or wrong and why it is right or wrong. They also help people define who they are, their role in the world, and how they should relate to one another. Religions explain the nature of the world relative to our place in it.

Thus, as a tool, understanding authority-based philosophical systems has value because it can help in the treatment of patients. It also increases your understanding about the positions of persons who may be involved in debates over healthcare issues, such as resource allocations, or clinical issues, such as abortion. In addition, it is important to understand authority-based philosophical systems relative to yourself. As a healthcare professional, your role requirements dictate that you do not impose your religious views on patients. At the same time, it is not part of the role for you to accept the imposition of another's values, even those of a patient.

These complex issues relate to professional ethics and are not part of the scope of this chapter. However, it does seem incumbent on all healthcare professionals to evaluate their own faith and to recognize the extent to which they might impose it on others. From the earliest tradition of Hippocrates, the charge was to heal the illness and the patient. More recently, the Declaration

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of Geneva from the World Medical Association (1983) stated that members of the medical profession would agree to the statement: "I will not permit considerations of religion, nationality, race, party politics, or social standing to intervene between my duty and my patient."[14]

Let's now turn our attention to the oldest non-authority-based ethical theory—virtue ethics.

Virtue Ethics

Virtue ethics traces its roots most especially to Aristotle (384–322 BCE). Aristotle sought to elucidate the highest good for humans. Bringing the potential of that good to actualization requires significant character development. The concept of character development falls into the area of virtue ethics, because its goal is the development of those virtues in the person and the populace.

Aristotle's ethics derived from both his physics and metaphysics. He viewed everything in existence as moving from potentiality to actuality. This is an organic view of the world, in the sense that an acorn seeks to become an oak tree. Thus, your full actuality is potentially within you. As your highest good, your potential actuality is already inherent, because it is part of your nature; it only needs development, nurture, and perfecting. This idea is still with us in many respects as part of the common morality.

Finding Our Highest Good

Just what did Aristotle conclude was our final cause or our highest good? The term Aristotle uses for this is *eudaimonia*. The typical translation is "happiness." However, this translation is inadequate and many scholars have suggested enhancements. Many prefer to use the translation "flourishing." However, any organic entity can flourish, such as a cactus, so the term is not an adequate synonym.

The major complaint about translating *eudaimonia* as "happiness" is that our modern view of happiness would render it subjective. No one can know if you are happy or not; you are the final arbiter. Aristotle thought *eudaimonia* applied only to humans, because it required rationality that goes beyond mere happiness. In addition, *eudaimonia* includes a strong moral component that is lacking from our modern understanding of happiness. In this sense, "happiness" would necessarily include doing the right thing, being virtuous. Others could readily judge if you were living a virtuous or "happy" life by observing your actions. For Aristotle, happiness is not a disposition, as in "he is a happy sort."

Eudaimonia is an activity. Indeed, children and other animals, unable to engage self-consciously in rational and virtuous activities cannot yet be in the state translated as "happy."[15] Because it is commonplace to describe children as being "happy," this is clearly not an adequate translation. Given these translation problems, I shall use the term *eudaimonia* rather than its translations of "happiness" or "flourishing." Essentially, *eudaimonia* is best understood as a perfection of character nurtured by engaging in virtuous acts over a life of experience.

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Essentially, *eudaimonia* is best understood as a perfection of character nurtured by engaging in virtuous acts over a life of experience.

The most important element of *eudaimonia* is the consideration of what it takes to be a person of good character. Such a person seeks to develop excellence in himself or herself. To be excellent, what sort of person should I be? Because Aristotle recognized the essential social and political nature of humans, the answer to this question would necessarily have to include consideration of how we should live together.

Developing a Professional as a Person of Character

Consider what it takes to develop a competent and ethical healthcare professional. The process involves a course of study at an accredited university taught by persons with credentials and experience in the field. It also includes various field experiences, such as clerkships, internships, and residencies or clinical experiences with patients. Part of the education includes coming to an understanding of what behaviors are appropriate for the role, which is often called *professional socialization*.

For all healthcare professions, the educational process includes a substantial dose of the healing ethic by specific instruction or by observation of role models. The most fundamental idea behind this healing ethic as a form of role formation is the healthcare professional's sublimation of his or her self-interests to the needs of the patient. This education also includes recognition of the idea that the healing ethic means first do no harm and that whatever actions are taken should provide a benefit.[16]

The Character of a Physician

The goal of professional education and socialization is to produce healthcare professionals of high character. Many professional ethics codes describe the character traits that define high character. These traits might also be considered virtues.[17] For example, the 2001 American Medical Association statement of the principles of medical ethics states that the principles are "standards of conduct which define the essentials of honorable behavior for the physician."[18] Essentially, the principles define the appropriate character traits or virtues for a physician.

Relative to virtue ethics, these traits or virtues combine to create not only a good physician, but also a person of good character. Like Aristotle's person of virtue, engaging in the activities of *eudaimonia* (clearly the translation "happiness" does not fit here) produces practical wisdom. "Moral virtue comes about as a result of habit."[19] The virtues come into being in us because "we are adapted by nature to receive them, and they are made perfect by habit."[20]

Not only is practice required, but the moral component is indispensable. Good physicians are not merely technically competent; they are persons of

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good character. How do we know this? Their actions coalesce to reveal integrity. In addition, a physician or any other person of good character does not undertake to do what is right simply to appear ethical. In a modern sense, the properly socialized physician or person has internalized the ethical expectations. To do the right things is part of their identity.[21]

To use Aristotle's term, physicians have become persons of practical wisdom. The mere fact that inculcation of such character traits is so important in all healthcare professions indicates the extent to which these ancient teachings are part of the common morality, or at least the professional morality within the healthcare professions. It is part of our cultural competence. In short, persons of virtue nurture *eudaimonia* because they believe it is the right way to live and "[w]ith the presence of practical wisdom will be given all the virtues."[22] Good physicians are living excellent lives; perfecting themselves is part of their self-identity.[23] These persons will, as a matter of course, act on the ethical principles that form the core of their identification of themselves with their role. In health care, principles function as virtues.

Principles of Biomedical Ethics as Virtues

The authors Tom Beauchamp and James Childress have popularized what they call the "principles of biomedical ethics" in texts that have gone through five editions, from 1978 to 2001.[24] These well-known principles are provided in the following list along with brief definitions (an extended discussion of these principles is provided in Chapter 2):

- *Autonomy* is the ability to decide for oneself. The word derives from the Greek word for "self" (*auto*) and "rule" (*nomos*). It means that people are free to make their own decisions. The failure to respect the personhood of others, making decisions for them without their consent, is *paternalism*.
- *Beneficence* is from the Latin root *bene*, meaning "to do well." More specifically, it derives from the Latin term *benefacere*, meaning "to do a kindness, provide a benefit." It is the practice of doing the good thing. Health care has clearly valued beneficence from its early Hippocratic origins. It is the second part of the dictum "first do no harm, benefit only." Professionalism requires healthcare practitioners to put the patients' interests before their own. When combined with beneficence, healthcare professionals hold dear the value, norm, or virtue of altruism.
- *Nonmaleficence* derives from the Latin *mal*, meaning "bad." A *malevolent* person wishes ill of someone. Thus, nonmaleficence means to *NOT* do wrong toward another. Clearly, this captures the first part of the Hippocratic dictum: "first do no harm . . ."
- *Justice* is a concept with a vast history and multiple interpretations. The etymology is Latin, and suggests more than just fairness. The terms *just* and *justice* include elements of righteousness ("she is a just person"), equity ("she received her just due"), and lawfulness ("to bring to justice").[25] A just person is fair, lawful, reasonable, correct, and hon-

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est.[26] Most writers in ethics discuss two kinds of justice: distributive and procedural. *Distributive justice* determines if burdens and benefits are shared properly. *Procedural justice* determines if the rules were applied properly in the hearing of a case. Because of the importance of justice in resource allocations, this topic will be discussed at length in Chapter 2.

I agree with Beauchamp and Childress that these concepts are foundational principles of healthcare ethics.[27] A person having these virtues as part of his or her character structure, self-definition, and actions would be considered to be a person of good character. In healthcare terms, such a person would be walking the talk of the healing ethic and would be a person of practical wisdom.

Elitism

A person who seeks to nurture *eudaimonia* through his or her actions achieves this goal after long practice of Aristotle's practical wisdom. Such a person also sets the standard for the right action in a particular situation. Thus, virtue ethics has the problem of being elitist. Aristotle was quite aware of this elitism, but it did not pose a problem to him 2300 years ago. He thought that some people were simply not capable of maximizing their potential to reach the highest good, owing to his view of the hierarchical nature of reality.[28]

Aristotle noted the difficulty of encouraging many to a character of virtue; a life of nobility and goodness.[29] Aristotle believed that most people are motivated by fear, living by emotions, and pursuing pleasures. They lack even a conception of the noble and truly pleasant, having never known it. Aristotle seemed to despair that once these bad traits have long been in place, they are impossible to remove. He concluded, "we must be content if, when all the influences by which we are thought to be good are present, we get some tincture of virtue."[30] The person of practical wisdom becomes the standard for ethical decision making. This leads to an understanding of how virtue ethics can facilitate the management of ethical conflicts.

Balancing Obligations from the Virtue Ethics Perspective

It is not possible to practice in the healthcare profession for long without encountering some kind of ethical dilemma because different principles of ethics or different virtues conflict. For example, some treatments involve harm yet provide a benefit. An experienced healthcare professional must be able to explain the relative benefits and risks and gain the cooperation of the patient for such treatments.

Sometimes one principle might create conflict. For example, physicians must know how to tell the truth to patients. Even though information can be regarded as therapy, information delivered at the wrong time or in the wrong way can be devastating. Information not delivered at the right time or never delivered at all could mean that the physician is not being honest and is guilty of paternalism. Learning how to deal with these issues effectively takes experience and theoretical knowledge.

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A major component of the patient–clinician relationship is the patients' trust that their caregivers have their best interests at heart and that they are competent. If patients perceive caregivers as persons of integrity, virtue, or practical wisdom, their confidence in their caregivers will increase. That increase in the patients' confidence has documented effects on enhancing the placebo effect.[31] How caregivers communicate, and even how they carry themselves, will do much to influence these perceptions.[32] The caregiver who knows how to do these things, who is an exemplar of the character traits and the virtues in the AMA's Principles of Medical Ethics, is a person of practical wisdom, at least when it comes to medical practice.

Caregivers with practical wisdom, which by necessity includes being of good character or virtuous, will be able to make appropriate decisions about the means to ends. This has significant implications for healthcare ethics. When faced with ethical challenges in medical care, such caregivers will have the practical wisdom to know how to weigh the various issues and concerns and form a conclusion. Because wise and good people can, and do, come to different conclusions about the ethically appropriate choice of action, persons of practical wisdom should consult with one another.

Healthcare organizations have sought to institutionalize this approach by using ethics committees. Those with practical wisdom in health care are far ahead in having a decades-long tradition of ethics committees, ethics consultations, institutional review boards, and the like. These administrative mechanisms make it easier to manage disagreement. The key here is that persons of good character, pursuing virtuous ends, are much more likely to make an appropriate choice than those without such experience or such character. These choices would appear to refute one of the usual criticisms levied against virtue ethics: that there is no clear way on how to resolve disputes when those who have practical wisdom disagree about the correct course of action.

Virtue ethics thus leads to the conclusion that, within health care at least, the probability is good that persons socialized to put the patient's interests first will come up with the ethically correct ranking of options. They will also respect the patient's wishes, even if they do not agree with those wishes. Of course, this depiction makes the situation sound much better than it is. Persons well trained in the healing ethic take unethical actions everyday. Is that a fault of the education or the person? Aristotle would fault the person. In Aristotle's view, some people, by nature, are unable to control their passions, their desires, and their emotions. Others are unable to act rationally. Some are just wicked.[33] Yes, the theory results in a form of elitism. However, it seems fair to say that health care has a major advantage over many other fields in that it has a strong educational and socialization process for developing the right character. In a sense, the purpose of the educational process is to develop a cadre of elite professionals. In doing so, they should become persons of high character.

Ethical Theories and Professional Roles

A knowledge of virtue ethics offers one further advantage. A person of practical wisdom should be better prepared to know when to use a particular ethical theory, depending on the role in which they find themselves. Again,

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take physicians as an example. Although physicians have a primary obligation to their patients, it is not their only role. Consider the following physician roles, none of which involves patients directly: conducting scientific studies; negotiating with vendors selling equipment and supplies; and hiring, firing, and supervising employees. In addition, physicians might be negotiating with third-party payers, lobbying on behalf of health policy issues, and conducting peer review of other physicians. They might also be involved in the management of healthcare organizations and participate on various advisory and regulatory agency boards. Many other non-patient-related tasks could be listed, such as working with community groups or serving as faculty as needed.

Some of the ethical theories work better in these roles than others. How do physicians choose the appropriate theory? The socialization process develops caregivers who are persons seeking the highest good, at least in health care. This foundational process should develop persons of integrity and practical wisdom who can manage the inevitable ethical dilemmas and make the best ethics decisions in any role. They can apply reason to the situation and make the best possible decision within their respective role.

Natural Law

The theory of natural law owes a great debt to Aristotle. Natural law also is important to Roman Catholic theology, given its origins with St. Thomas Aquinas. Many texts on ethics and medical ethics leave out natural law or give it short shrift. Some authors consider the theory a version of moderate deontology, defining *deontology* as having a different view from consequentialism . . . .[34] In the realm of healthcare ethics, such an approach appears overly limiting. As a tool in the ethical theory toolbox, there are a number of good reasons to know natural law theory. Even if philosophically this theory can be reduced to another, natural law is sufficiently definitive and important to consider on its own merits.[35]

One key to understanding natural law is its assumption that nature is rational and orderly. This theory goes back to the ancient Greeks, who believed that the cosmos was essentially unchanging in its order. Aristotle certainly believed in this.[36] This is now a statement of physics—a statement about the nature of the world—rather than a statement about ethics.

Natural Law's Relationship to Aristotle, St. Thomas Aquinas, and the Catholic Church

Aquinas' beliefs gained prominence in the Catholic Church at the Council of Trent (1545–1563) when Catholic reformers used his works to draft their decrees. In 1879, Pope Leo XIII declared Thomism (Aquinas' theology) to be eternally valid.[37] Nearly all writers recognize St. Thomas Aquinas as setting the standard for natural law theory, just as Aristotle is recognized as the standard bearer for virtue ethics.[38] Aquinas developed his theory in his work entitled *Summa Theologica*, meaning the "highest theology." The work is structured in the form of a series of questions, which St. Thomas answers. He also answers the criticisms of the questions to develop his theology. The

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major treatment of natural law occurs in what is called the treatise on law, or question 94, although there are many other relevant passages in other sections as well.[39]

The Thomistic conception of *natural law* proceeds as follows: "All things subject to Divine providence are ruled and measured by the eternal law" (ST IaIIae 91, 2). "The rational creature is subject to Divine providence in the most excellent way. . . . Wherefore it has a share of the Eternal Reason, whereby it has a natural inclination to its proper act and end: and this participation of the eternal law in the rational creature is called the natural law" (ST IaIIae 91, 2). This establishes that natural law is given by God and thus authoritative over all humans.

Aquinas went on to argue that all humans, as rational animals, can potentially know this law. "The light of natural reason, whereby we discern what is good and what is evil, which is the function of the natural law, is nothing else than an imprint on us of the Divine light. It is therefore evident that the natural law is nothing else than the rational creature's participation of the eternal law" (ST IaIIae 91, 2). Not only can we know the law, as rational and moral creatures we can violate it.

Recall Aristotle's concept of practical wisdom; Aquinas uses the same concept. In fact, he calls Aristotle "the Philosopher" and cites him as frequently as Scripture. The importance of practical reason, how it works, its similarity to Aristotle's conception of it, and the most concise statement of what the natural law compels are all found in the following quote:

> "Good" is the first thing that falls under the apprehension of the practical reason, which is directed to action: since every agent acts for an end under the aspect of good. Consequently the first principle of practical reason is one founded on the notion of good, viz. that "good" is that which all things seek after." Hence, this is the first precept of law, that good is to be done and pursued, and evil is to be avoided." All other precepts of the natural law are based upon this: so that whatever the practical reason naturally apprehends as man's good (or evil) belongs to the precepts of the natural law as something to be done or avoided (ST IaIIae 94, 2).

Unfortunately, some have stopped at this quote and simply say that natural law means to "do the good and avoid the evil."[40] Because this lacks clarity about what the good might be or any decision rule by which to decide what to do when goods conflict or when rankings are required, this statement alone does not constitute an ethical theory. It sells the theory short.[41]

Aquinas also drew on Aristotle's idea of potentiality moving to actuality and states that in the realm of what is good "all desire their own perfection" (ST Ia 5, 1). Only the fully actual would have full perfection, but anything that exists even in a relative way has some perfection (ST Ia 5, 1).[42] Again following Aristotle's lead, Aquinas notes that when it comes to practical reason, the rules might be clear, but their application might not be. In short, the details make the principle more difficult to apply (ST IaIIae 94, 4).

St. Thomas then offers an excellent example that shows the difficulty at hand. Everyone would agree that in general "goods entrusted to another

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should be restored to their owner," (ST IaIIae 94, 4). However, he noted that "it may happen in a particular case that it would be injurious, and therefore unreasonable, to restore goods held in trust; for instance, if they are claimed for the purpose of fighting against one's country. And this principle will be found to fail the more, according as we descend further into detail" (ST IaIIae 94, 4). Taking this practical wisdom approach even further, he generalized that "the greater the number of conditions added, the greater the number of ways in which the principle may fail" (ST IaIIae 94, 4).

Aquinas even went so far as to note that, although all are governed by the natural law, all might not know it or act upon it: "In some the reason is perverted by passion, or evil habit, or an evil disposition of nature" (ST IaIIae 94, 4).[43] This seems to add a quandary. All decisions are specific and the details will change, so how do we know what to do?

At this point, scholars disagree on exactly how Aquinas resolves the quandary, and we do not need to follow them in those debates. However, a decision principle is still needed for when there are disputes among the various actions that can be taken. The one most closely associated with natural law theory is discussed next.

Principle of Double Effect

The first principle that proposes to distinguish between the good and the evil is the *theory of double effect*. Derived from *Summa Theologica*, the principle has four key points:

- That we do not wish the evil effects, but make all reasonable efforts to avoid them;
- That the immediate effect be good in itself;
- That the evil is not made a means to obtain the good effect; for this would be to do evil that good might come of it—a procedure never allowed; the end cannot justify the mean;
- That the good effect be as important at least as the evil effect.[44]

The theory of double effect has use in applied ethics, such as medical ethics, when dealing with abortion, euthanasia, and other decisions where there is a conflict between a good and an evil. For example, abortion is an evil, but saving the life of a mother is a good. Euthanasia is an evil, but relieving pain by use of morphine is a good. If the person dies, and it was not intended, then is it acceptable? Major issues arise in the application of the theory concerning how to determine a person's intent. We know that not everyone is a person of practical wisdom who only has a good intent. However, how would we know this?[45]

At the policy-making level, is it acceptable to cut taxes for the rich at the expense of the poor? What good comes of it? Because there are few rich and many poor, does the good of the rich count more than the good lost by the poor? Note that the further we delve into these types of questions, the more important consequences seem to become, until natural law becomes a form of consequentialism, perhaps rule consequentialism.[46] It is not necessary to resolve these disputes here, because the purpose is to understand the theories for the

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purposes of making appropriate decisions in health care. Relative to that end, a second decision rule for natural law is available.

Entitlement to Maximize Your Potential

In seeking a principle to determine what is good and what is bad, it was not difficult to find specific behaviors listed in Aquinas. However, an excellent philosophical overview of natural law by Michael Murphy concluded that there are no obvious master principles, but plenty examples of flawed acts.[47] A lengthy article on ethics in the *Catholic Encyclopedia* suggests a goodly number of things that would be wrong or right under the dictum to always do good and avoid harm, but nothing about how to resolve conflicts among these requirements.[48]

The key to understanding this proposed decision rule relates to metaphysics: "Ethics especially is impossible without metaphysics, since it is according to the metaphysical view we take of the world that ethics shapes itself."[49] The Thomistic ethic draws heavily on the Aristotelian metaphysics that describes the world as a hierarchy of being, with all entities in it striving to reach their own complete state of actualization of their potential. This means that it is a part of the natural order for all entities to strive to maximize their potential. To deny something its ability to actualize its potential is to violate its very nature. Such a violation causes harm to the entity and would be a violation of its nature and the natural law to avoid harm. Thus, natural law proscribes any activities that would violate an entity's potential.[50] Concerns about termination of potential, at least for rational creatures, are evident in several contemporary healthcare issues.

Abortion, Euthanasia, and Social Justice

The ethics of natural law ethics are based on pursing perfection (the ability to know God), using God's providence that gives us the desire to move from potentiality to actuality, and having an obligation to do the good and avoid the evil. Once you understand the metaphysics and the meaning of the natural laws that flow from this theory, it is easy to understand why adherents of natural law would be opposed to several kinds of activity. For example, under natural law

- Abortion is clearly wrong, because it terminates the potential of a being ensouled at conception. The dead have no further potential to actualize, and life is the *sine qua non*[51] of having a potential to actualize.
- Arguments against birth control are similar to those used against abortion.
- Euthanasia is not quite so clear a violation of natural law, because medical technology is extending life and dying beyond anything imaginable to the theory's founders as being natural. Nonetheless, to take a life early, even to relieve suffering (*active euthanasia*), is to terminate a life ahead of its time. This cuts short what the life could have been. *Passive euthanasia* means simply allowing the person to die without doing anything to hasten the death. This includes not doing anything heroic to intervene. The definition of *heroic* changes as medical technology advances. Considerable discussion about the duty to alleviate

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suffering, what it means to "play God," and whether that is avoidable occupy medical ethics.[52] The double-effect theory plays a major role in these discussions.

- Suicide is directly opposed because a person's life is not his or her own; it belongs to God. According to natural law, it is wrong to undermine the right God has to your person.[53] Obviously, suicide terminates the person's potential as well.

Many religions and social activists place a considerable emphasis on social and political factors that prevent humans from actualizing their potential. These groups often are at the forefront of social justice movements addressing poverty, ignorance, unhealthy living conditions, and slavelike working conditions. Clearly, healthcare professionals need to understand natural law theory when working with patients who believe in its tenets and with those who advocate social justice. This might include those who are working to improve public health, social conditions, and/or human rights. Now let us look at another common ethical theory, deontology.

Deontology

The term *deontology* is derived from the Greek word *deon*, which means "duty." Thus, deontology is concerned with behaving ethically by meeting our duties. The ethical theory of deontology originates with the German philosopher Immanuel Kant (1724–1804).[54] Although, Kant's influence on deontology is significant, many other thinkers are part of the deontological tradition as well.[55] Nonetheless, just as we relied on Aristotle for virtue ethics and on Aquinas for natural law, Kant sets the standard for deontology. Before exploring the usefulness of Kant's theory, a detailed explanation of the theory is required. Note that Kant is one of the more difficult of philosophers to follow.

Kant's Metaphysics and Epistemology Ground His Ethics

Kant is most well known for his work in metaphysics and epistemology, the *Critique of Pure Reason*,[56] but he also did groundbreaking work in ethics. Kant's writings on ethics appear in several different volumes, with titles such as *Groundwork of the Metaphysics of Morals*[57] and *Critique of Practical Reason*,[58] among others.

The concept of honoring commitments clearly did not start with Kant, but his approach to the issue led to the identification of his ethical theory with deontology. Kant's work in metaphysics and epistemology had a significant influence on this approach and his ethical views. In what he called a "Copernican revolution for philosophy," Kant concluded that the belief that perception represented the world was incorrect, or at least incomplete. Instead, the structure of consciousness processes sense data through the means of categories of thought and two forms of intuition: space and time.

Of these categories of thought, the one that relates most directly to ethics is causality. All experiences are subject to causation, which in Kant's view undermines free will. In fact, he finds free will to be essential for ethics. If a

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person's every act is determined, how can he or she be held responsible for his or her choices?

At the same time, Kant's reasoning inexorably leads him to conclude that we cannot know what the world is like in and of itself. It is beyond knowing, because we cannot experience anything without use of the categories and forms of intuition. He thus divided the realm of being into the *phenomenal world* of experience and the *noumenal world*. We can think about the noumenal world, but we cannot directly experience it. Thus, we have "an unavoidable ignorance of things in themselves and all that we can theoretically *know* are mere appearances" (B xxix).[59] Relative to ethics, it should be clear from Kant's perspective that the metaphysical issue of whether free will is possible is foundational.[60]

Relative to morality, Kant argued that knowledge of the sensible world was insufficient for knowing the moral law.[61] Yet Kant argued that free will makes ethics possible. Free will is the precondition of ethics. If all things are determined by natural causes—causality is one of the categories—then our supposed ethical choices are specious, an illusion. The human as a natural phenomenon is determined by natural laws; causality applies to all natural phenomena. However, the self, in and of itself (the soul), is free from those laws.[62]

Kant recognized that this puts morality beyond the pale of empirical science, and indeed the question about free will is beyond such testing. However, Kant believed that he left a crack in the door that is wide enough to allow for morality. He does this by arguing that the concept of freedom, although not knowable in a scientific way, is something we can think about without contradiction: "Morality does not, indeed, require that freedom should be understood, but only that it should not contradict itself, and so should at least allow of being thought" (B xxix).[63] In this sense, Kant redefines humans as partaking in two kinds of reality: the phenomenal and the noumenal. According to Kant, "There is no contradiction in supposing that one and the same will is, in the appearance, that is, in its visible acts, necessarily subject to the law of nature, and so far *not free*, while yet, as belonging to a thing in itself, is not subject to that law, and is therefore *free*" (B xxviii).[64]

Freedom of the Will

Like Aristotle and Aquinas, Kant certainly thought good character was laudable. However, he was concerned that the properties that constitute good character, without a good will to correct them, could lead to bad outcomes. For example, courage and perseverance can be misused without the direction of good will.[65] Kant would go so far as to argue that one should act on the duty of obligation to the moral law regardless of any relationship that might have an outcome such as *eudaimonia*:[66] "A good will is good not because of what it performs or effects, not by its aptness for the attainment of some proposed end, but simply by virtue of its volition, that is, it is good in and of itself" (AK 4:394).[67] In other words, good will is good because it wills properly. Thus, Kant set a high standard. Some of his language even suggests that the true test of a good will is if the person continues to act out of duty and reverence for the moral law even

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when it has no personal benefit and might "involve many a disappointment to the ends of inclination" (AK 4:396).[68]

Reason, Autonomy, the Moral Law, and the Will

Kant is distinctive relative to his predecessors in seeking to ground our duties in a self-governing will. This is an appeal to reason itself being autonomous, meaning we are free to choose, and that if we choose according to reason, we shall conform to the moral law: "If reason completely determined the will, the action would without exception take place according to the rule" (AK 5:20).[69] One can see the extremely prominent principle of autonomy coming into play here.

Typically, an autonomous agent is one who makes his or her own rules and is responsible for his or her actions.[70] To violate that autonomy is to violate a person's innermost selfhood, something Kant develops as one form of the categorical imperative. Thus, the foundation of ethics is sought not in the development of a person of good character seeking to actualize his or her intrinsic nature, seeking the end of *eudaimonia*.[71] Instead, the subject matter of ethics is not character, but rather the nature and the content of the principles that determine a rational will. The free will is determined by moral principles that cohere with the categorical imperative. This abstruse approach, for many, simply disconnects the moral law and free will from real life.

The idea of autonomy here is not the view that individuals make their own laws. It means the laws that bind you in some sense derive from your own making, your own self.[72] For Kant, the will is free in the sense that it chooses to be bound by those principles of reason. This capacity to make such a choice is what makes humans members of what he called the "kingdom of ends." The person has chosen freely to bind him or herself to the constraints of the categorical imperative and the dictates of reason.

The requirement of the duty to obey the moral law to express a good will brings the notion of intent into the discussion. Why a person acts in such a way as to conform to the moral law is an important component of ethical evaluation in the Kantian scheme. Let us turn to what Kant thought would count as rational principles that would ground ethics or the moral law.

Kant attempted to discover the rational principle that would ground all other ethical judgments. He called this principle the *categorical imperative*. The categorical imperative is not so much a rule as a criterion for determination of what ethical principles meet the test of reason.[73] The imperative would have to be categorical rather than hypothetical, or conditional, because true morality should not depend on individual likes and dislikes or on abilities and opportunities. These are historical "accidents." Any ultimate principle of ethics must transcend them in order to meet the conditions of fairness. Kant developed several formulations of the categorical imperative. The most commonly presented ones follow:[74]

- Always act in such a way that you can also will that the maxim of your action should become a universal law (AK 4:421).[75] This principle often is caricatured as the Golden Rule: Do unto others as you would have them do unto you.[76] This does not capture the full meaning of what Kant had in

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mind, and may indeed miss the essence of his teachings, as he specifically disavowed that this was his intended meaning (AK 4:430).[77]

- Act so that you treat humanity, both in your own person and in that of another, always as an end and never merely as a means (AK 4:429).[78] Kant spoke of the good society as a place that was a kingdom of ends (AK 4:433–434).[79]

The Categorical Imperative as a Formal Decision Criterion

Although Kant believed that these two statements of the categorical imperative were formally equivalent, the first illustrates the need for moral principles to be applied universally. That a principle be logically consistent was important to Kant. The second formulation points to the radical distinction to be made between things and persons and emphasizes the necessity of respect for persons.

Kant's theory evaluates morality by examining the nature of actions and the will of agents rather than goals achieved. Therefore, a deontological theory looks at intentions rather than outcomes. You have done the right thing when you act out of your obligation to the moral law, not simply because you act in accordance with it. One reason for the emphasis on duties in Kant's deontology is that we are praised or blamed for actions within our control, and that includes our willing, not our achieving. Most people think that there is something wrong with saying that people are good when they do not have a good will and their good outcomes were merely happenstance. Kant *did* care about the outcomes of our actions, but he thought that, as far as the moral evaluation of actions was concerned, consequences did not matter. As Kant pointed out, this total removal of consequences "is strange enough and has no parallel in the remainder of practical knowledge" (AK 5:31).[80] Let us now look at the second version of the categorical imperative, which is much easier to understand and which is foundational in healthcare ethics.

The Categorical Imperative as Respect for Persons

The second version of the categorical imperative emphasizes respect for persons. According to Kant, you should "[s]o act as to treat humanity, whither in thine own person or in that of any other, in every case as an end withal, never as means only" (AK 4:429).[81] People, unlike things, ought never to be merely used. Their value is never a means to our ends; they are ends in themselves. Of course, a person might be useful as a means, but that person must always be treated with respect. Kant holds this view because of his belief that people are rational and that this bestows them with absolute worth: Our "rational nature exists as an end in itself" (AK 4:428).[82] This makes people unique in the natural world. In this sense, it is our duty to give every person consideration, respect, and dignity. Individual human rights are acknowledged and inviolable in a deontological system. The major emphasis on autonomy in health care springs from these considerations and others like it. Although most people who defend autonomy and treating people as ends and not merely as means do not use these formalistic Kantian reasons, this principle of autonomy is foundational in healthcare ethics. It is part of health care's common morality.

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The Categorical Imperative and the Golden Rule

According to the categorical imperative, if the maxim or the rule governing an action is not capable of being universalized, then it is unacceptable. Note that universalizability is not the same as universality. Kant's point is not that we would all agree on some rule. Instead, we must logically be able to will that it be made universal. This is why the concept seems very much like the Golden Rule: Do unto others as you would have them do unto you.[83] If you cannot will that everyone follow the same rule, your rule is not a moral one. As indicated earlier, many think Kant's first formulation of the categorical imperative implies or even is a restatement of the Golden Rule. However, Kant specifically repudiates the Golden Rule interpretation (AK 4:430, note 13).[84]

Kant does not believe the Golden Rule properly describes his views. Like most others, he saw the justification for the Golden Rule in terms of consequences and fairness. If it is fair for me to do something, then it should be fair for everyone. Alternatively, in consequential terms, we typically hear officials, merchants, managers, and parents, when exceptions to policy are being sought, say that if I do X for you I have to do X for everyone. If exceptions were made, then the consequences would be bad and unfair.

Kant wanted to get beyond such issues. He wanted to know whether an act was performed out of duty to moral law and thus expressed the good will. He stipulated that the moral agent acting solely out of the good will should ignore empirical considerations such as consequences, fairness, inclinations, and preferences. For Kant, an act carried out from an inclination, no matter how noble, is not an act of morality (AK 4:398).[85] Indeed, he went so far as to say that the less we benefit from acting on the moral law, the more sublime and dignified it is (AK 4:425).[86] He did favor such acts, but resisted calling them "moral."

Acts take on moral worth if the person acts solely from duty to the moral law, absent any emotional inclinations or tangible benefits. This sets up the very difficult standard that we can only know if persons are morally worthy or obeying the moral law when there is nothing in it for them. Their actions would be opposed to their desires, inclinations, even their self-interest. Taking such an extreme position essentially disconnects Kant from the real world of where people live and make ethical judgments.

Virtue Ethics and Kant's Moral Law

Although likely controversial, it seems, for purposes of healthcare ethics, that the best way to make sense of Kant is to conceive of the person of good will in a manner akin to Aristotle's virtue ethics. Thus, to make Kantian deontology useful, you could say that a person of good will also is a person of practical wisdom as described by Aristotle. Does this inclusion of Aristotle reject Kant's work? No, but a critical analysis and comparison to virtue ethics is warranted.

Although Kant's theory suffers from being disconnected from any normal motivational structure in human life, it still has applications in healthcare ethics.[87] The deontological theory emphasizes the attention to duty found in all codes of ethics in health care. Kant put into sharp relief the ethical idea

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that it is wrong for someone to claim they can follow a principle or maxim that suits their interests, but would not want others to do the same. This analysis is the underpinning of the critique of ethical egoism and relativistic arguments. Most importantly for health care is the recognition of human dignity and autonomy. To use people solely as means to an end, whether as teaching material in medical schools, prisoners in research experiments, or slaves, is fundamentally a violation of all being. Now, having looked at Kant as the representative of deontology, some common critiques of deontology are merited.

Deontology poses two problems that lead many to reject it. First, the statement of categorical imperatives, maxims, duties, rules, or commandments yields only absolutes. Kant really has only one absolute. His absolute is that your action must be motivated solely by a good will, a reverence for, and an obligation to the moral law formalized by the categorical imperative. However, the lack of prescriptive content leaves many unsatisfied. Actions either pass or fail with no allowance for a "gray area." Virtue ethics handles the gray areas by depending on the wisdom of the person of practical wisdom. This is one reason why as an ethical tool virtue ethics enables us to handle the problems of healthcare ethics more robustly.

The inability to make distinctions between lesser evils or greater goods is the other problem. Moral dilemmas are created when duties come into conflict and there is no mechanism for resolving them. Kant, with his very limited description of only one ethical duty—to obey the moral law—can claim to escape this problem within his philosophy. He used the radical view that such decisions are outside the bounds of morality if they are to be based on inclinations or consequences. Defining the real world of ethics in this radical way does not help much when you are faced with decisions that involve your inclinations and the weighing of consequences. Even if you have, as Kant seemed to think, only one duty, it is a formal one, and its various manifestations could conflict.

Virtue ethics and the natural law theory face this problem of conflicting duties as well. For example, whereas abortion is clearly wrong under the natural law theory, the outcome of unwanted children, starving children, child abuse, overcrowding, malnutrition, and so on also have moral bearing. Duties often conflict in healthcare situations. For example, if I tell the truth in some situation, it may lead to someone getting hurt, when a lie could have prevented it. My duty is both not to lie and not to do things that lead others to harm. No matter what I do, a duty is violated. Pure deontology theory does not allow for a theoretically satisfying means of ranking conflicting duties. However, most duty-driven people are not going to be so caught up with the theory of deontology that they find themselves unable to rank conflicting duties. Virtue ethics offers the guidance of a person of practical wisdom using the available tools of considered judgments, common morality, ethical theories, and ethical principles to resolve the difficulty and move on.

Of the theories presented so far, virtue ethics offers a much more useful and helpful approach in achieving ethical processes and ethical outcomes in the realm of healthcare. Virtue ethics is more interested in the development of ethical persons than in the development of maxims and imperatives. The

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normal understanding of the Golden Rule works perfectly well in ethical decision making within the framework of virtue ethics, even if Kant himself disavowed it.

The policy implications for deontology are significant because of the emphasis on duty and the training of most healthcare professionals in the duties incumbent upon them. The emphasis on duty leads most clinicians to consider themselves deontologists. However, most would balk at the pure Kantian version of duty and would more readily assent to the duties experienced by a person of practical wisdom, following the virtue ethics tradition. Duty-driven clinical staff can walk into a meeting and know in advance what the right thing to do is: to maximize the benefit to their patients. This is their duty, which is usually codified in their professional code of ethics. If they had to rank their duties, they would be patient first, their profession second, other clinical professionals third, with maybe their employing organization a distant fourth.

Having such a clear sense of their duties and having only a few duties on the list makes it very easy for clinicians to talk about their obligations to patient care. In contrast, healthcare managers and officials who make policy have a much more difficult ethical chore. They must balance competing claims among many groups. Their loyalty is not simply to one group, such as patients. For healthcare managers, even if their loyalty is only to patients, that loyalty to them is in the aggregate. Managers represent the organization, whereas clinicians represent the patients. The ethical obligations of managers are much more complex; if the organization fails, the clinicians will not be able to help the patients. Let us now examine the ethical theory that describes how most managers work, consequentialism.[88]

Consequentialism

Consequentialist moral theories evaluate the morality of actions in terms of progress toward a goal or end. The consequences of the action are what matter, not their intent. This is in contrast to previously noted theories (e.g., deontology, virtue ethics, and natural law) that take intent into account. Consequentialism is sometimes called *teleology*, using the Greek term *telos*, which refers to "ends." Thus, the goal of consequentialism is often stated as the greatest good for the greatest number. Consequentialism has several versions, the best known of which is utilitarianism. *Utilitarianism* defines morality in terms of the maximization of the net utility expected for all parties affected by a decision or action. For the purposes of discussion, consequentialism and utilitarianism are used as synonyms.

For the consequentialist, the person's intentions are irrelevant to the ethical evaluation of whether the deed is right or wrong. Outcomes are all that matter. The consequentialist will agree that intentions do matter, but only to the evaluation of a person's character, not the evaluation of the morality of his or her acts. Remember that in natural law, virtue ethics, and deontology, part of the ethical assessment concerns the person's intention. The consequentialist would say that intention simply confuses two issues: (1) whether the act itself is leading to good or bad outcomes and (2) whether the person carrying out the

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act should be praised for it or not. Consequentialists consider the second issue to be independent of moral consideration relative to the act. It is relevant to the evaluation of the person's moral character. Of course, to leave out intentions completely seems to violate a deep sense of our understanding about what it means to be ethical. Most people find something wrong with saying an act is ethical if it happened by accident.

Types of Consequentialism

The two major types of consequentialism are as follows:[89]

- **Classical utilitarianism (or act consequentialism).** Each act is considered based on its net benefit. This version of utilitarianism has received the most criticism and is not supported by modern ethicists. Nonetheless, it makes a convenient target for those who dislike consequentialism.
- **Rule consequentialism.** The decision maker develops the rules that will have the greatest net benefit.[90] The development of rules to guide conduct is clearly similar to the actions of managers who develop policies.

In organizational healthcare settings, policymaking is an important component of the work, and consequentialism often is used. For example, a diversity policy could readily be construed as being justified by rule consequentialism, as could policies to further informed consent. Lawmakers and administrators who set health policies at the national level also use consequential arguments to justify decisions, such as requirements to provide indigent care or emergency services.

Classical Utilitarianism

Classical utilitarians spoke of maximization of pleasure or happiness. Classical utilitarianism is most often associated with the British philosopher John Stuart Mill (1806–1873). He developed the theory from a pleasure-maximizing version put forward by his mentor Jeremy Bentham (1748–1832). As clearly stated by Mill, the basic principle of utilitarianism is that actions are right to the degree that they tend to promote the greatest good for the greatest number.[91]

Of course, it is unclear what constitutes "the greatest good." For Bentham, it was simply the tendency to augment or diminish happiness or pleasure. Bentham, being a hedonist in theory, did not try to make distinctions about whether one form of pleasure or happiness was better than another.

For Mill, however, not all pleasures were equally worthy. He defined "the good" in terms of well-being and distinguished it not just quantitatively, but also qualitatively, between various forms of pleasure.[92] Mill would be closer to the virtue theory idea of *eudaimonia* as a goal by specifying qualitative distinctions rather than simply adding up units of happiness or pleasure.[93] Indeed, Mill said that one is duty bound to perform some acts, even if they do not maximize utility.[94] In the case of Bentham and Mill, a conception of what is the appropriate aim of human activity is presupposed. Thus, consequentialists would differ from Kant in terms of defining the proper human good because Kant thought the good will was the precondition for deserving happi-

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ness. He would not have thought happiness-seeking acts were moral acts, because they derive from inclination.

A defining characteristic of any type of consequentialism is that the evaluation of whether an outcome is good or bad should be, in some sense, measurable, or that the outcomes should be within the realm of predictability. Thus, in the realm of consequentialism, ethical theory attempts to become objective, seeking a foundation that is akin to the sciences. This principle is enshrined in the world of commerce, trade, management, and administration as the *cost-benefit analysis approach*.

As a theory, consequentialism is not tied as closely to its founder as were the previous three theories. Thus, rather than probing the depths of Mill's writing, a more free-ranging approach is used and various versions of consequentialism that are in play today are presented. This approach will avoid the considerable controversies surrounding what Mill meant by his theories[95] and draw out of consequentialism tools that are useful to persons dealing with issues in healthcare ethics.

Relative to what the consequentialism means, Bentham insisted that "the greatest number" included all who were affected by the action in question with "each to count as one, and no one as more than one."[96] Thus, in Bentham's version of the theory the various intrinsic goods that counted as utility would have an equal value, such that one unit of happiness for you is not worth more than one unit of happiness for me. Quite clearly, to talk about units of "happiness" is far-fetched, and indeed that is one of the criticisms of the theory.[97] However, numerous correctives to the theory have been advanced over the years, and some of these are helpful.

Unlike deontology and natural law with conflicting absolutes, consequentialism of any form allows for degrees of right and wrong. If the consequences can be predicted and their utility calculated, then in such situations the choice between actions is clear-cut: Always choose those actions that have the greatest utility. For this reason, the theory has had great appeal in economic and business circles. However, in healthcare decision making the economic view of utility is not fully satisfactory. For example, how do you compute the suffering of someone whose spouse has been disabled? Although attorneys do calculate the monetary value of life years lost when a person is injured, whether monetary settlements can really compensate for a lost livelihood or a broken future is debatable.

In spite of this objection, managers of healthcare organizations, including clinical managers, must often think in terms of the aggregate when evaluating their decisions. Persons taking the tack of a deontologist and trying to fulfill their duty can readily say that their obligation is to the patient. Managers have to consider the patients in the aggregate, the organization, the larger community, and their employees in their decision making. Managers' divided duties and obligations are part of their job descriptions, as opposed to the single obligation to the patient that clinicians enjoy. Managers also are trained to consider their decisions in terms of maximization—the best outcome for the resources expended is the greatest good[98]—or as managers say, the "biggest bang for the buck." Of course, in management, as in ethics, problems arise:

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- It is not always clear what the outcome of an action will be, nor is it always possible to determine who will be affected by it.
- The calculation required to determine the right decision is both complicated and time consuming.
- Because the greatest good for the greatest number is described in aggregate terms, the good might be achieved under conditions that are harmful to some, so long as that harm is balanced by a greater good. This leads to the attack that consequentialism means that "the end justifies the means."[99]

The theory fails to acknowledge any individual rights that could be violated for the sake of the greatest good, which is sometimes called the "tyranny of the majority." Indeed, even the murder of an innocent person would seem to be condoned if it served the greater number. This complaint is similar to the prior complaint, but notes that consequentialism ignores the existence of basic rights and ethical principles such as autonomy and beneficence. The fact that Mill would categorically deny this by saying some acts are wrong, regardless of the consequences, is held as a violation of his own stated philosophy. Of course, we are not seeking doctrinal purity, but useful tools to help us in healthcare ethics.

Lastly, who has time to run endless computations every time a decision is needed? "Analysis paralysis" would be the predicted outcome, which would not maximize any version of utility. In any case, because of these problems few philosophers today subscribe to consequentialism.[100] The proposed improvement to several of these problems is rule consequentialism.

Rule Consequentialism

The idea behind rule consequentialism is that behavior is evaluated by rules that would lead to the greatest good for the greatest number. At this point, the theory begins to tie in more clearly to virtue ethics and to the person who has achieved practical wisdom. It takes a person of some experience to know how to develop rules that will likely lead to the greatest good for the greatest number. Managers and government officials would call these rules *policies*. Now, once the policy is developed, presumably by evaluation of the likely outcomes, then the person who needs to make a decision refers to the applicable policy instead of having to make endless evaluations and calculations. Indeed, a person of practical wisdom might well conclude that long-term utility is undermined by acts of injustice. He or she would then develop a policy that recognizes and respects autonomy. Rule utilitarianism thus could use the utility principle to justify rules establishing human rights and the universal prohibition of certain harms. They would codify the wisdom of experience and preclude the need for constant calculation.

Rule consequentialism looks like the very same activity in which managers and policymakers engage when they make policies and procedures. A policy is a general statement meant to cover any number of situations. The person creating it makes the decision that following the policy is the best way to achieve the organization's goals. Procedures are then used as the means to carry out the created policies. Managers and government officials have been using this

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process for a long time. Overall, it works well, even though rules or policies do not work fairly in every situation.

Indeed, the failure of the rules to fit every situation is one of the reasons to have humans in charge instead of machines. At this point, the inclusion of a person of practical wisdom, from the virtue ethics tradition, comes into play. Managers or clinicians (persons of practical wisdom) can decide if the special circumstances warrant making an exception to the rule when judgments need to be made. If so, the rule could be modified to consider these special circumstances. In this way, fairness is preserved.

These exceptions might be justified by such material reasons as need, merit, potential, or past achievement. However, the manager or policymaker will also have to recognize, and be willing to accept, that sometimes the enforcement of a rule will lead to unfair outcomes. However, the principle is still sound and much better than the chaos of trying to evaluate the probable consequences of a situation each time a decision is required.[101]

Rule consequentialism can also incorporate the goals of negative consequentialism. The idea behind *negative consequentialism* is that alleviation of suffering is more important than the maximization of pleasure. Further, to have as a goal alleviation of suffering incorporates into the goal the protection of the powerless, the weak, and the worse off. Thus, from a social policy point of view, rules that operate as safety nets can accomplish this goal. Allowing access to emergency treatment regardless of ability to pay is an obvious healthcare example. Now let us look at the last version of consequentialism, preference consequentialism.

Preference Consequentialism

Preference consequentialism argues that the good is the fulfillment of preferences and the bad is frustration of desires or preferences. People in this sense are not seen as having preferences for pleasure or happiness per se; their preferences are left to them. Thus, autonomy becomes a bedrock value. For example, persons preferring to suffer great sacrifices to get into medical school are seeking to fulfill their preferences.

In another example, a patient could have termination of treatment as a preference, even if it leads to their early death. It is hard to imagine how that leads to happiness or pleasure when the person is not alive to experience such states. Other preferences could be losing weight, making a new friend, or rearing a healthy child. Note the similarity of this point of view to the emphasis in health care of respecting peoples' wishes that forms part of the general attack on paternalism. The theme here is to find out a person's expectations and then to seek to meet them. Within preference consequentialism, any number of states or conditions might be preferred, owing to the vast variability among people's desires. Consequentialism of this form is compatible with many different theories about which things are good or valuable.

How can someone know another person's preferences when making decisions that involve that person? Health care has developed clearly enunciated procedures in the area of informed consent to answer this question. One can also speak of *substituted judgment*, when the preferences of a person who is

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now incompetent are known.[102] In cases where the person has not communicated his or her preferences, we are forced to fall back on what is called the "best interests standard," or, more commonly, the "reasonable person standard." What would a reasonable person want in the circumstances at hand?[103] Healthcare ethicists have done a decent job in trying to discern what the preferences are of an individual who has become incompetent. However, policy-making decisions have an impact on large groups of people, most of whom will be personally unknown to the decision makers. Development of the tools to ascertain the preferences of a large aggregate of individuals is a much different task.[104] The tack that seems to occur is that the decision maker applies the "reasonable person standard" to the aggregate. However, considerable evidence suggests that such a standard may fall considerably short of meeting that person's actual preferences, whether it is what a reasonable person would want or not.[105] Simply put, the preferences humans have are so diverse and so changeable that it might not even make sense to use them as a standard for maximization.

Evaluation of Consequentialism

One of the most common criticisms of consequentialism is that it appears to allow some to suffer mightily if the net outcome is an improvement for a greater number. This argument is specious. The concept of respect for autonomy appears to be presupposed by the very statement that the good sought is the greatest good for the greatest number. Although consequentialists might talk about utility, the good in mind has to include respect for the personhood of the others as a minimum requirement. If not, why would they even be included in the prescription? If respect for the other is not presupposed, then it seems the theory would really devolve into a form of egoism. Thus, respect for the wants, preferences, hopes, and choices of others must be implicit for the theory to remain intact. Lacking this foundational component, many seem to think that the theory means that the ends justify the means, as noted earlier. Such a view is off base relative to the intent of the theory.

Mill himself stated this quite clearly in his classic essay, "On Liberty." He said, "the only freedom which deserves the name is that of pursuing our own good in our own way, so long as we do not attempt to deprive others of theirs, or impede their efforts to obtain it."[106] It is difficult to think of a more obvious reference to the respect for the autonomy of others and their liberty to pursue it. Some argue that this meant that Mill was really a deontologist. However, such arguments seem arcane, academic, and irrelevant to our purposes. Thus, I consider it a compliment to Mill that he recognized the need to temper his "greatest good for the greatest number" with respect for basic principles of autonomy and freedom.

ETHICAL THEORIES AND THEIR VALUE TO HEALTHCARE PROFESSIONALS

Over thousands of years, no ethical principle or theory has survived criticism by trained philosophers without serious flaws emerging. Nonetheless,

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healthcare professionals cannot throw up their hands. Decisions must be made, and reasons must be given for those decisions. Leadership often means choosing a course that you know some will not support.[107] Healthcare professionals understand the need for picking and choosing among the theories to work with the circumstances at hand.[108] This is why the person of practical wisdom, from the virtue ethics tradition, serves as the best model and is the model person the various healthcare professions have sought to produce. In the case of physicians, the tradition goes back for millennia. For other healthcare professions, the time period for development of a sense of professionalism, for production of persons of practical wisdom, is much shorter.[109]

The clinician and the healthcare manager will use their practical wisdom to advance the interests of specific patients, patients in the aggregate, the community, and the organization by drawing upon principles and theories as necessary to advance these interests. For managers, having rules that tend to provide the greatest good for the greatest number over the long term functions as a guiding principle in the same way that duties do for the clinician. Both clinicians and managers can come to the table with some clear ideas about what is appropriate to do in a given situation. The clinician has the emotional upper hand, because most people respond better to appeals that are directed toward helping a specific individual rather than protecting a policy. Nonetheless, the manager is well equipped by understanding the proper role of rules or policies.

For people in the policy-making arena, the evaluation of the behavior or motivations of various stakeholders will be enhanced if they determine the ethical system these stakeholders are likely to be using. Clinicians are likely to take a deontological approach, because their training makes their primary duty to the individual patient. They will not be as concerned with the external consequences of the decision (e.g., costs, inconvenience to the family, etc.) as they are with whether the right thing is done for the patient's medical care. The right thing is that which allows them to meet their duty and therefore uphold their sense of themselves as upholding the integrity of the profession. In other words, they want to uphold their sense of themselves as virtuous persons, persons of practical wisdom in the field of medicine or health care, doing the right thing for their patients. The right thing includes not only meeting their duty, but also evaluating the consequences of their decisions on the patients and their families.

Managers are in a more difficult position, because they have obligations to many stakeholders, not just to the individual patient. Those obligations are often unequal, sometimes conflicting. Sometimes their best strategy is to recognize that they lack the luxury of having obligations that are so pure and easily defined. Instead, they have to think of multiple and conflicting stakeholders and try to develop a solution that will generate the greatest good for the greatest number. All the while, they must respect the principles of autonomy, justice, beneficence, and nonmaleficence.[110] In their experience, the rules they adhere to have had those positive results; therefore, they suggest them in the current case. It is clear to see that the ethical challenge for a healthcare manager is more difficult than for those working from a strictly clinical perspective.

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SUMMARY

This chapter makes it clear that no one ethics theory is sufficient for all healthcare decision making. However, a review of the principle features of main ethics theories used in health care provides a toolbox for decision making. After a brief explanation of authority-based ethics, a discussion of the features and use of natural law theory is provided. This is followed by two prominent ethics theories used in health care: utilitarianism and deontology. Finally, there is a discussion on the merits of considering virtue ethics as a healthcare professional.

The twenty-first century promises challenging healthcare ethics issues for individuals, organizations, and society. Therefore, a deeper understanding and the ability to apply ethics theory will be even more necessary for appropriate responses to these challenges. As you noticed in this chapter, ethical theory has not been developed in a vacuum. Each theorist studied the works of those who went before him and provided his own wisdom. Similarly, theories form the basis for the main ethical principles used in healthcare practice and decision making. You will find a discussion of these principles in Chapter 2. In addition, subsequent chapters will apply the both theories and principles to current and future healthcare challenges.

QUESTIONS FOR DISCUSSION

1. Why should you have a foundation in ethics if you are involved in health care? Are you not already a good person?
2. How can you use the tenants of natural law in your practice of health care?
3. What are the key features or points to remember about virtue ethics?
4. Why is deontology still important in contemporary healthcare practice? How can you use the categorical imperative to make decisions in today's healthcare practice?
5. How does utilitarianism affect healthcare decision making? Do you think this theory will be useful for making decisions about future issues?

NOTES

1. For a good overview of the value of cultural competence in health care, see J. R. Betancourt, A. R. Green, and J. E. Carillo, *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches* (The Commonwealth Fund, 2002). Available at www.cmwf.org/usr_doc/betancourt_culturalcompetence_576.pdf. Accessed October 14, 2006.
2. T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001). Oxford University Press popularized these four concepts, starting with the first edition in 1979. The concepts, or "principles," as these authors call them, are examined later. The authors consider the principles to be more valuable than the

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theories (Chapter 9). For purposes of clinical medical ethics, this ordering may be appropriate. It seems less suitable for the more general category of healthcare ethics, which includes policymaking well beyond the bedside.

3. Some authors distinguish deontology from consequentialism solely by the fact that it places total or some limits on the relevance of the consequences in the deliberations. See T. A. Mappes and J. S. Zembaty, *Biomedical Ethics*, 2nd ed. (New York: McGraw Hill, 1981), 4.
4. R. Benedict, "A Defense of Moral Relativism," *Journal of General Psychology* 10 (1934): 59–82. This work is one of the most influential and most reprinted contemporary defenses of ethical relativism, which was written by a leading figure in twentieth-century anthropology. It is reprinted in numerous anthologies, including *Everyday Life*, 3rd ed., edited by C. Sommers and F. Sommers (San Diego: Harcourt, Brace and Jovanovich, 1992). This reference was found at http://ethics.acusd.edu/theories/relativism/. Accessed June 15, 2006. The source contains an excellent bibliography on this subject and many other ethical issues, as well as videos, Internet accessible articles, and PowerPoint presentations. It is maintained by L. M. Hinman, Professor of Philosophy and Director of the Values Institute at the University of San Diego.
5. See K. Popper, *The Logic of Scientific Discovery* (New York: Basic Books, 1959), for the defense of falsifiability as a criterion of scientific knowledge.
6. V. Klingenborg, "On the Recentness of What We Know," *New York Times*, August 9, 2006. Available at http://nytimes.com/2006/08/09/opinion/09talkingpoints.html. Accessed August 13, 2006.
7. H. LaFollettee, "The Truth in Relativism," *Journal of Social Philosophy* (1991): 146–154. Available at www.stpt.usf.edu/hhl/papers/relative.htm. Accessed June 15, 2006.
8. The lack of certainty and infallibility disturbs many. See M. J. Slick, "Ethical Relativism" (Christian Apologetics and Research Ministry, 2003). Available at www.carm.org/relativism/ethical.htm. Accessed June 15, 2006. This organization renounced relativism because "right and wrong are not absolute and must be determined in society by a combination of observation, logic, social preferences and patterns, experience, emotions, and 'rules' that seem to bring the most benefit." According to this group, this messy process was improved by reliance on Scripture.
9. In an introductory chapter, a complete account is not possible. However, for an extensive bibliography see L. M. Hinman, "A Survey of Selected Internet Resources on Ethical Egoism," *Ethics Updates* (2004). Available at http://ethics.acusd.edu/theories/egoism/. Accessed June 13, 2006.
10. See, for example, A. Rand, *Virtue of Selfishness* (New York: Signet, 1964).
11. The Ayn Rand Institute Web site recommends L. Peikoff, *Objectivism: The Philosophy of Ayn Rand* (London: Meridian, 1993). Available at www.aynrand.org/site/PageServer?pagename=objectivism_intro. Accessed June 15, 2006.
12. A. Rand, *Introducing Objectivism* (Ayn Rand Institute, 1962). Available at www.aynrand.org/site/PageServer?pagename=objectivism_intro. Accessed June 15, 2006.
13. The spiritual dimension is one of the nine elements of the patient-centered care model championed by the Planetree model. See S. B. Frampton, L. Gilpin, and P. A. Charmel, *Putting Patients First: Designing and Practicing Patient-Centered Care* (San Francisco: Jossey-Bass, 2003). Available at www.planetree.org/about/components.htm. Accessed June 5, 2006. See also B. Justice, *Who Gets Sick: How Beliefs, Moods and Thoughts Affect Your Health*, 2nd ed. (Houston: Peak Press, 2000). This book provides an overview of the scientific literature relative to how mental states, including spiritual states, influence healing. For more recent articles, see L. Guterman, "Duping the Brain Into Healing the Body," *Chronicle of Higher Education* 52, no. 15 (2005): A12; H. Koneig, "Meeting the spiritual needs of patients," *The Satisfaction Monitor* (July-August 2003). Available at www.pressganey.com/products_services/readings_findings/satmon/print_article.php?article_id=94. Accessed June 16, 2006.
14. World Medical Association, "The Declaration of Geneva" (World Medical Association, 1983). Available at www.phrusa.org/research/methics/methicsint.html. Accessed June 16, 2006.

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The URL includes several other organizational statements relating to medical ethics, mostly in the form of codes of medical ethics.

15. Following the tradition, the references used to locate the passage are cited by the name of the work and the particular line number. See *Nicomachean Ethics*, Bk I, Chp 9, 1099b32-1100a5. The actual version used is R. McKeon, *Basic Works of Aristotle* (New York: Random House, 1971).
16. Very substantial arguments arise over just what *harm* and *benefit* mean, but those are not necessary to consider here. The exact words noted do not occur in the Hippocratic Corpus. However, it is clearly stated in *Of the Epidemics*, Bk. I, section II, part 5: "The physician must . . . have two special objects in view with regard to disease, namely, to do good or to do no harm." Available at http://classics.mit.edu/Hippocrates/epidemics.html, an online collection of the Hippocratic Corpus. Accessed June 7, 2006.
17. There is a considerable discussion about what virtues are, which ones are important, and the like. I shall have to leave that debate aside and simply hope the reader has an ordinary conception of what a virtue is.
18. See American Medical Association, *Principles of Medical Ethics* (Chicago: American Medical Association, 2001). Available at www.ama-assn.org/ama/pub/category/2512.html. Accessed June 18, 2006.
19. *Nicomachean Ethics*, Bk I, Chp 2, 1103a17.
20. *Nicomachean Ethics*, Bk I, Chp 2, 1103a25.
21. The following material on honesty was inspired by R. Hursthouse, "Virtue Ethics," *Stanford Encyclopedia of Philosophy* (2003). Available at http://plato.stanford.edu/entries/ethics-virtue/. Accessed May 12, 2006. I have rewritten it to fit healthcare professionals from its original, more general appeal.
22. *Nicomachean Ethics*, Bk. 6, Ch. 13, 1145a2–3.
23. This seeking of self-perfection has a major influence in Western culture, extending from the Greeks into the Roman stoics and then into Christianity. In some interpretations, Islamic *jihad* means a similar struggle with the self, a striving for spiritual self-perfection. Muslims knew Aristotle's teachings far in advance of Christendom. After the decline of Rome, Aristotle's work was lost in the West. However, in the ninth century, Arab scholars introduced Aristotle to Islam, and Muslim theology, philosophy, and natural science all took on an Aristotelian cast. After the Crusades, Arab and Jewish scholars reintroduced Aristotelian thought in the West. The correct interpretation of *jihad* is a matter of considerable debate and not a topic here.
24. T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001).
25. T. F. Hoad (Ed.), "Justice," in *The Concise Oxford Dictionary of English Etymology* (New York: Oxford University Press, 1996). Available at www.oxfordreference.com/views/ENTRY.html?subview=Main&entry=t27.e8229. Accessed June 19, 2006.
26. For example, a teacher might say, "your response did the subject justice," meaning it was right and it was a more than merely adequate response, it was good. Or, one might say, "The person showed the justice of their claim," meaning it was a proper and correct claim.
27. T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001).
28. Aristotle thought slavery was okay, because some could comprehend the rational principle, but not possess it. They acted from instinct. *Politics*, Bk II, Chp. 5. Aristotle described barbarians as brutish, along with people of vice. *Nicomachean Ethics*, Bk VII, Chp 1, 1145a30 and Chp. 5, 1148a15–30. By nature, some people should rule and others be ruled. He thought Greeks should rule barbarians "for by nature what is barbarian and what is slave are the same." *Politics* Bk I, chp.2, 1252 b 8. Women were inferior by nature to men as well: "The relationship between the male and the female is by nature such that the male is higher, the female lower, that the male rules and the female is ruled." *Politics*, Bk I, Chp. 4, 1254 b 12–14. The hierarchy of being and value had significant importance politically for millennia and such views still do today. Obviously, metaphysics influences our lives. The common morality has changed relative to many of these views.

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29. *Nicomachean Ethics*, Bk. X, Ch. 9, 1179b5–10.
30. *Nicomachean Ethics*, Bk. X, Ch. 9, 1179b18. The other sentiments are written directly preceding this line. A *tincture* of something seems to suggest that it is not quite the real thing, although it could do some good. So many various definitions of the term *tincture* exist that it is difficult to get a precise understanding of the meaning of the phrase.
31. See B. Justice, *Who Gets Sick: How Beliefs, Moods, and Thoughts Affect Your Health*, 2 ed. (Houston: Peak Press, 2000). This book reviews the scientific literature on the subject. Although dated, it still provides an excellent introduction to the field.
32. In the realm of healthcare management, providing cues to quality to assure the patients that the services are appropriate is part of the management of the dimensions of quality. See V. A. Zeithaml, M. J. Bitner, and D. D. Gremler, *Services Marketing*, 4th ed. (New York: McGraw Hill, 2006). See S. B. Frampton, L. Gilpin, and P. A. Charmel, *Putting Patients First: Designing and Practicing Patient-Centered Care* (San Francisco: Jossey-Bass, 2003).
33. Some of these issues are discussed in *Nicomachean Ethics*, Bk. VII, Chs. 1–10, 1145a15–1154b30.
34. T. A. Mappes and J. S. Zembaty, *Biomedical Ethics*, 2nd ed. (New York: McGraw Hill, 1981), 7. The brush seems much too wide that paints all ethical theories as either more or less consequentialist.
35. For an extremely informative philosophical overview of natural law theory in general and Aquinas' version of it in particular, including an excellent defense of how natural law does not neatly fall into either deontology or consequentialism, see M. Murphy, "The Natural Law Tradition in Ethics," *Stanford Encyclopedia of Philosophy*, Edward N. Zalta, Ed. (2002). Available at http://plato.stanford.edu/archives/win2002/entries/natural-law-ethics/. Accessed June 19, 2006.
36. On how the heavens have never changed in their orderly cycles, see *On the Heavens*, Bk. I, Ch. 3, 270b10–17.
37. See G. Kemerling, *Thomas Aquinas* (*PhilosophyPages.com*, 2002). Available at www.philosophypages.com/ph/aqui.htm. Accessed June 19, 2006. See also S. Richards, *Faithnet.org.uk* (2006). Available at www.faithnet.org.uk/Theology/aquinas.htm. Accessed June 19, 2006.
38. For more modern writers in the field of natural law see, in alphabetical order, T. D. J. Chappell, *Understanding Human Goods* (Edinburgh: Edinburgh University Press, 1995); J. Finnis, *Aquinas: Moral, Political, and Legal Theory* (Oxford: Oxford University Press, 1998); P. Foot, *Natural Goodness* (Oxford: Oxford University Press, 2000); J. E. Hare, *God's Call* (Grand Rapids: Eerdmans, 2001); M. Moore, "Good without God," in *Natural Law, Liberalism and Morality*, R. P. George, Ed. (Oxford: Oxford University Press, 1996); and M. C. Murphy, *Natural Law and Practical Rationality* (Cambridge: Cambridge University Press, 2001).
39. The entire work is available online. St. Thomas Aquinas. 1259. Benziger Bros. edition, 1947. *Summa Theologica*. Translated by Fathers of the English Dominican Province. Christian Classics Ethereal Library. The online index is available at www.ccel.org/a/aquinas/summa/home.html. Accessed June 20, 2006. Question 94 is found at www.ccel.org/a/aquinas/summa/FS/FS094.html#FSQ94OUTP1. The standard reference format for something in *Summa Theologica* is, for example, ST IaIIae 94, 4. This is interpreted to mean it is the *Summa Theologica*; it is the first part of the second part; it is question 94; and it is article four.
40. J. S. Rakish, B. B. Longest, Jr., and K. Darr, *Managing Health Service Organizations*, 3rd ed. (Baltimore: Health Professions Press, 1992), 103; K. Darr, *Ethics in Health Services Administration*, 2nd ed. (Baltimore: Health Professions Press, 1991), 18.
41. For a better account within the healthcare literature, see J. W. Carlson, "Natural Law Theory," in *Biomedical Ethics*, 2nd ed., T. A. Mappes, and J. S. Zembaty (Eds.) (New York: McGraw Hill, 1981), 37–43, and M. C. Brannigan and J. A. Boss, *Healthcare Ethics in a Diverse Society* (Mountain View: Mayfield Publishing, 2001), 23–25.
42. Debating how something can have partial perfection need not concern us here.
43. This also contradicts some commentators, who say that it assumes all rational beings will agree on the content of the natural law. For this error, see M. C. Brannigan and J. A. Boss, *Healthcare Ethics in a Diverse Society* (Mountain View: Mayfield Publishing, 2001), 24.

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44. For an extensive discussion of this approach in the healthcare literature, see T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001), 128–132.
45. To go further into such controversies, see, as examples, P. J. Cataldo, "The Principle of the Double Effect," *Ethics & Medics*, 20 (March 1995), 1-3; B. Ashley and K. O'Rourke, *Healthcare Ethics: A Theological Analysis*, 4th ed. (Washington, D.C.: Georgetown University Press, 1997), 191–195; and D. B. Marquis, "Four Versions of Double Effect," *Journal of Medicine and Philosophy* 16 (1991): 515–544.
46. A similar insight was noted by T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 2nd ed. (New York: Oxford University Press, 1983), 115.
47. M. Murphy, "The Natural Law Tradition in Ethics," *Stanford Encyclopedia of Philosophy*, Edward N. Zalta (Ed.) (2002). Available at http://plato.stanford.edu/archives/win2002/entries/natural-law-ethics/. Accessed June 19, 2006.
48. V. Cathrein, "Ethics," *Catholic Encyclopedia Online*, K. Knight (Ed.) (2003). Available at www.newadvent.org/cathen/05556a.htm. Accessed June 20, 2006.
49. V. Cathrein, "Ethics," Catholic Encyclopedia Online, K. Knight (Ed.) (2003). Available at www.newadvent.org/cathen/05556a.htm. Accessed June 20, 2006.
50. This theory does not appear to protect nonhuman animals, plants, dammed rivers, strip-mined mountains, and the like. Given their lack of rationality, not being made in the image of God, their lower level in the hierarchy of being, being a means to our ends, their potential would matter less. In the Aristotelian scheme, only angels were between humans and the unmoved mover, or God. Later on, Descartes, although not favored by either Catholics or Protestants in his time, made a fundamental distinction between mind and matter. Only humans were believed endowed with mind capacity. Mind easily translated into concepts like soul. Thus, the rest of the natural world, being without mind or soul, did not require us to worry about whether its potential was going to be circumscribed by our actions upon it.
51. For persons not familiar with this Latin term, the exact translation is "without that nothing." The typical way to understand it is that whatever is referred to is the essential element.
52. For some classics in this field, see R. M. Veatch, *Death, Dying, and the Biological Revolution: Our Last Quest for Responsibility* (New Haven: Yale University Press, 1976); J. Rachels, "Euthanasia," in *Matters of Life and Death: New Introductory Essays in Moral Philosophy*, T. Regan (Ed.) (New York: Random House, 1980).
53. V. Cathrein, "Ethics," *Catholic Encyclopedia Online*, K. Knight (Ed.) (2003). Available at www.newadvent.org/cathen/05556a.htm. Accessed June 20, 2006.
54. Most of his works appear to be available free online at http://oll.libertyfund.org/Intros/Kant.php, along with works of many other authors. I do not know whether the translations are those most accepted by scholars.
55. Although in near complete disagreement about the substance of their respective views, John Rawls and Robert Nozick are considered deontologists. Their views are key to understanding current political debates.
56. I. Kant, *Critique of Pure Reason*, trans. N.K. Smith, (New York: St. Martin's Press, 1781 [1965 ed.]).
57. I. Kant, *The Moral Law*, trans. H. J. Patton, (London: Hutchinson University Press, 1785 [1948 ed.]).
58. I. Kant, *The Critique of Practical Reason*, translated by L. W. Beck, (Indianapolis: Bobbs-Merrill, 1788 [1956 ed.]).
59. I. Kant, *Critique of Pure Reason*, trans. N. K. Smith, (New York: St. Martin's Press, 1781 [1965 edition]), pp. 29. The "B xxix" refers to the standard paging of the work. The "B" indicates this passage is in the *Critique*'s second edition only.
60. There is vast literature on the issues involved in whether free will exists. Different flavors of determinism are discussed and different perspectives on what it means to say someone acts freely. Although these issues are important, they simply cannot be broached here. For a good overview of the issues and the approaches taken by various religions, as well as various

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thinkers, see W. K. Frankena, *Ethics: Foundations of Philosophy Series* (Englewood Cliffs, NJ: Prentice Hall, 1963), 54–62, and T. O'Conner, "Free Will," *Stanford Encyclopedia of Philosophy*, Edward N. Zalta (Ed.) (2005). Available at http://plato.stanford.edu/entries/freewill/. Accessed September 17, 2006.

61. What the moral law is will be taken up with the discussion of the categorical imperative.
62. I. Kant, *Critique of Pure Reason*, trans. N. K. Smith, (New York: St. Martin's Press, 1781 [1965 ed.]), 26–29 (Bxxv–bxxx).
63. I. Kant, *Critique of Pure Reason*, trans. N. K. Smith, (New York: St. Martin's Press, 1781 [1965 ed.]), 29.
64. I. Kant, *Critique of Pure Reason*, trans. N. K. Smith, (New York: St. Martin's Press, 1781 [1965 ed.]), 28.
65. I. Kant, "Fundamental Principles of the Metaphysics of Morals," translated by T. K Abbott, *Basic Writings of Kant*, A. L. Wood, Ed. (New York: Modern Library, 1785 [2001 ed.]), 151.
66. *Eudaimonia* is often improperly translated as "happiness."
67. I. Kant, "Fundamental Principles of the Metaphysics of Morals," translated by T. K Abbott, *Basic Writings of Kant*, A. L. Wood, Ed. (New York: Modern Library, 1785 [2001 ed.]), 152.
68. I. Kant, "Fundamental Principles of the Metaphysics of Morals," translated by T. K Abbott, *Basic Writings of Kant*, A. L. Wood, Ed. (New York: Modern Library, 1785 [2001 ed.]), 154–155.
69. I. Kant, *Foundations of the Metaphysics of Morals*, translated by L. W. Black (Indianapolis, IN: Bobbs-Merrill, 1959). The "AK 20" is the conventional page numbering used in Kant scholarship, locating this quote within the 22 volumes in the Preussische Akademie edition. Different pagination is used when referring to the *Critique of Pure Reason*.
70. T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001), 57–112, provides a good discussion of autonomy in the context of medical ethics. E. E. Morrison, *Ethics in Health Administration: A Practical Approach for Decision Makers* (Sudbury, MA: Jones and Bartlett, 2006), 25–44, provides a discussion tailored to health care managers.
71. *Eudaimonia* is often improperly translated as "happiness." For its full meaning, see the discussion in text.
72. R. Johnson, "Kant's Moral Philosophy," in *Stanford Encyclopedia of Philosophy*, E. N. Zalta (Ed.) (February 26, 2004). Available at http://plato.stanford.edu/archives/spr2004/entries/kant-moral/. Accessed June 22, 2006. Given this understanding, Rousseau's famous statement that if people do not value freedom they must be "forced to be free" makes somewhat more sense. Nonetheless, forcing people to manifest your ideas of their highest purpose is *prima facie* paternalism.
73. T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001), 348–351, provide a useful summary of these issues.
74. Kant posits a third version of the categorical imperative, "The Idea of the Will of Every Rational Beings as a Universally Legislative Will." (AK 4:431). I. Kant, "Fundamental Principles of the Metaphysics of Morals," translated by T. K Abbott, *Basic Writings of Kant*, A. L. Wood (Ed.) (New York: Modern Library, 1785 [2001 ed.]), 188. However, since this seems to mostly restate the emphasis on autonomy found in the second version, I shall not take up analysis of it separately.
75. I. Kant, "Fundamental Principles of the Metaphysics of Morals," translated by T. K Abbott, *Basic Writings of Kant*, A. L. Wood (Ed.) (New York: Modern Library, 1785 [2001 ed.]), 178.
76. For a sampling of sources stating or suggesting Kant's categorical imperative is the Golden Rule, see J. S. Rakish, B. B. Longest, Jr., and K. Darr, *Managing Health Service Organizations*, 3rd ed. (Baltimore: Health Professions Press, 1992), 103; K. Darr, *Ethics in Health Services Administration*, 2nd ed. (Baltimore: Health Professions Press, 1991), 18; M. C. Brannigan and J. A. Boss, *Healthcare Ethics in a Diverse Society* (Mountain View: Mayfield Publishing, 2001), 29; J. O. Hertzler, "On Golden Rules," *International Journal of Ethics* 44, no. 4 (1934): 418–436; S. B. Thomas, "Jesus and Kant, a Problem in Reconciling Two Different Points of View," *Mind* 79, no. 314 (April 1970): 188–199; P. Weiss, "The Golden Rule," *Journal*

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of Philosophy 38, no. 16 (July 31, 1941): 421–430; J. E. Walter, "Kant's Moral Theology," *Harvard Theological Review* 10, no. 3 (July 1917): 272–295, esp. 293. Those who write about ethics without having philosophical training are even more likely to make this mistake. A Web site on engineering ethics simply indicates that the categorical imperative is the Golden Rule; see www.engr.psu.edu/ethics/theories.asp. Accesed September 9. 2006. I have even made the error myself in discussing ethical theories in the healthcare literature. The following articles were part of a column on healthcare ethics. See J. Summers, "Managers Face Conflicting Values," *Journal of Health Care Material Management* 7, no. 5, (July 1989): 89–90; J. Summers, "Clinicians & Managers: Different Ethical Approaches to Honoring Commitments," *Journal of Health Care Material Management* 7, no. 4 (May–June 1989): 62–63; J. Summers, "Determining Your Duties," *Journal of Health Care Material Management* 7, no. 3 (April 1989): 80–81; J. Summers, "Duty and Moral Obligations," *Journal of Health Care Material Management* 7 no. 2 (February–March 1989): 80–83; J. Summers, "Ethical Theories: An Introduction," *Journal of Health Care Material Management* 7, no. 1, (January 1989): 56–57. The fact something looks like something else does make it that something else.

77. The disavowal occurs in a footnote in I. Kant, "Fundamental Principles of the Metaphysics of Morals," translated by T. K. Abbott, *Basic Writings of Kant*, A. L. Wood (Ed.) (New York: Modern Library, 1785 [2001 edition]), 187, note. 13. To the normal reader the footnote would not clearly indicate it references the Golden Rule since Kant cited it in Latin and none of the terms have any resemblance to the English version of the Golden Rule.
78. I. Kant, "Fundamental Principles of the Metaphysics of Morals," translated by T. K. Abbott, *Basic Writings of Kant*, A. L. Wood (Ed.) (New York: Modern Library, 1785 [2001 ed.]), 186.
79. I. Kant, "Fundamental Principles of the Metaphysics of Morals," translated by T. K. Abbott, *Basic Writings of Kant*, A. L. Wood (Ed.) (New York: Modern Library, 1785 [2001 ed.]), 190–191.
80. I. Kant, *Foundations of the Metaphysics of Morals*, translated by Lewis White Black (Indianapolis: Bobbs-Merrill, 1959), 31.
81. I. Kant, "Fundamental Principles of the Metaphysics of Morals," translated by T. K. Abbott, *Basic Writings of Kant*, A. L. Wood (Ed.) (New York: Modern Library, 1785 [2001 ed.]), 186.
82. I. Kant, "Fundamental Principles of the Metaphysics of Morals," translated by T. K. Abbott, *Basic Writings of Kant*, A. L. Wood (Ed.) (New York: Modern Library, 1785 [2001 ed.]), 186.
83. For a good history of the Golden Rule, including versions that precede the Christian formulation at Matthew 7:12, see J. O. Hertzler, "On Golden Rules," *International Journal of Ethics* 44, no. 4 (July 1934): 418–436.
84. I. Kant, "Fundamental Principles of the Metaphysics of Morals," translated by T. K. Abbott, *Basic Writings of Kant*, A. L. Wood (Ed.) (New York: Modern Library, 1785 [2001 ed.]), 187, no. 13.
85. I. Kant, "Fundamental Principles of the Metaphysics of Morals," translated by T. K. Abbott, *Basic Writings of Kant*, A. L. Wood (Ed.) (New York: Modern Library, 1785 [2001 ed.]), 156.
86. I. Kant, "Fundamental Principles of the Metaphysics of Morals," translated by T. K. Abbott, *Basic Writings of Kant*, A. L. Wood (Ed.) (New York: Modern Library, 1785 [2001 ed.]), 183.
87. Some of the ideas in this section were drawn from F. Feldman, "Kant's Ethical Theory", in *Biomedical Ethics*, T. A. Mappes and J. S. Zembaty (Eds.) (New York: McGraw-Hill, 1981), 26–37, esp. pp. 36–37.
88. Healthcare managers do have a fiduciary duty to the organization and its patients. Such duties are described as duties of care and loyalty created when a person undertakes to act for the benefit of another as to whom he has a relationship implying confidence and trust and creating the expectation that he will act with a high degree of good faith.
89. For a very good overview of these views and a critical review as well, see A. Gandjour and K.W. Lauterbach, "Utilitarian Theories Reconsidered: Common Misconceptions, More Recent Developments, and Health Policy Implications," *Health Care Analysis* 11, no. 3 (September 2003): 229–244. A different source lists ten versions of consequentialism, see W. Sinnott-Armstrong, "Consequentialism," *The Stanford Encyclopedia of Philosophy* (Winter 2003 ed.), Edward N. Zalta (Ed.). Available at http://plato.stanford.edu/entries/consequentialism/. Accessed September 14, 2006. At least three versions of rule consequentialism are described;

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see B. Hooker, "Rule Consequentialism," *The Stanford Encyclopedia of Philosophy* (Winter 2003 ed.), Edward N. Zalta (Ed.). Available at http://plato.stanford.edu/entries/consequentialism-rule. Accessed May 12, 2006.

90. Deontology can also be divided into rule and act deontology, although I did not find the distinction useful here. See W. K. Frankena, *Ethics: Foundations of Philosophy Series*, (Englewood Cliffs: Prentice Hall, 1963), 21–25.
91. J. S. Mill, *Utilitarianism* (1863). Available at www.utilitarianism.com/mill1.htm, Chapter II, para. 2. Accessed September 10, 2006. Owing to the many printed versions, I am citing it by reference to chapter and paragraph.
92. J. S. Mill, *Utilitarianism* (1863). Available at www.utilitarianism.com/mill1.htm, Chapter II, para. 2. Accessed September 10, 2006. Owing to the many printed versions, I am citing it by reference to chapter and paragraph.
93. *Eudaimonia* was discussed previously and is human happiness that necessarily includes pursuit of the good for humans qua humans.
94. See D. Lyons, "Mill's Theory of Morality," *Nous* 10, no. 2 (April 1976): 101–120, esp. pp. 103–104. He draws this conclusion from Mill's discussion of duty and punishment in *Utilitarianism*, Chapter V, para. 14–15, where Mill finds that punishment is necessary for persons not fulfilling their duties, without regard to any specific calculation of consequences. The fact that this begins to sound like deontology we shall leave unchallenged.
95. For example, D. Lyons, "Mill's Theory of Morality," *Nous* 10, no. 2 (April 1976): 101–120, notes the considerable debate over whether Mill was an act utilitarian or a rule utilitarian and over whether considerations other than utility entered into the decision calculus. He cites considerable sources on both sides of the debate.
96. Discussed by S. Gosepath, "Equality," *The Stanford Encyclopedia of Philosophy* (Winter 2003 ed.), Edward N. Zalta (Ed.). Available at http://plato.stanford.edu/entries/equality/. Accessed September 10, 2006.
97. For an extremely well-written, even witty, analysis of this difficulty, see M. Sagoff, "Should Preferences Count?" *Land Economics* 70, no. 2. (May 1994): 127–144. For a very abstruse and technical paper reaching essentially similar conclusions, see D. M. Hausman, "The Impossibility of Interpersonal Utility Comparisons," *Mind* 104, no. 415 (July 1995): 473–490.
98. See J. Summers, "Managers Face Conflicting Values," *Journal of Health Care Material Management* 7, no. 5 (May–June 1989); J. Summers, "Clinicians & Managers: Different Ethical Approaches to Honoring Commitments," *Journal of Health Care Material Management* 7, no. 4 (May–June 1989): 62-63; J. Summers, "Determining Your Duties," *Journal of Health Care Material Management* 7, no. 3 (April 1989): 80–81; J. Summers, "Duty and Moral Obligations," *Journal of Health Care Material Management* 7, no. 2 (February–March 1989): 80–83.
99. One of the common texts used for teaching healthcare managers the principles of management includes a section on ethics. Although much of the section is on point and the overall text is excellent, the discussion of consequentialism does not even mention that the typical understanding is the "the greatest good for the greatest number," but instead simply says "a summary statement that describes utilitarian theory is 'the end justifies the means.'" See J. S. Rakish, B. B. Longest, Jr., and K. Darr, *Managing Health Service Organizations*, 3rd ed. (Baltimore: Health Professions Press, 1992), 102. The author of the statement, Kurt Darr, had previously written K. Darr, *Ethics in Health Services Administration*, 2nd ed. (Baltimore Health Professions Press, 1991). In that text he did mention the idea of "the greatest good for the greatest number" along with "the end justifying the means," but thought both attributable to utilitarians, although not to be "applied without qualification" (p. 16). Those qualifications were not discussed. Unfortunately, many healthcare managers who were only exposed to the more general management theory book never would know about the greatest good for the greatest number and would likely perceive consequentialism as inherently allowing an evil to seek a good. For one of many other examples of misunderstanding consequentialism, see K. Anderson, *Utilitarianism: The Greatest Good for the Greatest Number* (Probe Ministries, 2004). Available at www.probe.org/content/view/1379/130/. Accessed Sep-

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tember 10, 2006. G. Koukl, "Means and Ends," *Stand To Reason* (1994). Available at www.str.org/site/News2?page=NewsArticle&id=5444. Accessed September 10, 2006. Many of the sites making the claim that utilitarianism means the end justifies the means were religious sites. For an example of a business misreading of Mill's consequentialism, see R. Scruton, "Thoroughly Modern Mill," *Wall Street Journal*, May 19, 2006, A10. Available at http://online.wsj.com/article_email/SB114800167750457376-lMyQjAxMDE2NDI4MjAyMDIxWj.html. Accessed September 10, 2006. Scruton considers Lenin, Hitler, Mao, Stalin, and common criminals as "pious utilitarians." See also http://en.wikipedia.org/wiki/The_ends _justify_the_means for how this publicly edited source ties consequentialism to the theory. To define a theory by one of its criticisms is exceedingly off base.

100. B. Hooker, "Rule Consequentialism," *The Stanford Encyclopedia of Philosophy*, (Winter 2003 ed.), Edward N. Zalta (Ed.). Available at http://plato.stanford.edu/entries/consequentialism-rule. Accessed May 12, 2006. Hooker provides the reasons for this rejection and cites a large body of scholarship to support his contention. See also E. Millgram, "What's the Use of Utility?" *Philosophy and Public Affairs* 29, no. 2 (Spring 2000): 113–136, esp. p. 126.
101. A criticism in the philosophical literature is that revision of the rule to deal with exceptions leads inevitably back to act consequentialism. See B. Hooker, "Rule Consequentialism," *The Stanford Encyclopedia of Philosophy*, (Winter 2003 ed.). Edward N. Zalta (Ed.). Available at http://plato.stanford.edu/entries/consequentialism-rule. Accessed May 12, 2006. Practical experience as a manager and an educator of managers suggests that any manager worth having learned long ago not to let this happen.
102. T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001), 98–102, discuss the substituted judgment approach and find it lacking. They promote the phrase "pure autonomy standard" for what I understand as the substituted judgment approach. Their change in terminology has not been picked up in the healthcare literature as a replacement for substituted judgment.
103. See E. E. Morrison, *Ethics in Health Administration: A Practical Approach for Decision Makers* (Sudbury, MA: Jones and Bartlett, 2006), 28; and T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001), 102–103.
104. In political decision making, we fall back on the idea of having an elected person who represents us. Those representatives collect information about what their constituents think in a number of ways. In the organizational setting, the entire discipline of market research can be brought to bear. However, these information-gathering methods are seldom quick or inexpensive.
105. For an extremely well-written, even witty, analysis of this difficulty, see M. Sagoff, "Should Preferences Count?" *Land Economics* 70, no. 2 (May 1994): 127–144. For a very abstruse and technical paper reaching essentially similar conclusions, see D. M. Hausman, "The Impossibility of Interpersonal Utility Comparisons," *Mind* 104, no. 415 (July 1995): 473–490.
106. J. S. Mill, "On Liberty." (1863). Chapter I, para. 13. Available at www.utilitarianism.com/ol/htm. Accessed September 10, 2006. Owing to the many printed versions, I am citing it by reference to chapter and paragraph.
107. I again refer the reader to P. Tillich, *The Courage to Be* (New Haven: Yale University Press, 1952) for helpful thoughts on coping with difficult quandaries about the meaning of life and difficult choices in life.
108. See J. S. Rakish, B. B. Longest, Jr., and K. Darr, *Managing Health Service Organizations*, 3rd ed. (Baltimore: Health Professions Press, 1992), 106. Authors stress the balancing and eclectic nature of the work of the manager in drawing on the ethical theories and principles. See also M. C. Brannigan and J. A. Boss, *Healthcare Ethics in a Diverse Society* (Mountain View: Mayfield Publishing, 2001), 28, for a similar view. See E. E. Morrison, *Ethics in Health Administration: A Practical Approach for Decision Makers* (Sudbury, MA: Jones and Bartlett, 2006), 20–22, for thoughts on what it means to healthcare managers to draw these ideas together into a personal ethic.
109. Whereas nurses can trace their origins to Florence Nightingale (1820–1910), the professional society of healthcare managers, the American College of Healthcare Executives,

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traces its origins to 1933. The organization was founded for the purpose of developing a profession of healthcare managers. See www.ache.org/CARSVCS/wesbury_fellowship.cfm. Accessed September 16, 2006. Many other healthcare professions are even more recent in origin.

110. See J. Summers, "Doing Good and Doing Well: Ethics, Professionalism and Success," *Hospital and Health Services Administration* 29, no. 2 (March–April 1984): 84–100 for an early discussion in the healthcare literature about the integration of these values and approaches.