CHAPTER 1

CONSIDERING MORAL PHILOSOPHIES AND PRINCIPLES

What sources guide us in ethical decision making? How do they help us identify and act on the morally correct choice? Philosophers, theologians, and others grapple with such questions. The clearest tradition of ethics in Western medicine dates from the ancient Greeks. Throughout the 20th century and into the 21st century, managers and nurses have formally sought to clarify, establish, and, sometimes, enforce ethical standards. Their codes and activities incorporate philosophies about the ethical relationships of providers to one another, to patients, and to society. For managers, the appropriate relationship with the organizations that employ them is an added dimension of their codes.

A natural starting point for discussing ethics and understanding how to resolve ethical problems is to review the moral philosophies that have had a major influence on Western European thought and values. Among the most prominent of these philosophies are utilitarian teleology; Kantian deontology; natural law as formulated by St. Thomas Aquinas; and the work of the 20th-century American philosopher John Rawls. The latter part of the 20th century saw renewed interest in casuistry and virtue ethics. Its emphasis on the individual makes virtue ethics especially helpful in guiding action for managers. In addition, the ethics of care is considered briefly.

Principles derived from these moral philosophies provide the framework or moral (ethical) underpinnings for delivery of health services by organizations. These principles will assist managers (and health services caregivers) in honing a personal ethic. The derivative operative principles are respect for persons, beneficence, nonmaleficence, and justice. Virtue ethics stands on its own as a moral philosophy; also, it helps supplement the principles when they lack rigor in analyzing or solving ethical problems.

The following case about Baby Boy Doe is true. State and federal law would prevent it today. Its simplicity and starkness make it a useful paradigm against which to apply the moral philosophies and derivative principles discussed in this chapter.

Baby Boy Doe

In 1970, a male infant born at a major East Coast medical center was diagnosed with mental retardation and duodenal atresia (the absence of a connection between the stomach and intestine). Surgeons determined that although the baby was very small, the atresia was operable, with a high probability of success. The surgery would not alter the baby's mental retardation, but would permit him to take nourishment by mouth.

The baby's parents decided to forego the surgery—something they had the legal right to do—and over the course of the following 2 weeks, the infant was left to die from dehydration and starvation. No basic determination of the extent of mental impairment had been made, nor could it have been, at the time the infant died. Neither hospital personnel nor state family and social services sought to aid him.

This case sends a shudder through most people. Feelings or emotions, however, are insufficient. If managers are to be effective in addressing and solving—or, preferably, preventing—such problems, they must identify and understand the issues involved, know the roles of staff and organization, and apply guidelines for ethical decision making. Following a discussion of moral philosophies and ethical principles, the case of Baby Boy Doe is analyzed.

MORAL PHILOSOPHIES

Utilitarianism

Utilitarians are consequentialists: They evaluate an action in terms of its effect rather than the action's intrinsic attributes. Synonymous with utilitarians are teleologists (from the Greek *telos*, meaning end or goal). Utilitarianism has historical connections to hedonism (Epicureanism), which measured morality by the amount of pleasure obtained from an act or a rule as to how to act—greater pleasure was equated with greater morality. This theory was refined by two 19th-century English philosophers, Jeremy Bentham and John Stuart Mill. Mill's elaboration of utilitarianism was the most complete. Unlike Bentham, Mill sought to distinguish pleasures (the good) on qualitative grounds. Questions about the superiority of certain pleasures, such as listening to a piano concerto, were to be answered by consulting a person of sensitivity and broad experience, even though requiring such judgments diminished the objectivity of utilitarianism. Mill stressed individual freedom. In *On Liberty*, he noted that freedom is requisite to producing happiness and that this makes it unacceptable for the rights of any group or individual to be infringed in significant ways.

In determining the morally correct choice, utilitarians ignore the means of achieving an end and judge the results of an action by comparing the good produced by a particular action to the good produced by alternatives or the amount of evil avoided. Modified utility theory is the basis for the cost–benefit analysis commonly used by economists and managers. "The greatest good for the greatest number" and "the end justifies the means" are statements attributable to utilitarians. However, these statements are only crude gauges of utilitarianism, inappropriately applied without qualification.

Utilitarianism is divided into *act utility* and *rule utility*. Both measure consequences, and the action that brings into being the most good (understood in a nonmoral sense) is deemed the morally correct choice.

Act utilitarians judge each action independently, without reference to preestablished guidelines (rules). They measure the amount of good, or (nonmoral) value brought into being, and the amount of evil, or (non-moral) disvalue avoided by acting on a particular choice. Each person affected is counted equally, which seems to assign a strong sense of objectivity to this moral philosophy. Because it is episodic and capricious, act utilitarianism is incompatible with developing and deriving the ethical principles needed for a personal ethic, organizations' philosophies, and codes of ethics. Therefore, it receives no further attention.

Rule utilitarians are also concerned only with consequences, but they have prospectively considered various actions and the amount of good or evil brought into being by each. These assessments are used to develop rules (guidelines) for action, because it has been determined that, overall, certain rules produce the most good and result in the least evil or "un-good."

Therefore, these rules determine the morally correct choice. The rules are followed for all similar situations, even if they sometimes do not produce the best results. The rule directs selection of the morally correct choice. Rule utilitarianism assists in developing moral principles for health services management. Following Mill, however, it must be stressed that the underlying context and requirement is that liberty be maximized for all.

Deontology

Deontologists adhere to a formalist moral philosophy (in Greek, *deon* means duty). The foremost proponent of deontology was Immanuel Kant, an 18th-century German philosopher. Kant's basic precept was that relations with others must be based on duty. An action is moral if it arises solely from "good will," not from other motives. According to Kant, good will is that which is good without qualification. Unlike utilitarians, deontologists view the end as unimportant, because, in Kant's view, persons have duties to one another as moral agents, duties that take precedence over the consequences of actions. Kantians hold that certain absolute duties are always in force. Among the most important is respect, or the Golden Rule ("Do unto others as you would have them do unto you"). Kant argued that all persons have this duty; respect toward others must always be paid.

Actions that are to be taken under the auspices of this duty must first be tested in a special way, a test Kant termed the *categorical imperative*. The categorical imperative requires that actions under consideration be universalized. In other words, if a principle of action is thought to be appropriate, a determination is made as to whether it can be consistently applied to all persons in all places at all times. There are no exceptions, nor can allowances be made for special circumstances. If the action under consideration meets the test of universality, it is accepted as a duty. The action fails the test if it is contradictory to the overriding principle that all persons must be treated as moral equals and, therefore, are entitled to respect. Truth telling is a prominent example of a duty that meets the categorical imperative. Because the categorical imperative tests the results (ends) of actions, Kantian deontology must be considered teleological (ends-based).

For the Kantian deontologist, it is logically inconsistent to argue that terminally ill persons should be euthanized, because this amounts to the self-contradictory conclusion that life can be improved by ending it. Similarly, caregivers should not lie to patients to improve the efficiency of healthcare delivery; such a policy fails the test of the categorical imperative because it treats patients as means to an end—efficiency—rather than as moral equals. The Golden Rule is the best summary of Kant's philosophy. Having met the test of the categorical imperative, Kantian deontology does not consider results or consequences. This does not mean that managers must ignore consequences, but that the consequences of an action are neither included nor weighed in ethical decision making using Kantian deontology.

Natural Law

Mill defined morally right actions by the happiness or nonmoral value produced. Kant rejected all ethical theories based on desire or inclination. Unlike Mill and Kant, natural law theorists contend that ethics must be based on concern for human good. They also contend that good

cannot be defined simply in terms of subjective inclinations. Rather, there is a good for human beings that is objectively desirable, although not reducible to desire.[1] Natural law holds that divine law has inscribed certain potentialities in all things, which constitute the good of those things. In this sense, the theory is teleological because it is concerned with ends. Natural law is based on Aristotelian thought as interpreted and synthesized with Christian dogma by St. Thomas Aquinas (1225–1274).[2]

The potentiality of human beings is based on a uniquely human trait, the ability to reason. Natural law bases ethics on the premise that human beings will do what is rational, and that this rationality will cause them to tend to do good and avoid evil. Natural law presumes a natural order in relationships and a predisposition by rational individuals to do or to refrain from doing certain things. Our capability for rational thought enables us to discover what we should do. In that effort, we are guided by a partial notion of God's divine plan that is linked to our capacity for rational thought. Because natural law guides what rational human beings do, it serves as a basis for positive law, some of which is reflected in statutes. Our natural inclination directs us to preserve our lives and to do such rational things as avoid danger, act in self-defense, and seek medical attention when needed. Our ability to reason shows that other human beings are like us and therefore entitled to the same respect and dignity we seek. A summary statement of the basic precepts of natural law is "do good and avoid evil." Using natural law, theologians have developed moral guidelines about medical services, which are described in Chapters 10 and 11.

Rawls's Theory

The contemporary American moral philosopher John Rawls died in 2002. Rawls espoused a hybrid theory of ethics that has applications in health services allocation and delivery. His theories were expounded in his seminal work, *A Theory of Justice*, originally published in 1971. They are redistributive in nature, and the philosophical construct that he used results, with some exceptions, in egalitarianism in health services.

Rawls's theory uses an elaborate philosophical construct in which persons are in the "original position," behind a veil of ignorance. Such persons are rational and self-interested but know nothing of their individual talents, intelligence, social and economic situations, and the like. Rawls argues that persons in the original position behind a veil of ignorance will identify certain principles of justice. First, all persons should have equal rights to the most extensive basic liberty compatible with similar liberty for others (the *liberty principle*). Second, social and economic inequalities should be arranged so that they are both reasonably expected to be to everyone's advantage and attached to positions and offices open to all (the *difference principle*).[3] According to Rawls's theory, the liberty principle governing political rights is more important and precedes the difference principle, which governs primary goods (distributive rights), including health services.

Rawls argued that hypothetical rational and self-interested persons in the original position will reject utilitarianism and select the concepts of right and justice as precedent to the good. Rawls concluded that rational self-interest dictates that one will act to protect the least well-off because (from the perspective of the veil of ignorance) anyone could be in that group. He

termed this *maximizing the minimum position* (*maximin*).

When applied to primary goods, one of which is health services, Rawlsian moral theory requires egalitarianism. *Egalitarianism* is defined to mean that rational, self-interested persons may limit the health services available to people in certain categories, such as particular diseases or age groups, or limit services provided in certain situations. It is also rational and self-interested for persons in the original position not to make every good or service available to everyone at all times.

Rawls's theory permits disproportionate distribution of primary goods to some groups, but only if doing so benefits the least advantaged. This is part of the difference principle and justifies elite social and economic status for persons such as physicians and health services managers if their efforts ultimately benefit the least advantaged members of society.

Casuistry and the Ethics of Care

Casuistry Many historical definitions of casuistry are not flattering. They include a moral philosophy that uses sophistry and encourages rationalizations for desired ethical results, uses evasive reasoning, and is quibbling. Despite these unflattering definitions and a centuries-long hiatus, advocates of casuistry see it as a pragmatic approach to understanding and solving problems of modern biomedical ethics. *Casuistry* can be defined as a kind of case-based reasoning in historical context. A claimed strength is that it avoids excessive reliance on principles and rules, which, it is argued, provide only partial answers and often fall short of comprehensive guidance for decision makers.

A significant effort to rehabilitate casuistry was undertaken by Jonsen and Toulmin,[4] who argued that

> Casuistry redresses the excessive emphasis placed on universal rules and invariant principles by moral philosophers. . . . Instead we shall take seriously certain features of moral discourse that recent moral philosophers have too little appreciated: the concrete circumstances of actual cases, and the specific maxims that people invoke in facing actual moral dilemmas. If we start by considering similarities and differences between particular types of cases on a practical level, we open up an alternative approach to ethical theory that is wholly consistent with our moral practice.

At its foundation casuistry is similar to the law, in which court cases and the precedents they establish guide decision makers. Beauchamp and Walters[5] stated that

> In case law, the normative judgments of a majority of judges become authoritative, and . . . are the primary normative judgments for later judges who assess other cases. Cases in ethics are similar: Normative judgments emerge through majoritarian consensus in society and in institutions because careful attention has been paid to the details of particular problem cases. That consensus then becomes authoritative and is extended to relevantly similar cases.

In fact, this process occurs in organizations when ethics committees, for example, develop a body of experience with ethical issues of various types—their reasoning uses paradigms and analogies.

Clinical medicine is case focused. Increasingly, cases are being used in management education. This development has made it natural to employ a case approach in health services. Traditionally, ethics problem solving in health services has applied moral principles to cases —from the general to the specific, or deductive reasoning. Classical casuists, however, used a kind of inductive reasoning—from the specific to the general. They began by stating a paradigm case with a strong maxim (e.g., "thou shalt not kill") set in its most obvious

relevance to circumstances (e.g., a vicious attack on a defenseless person). Subsequent cases added circumstances that made the relevance of the maxim more difficult to understand (e.g., if defense is possible, is it moral?). Classical casuists progressed from being deontologists to teleologists and back again, as suited the case, and adhered to no explicit moral theory.[6] Jonsen[7] argued that modern casuists can profitably copy the classical casuists' reliance on paradigm cases, reference to broad consensus, and acceptance of probable certitude (defined as assent to a proposition but acknowledging that its opposite might be true). Casuistry has achieved a prominent place in applied administrative and biomedical ethics. Increasing numbers of cases and a body of experience will lead to consensus and greater certainty in identifying morally right decisions.

Ethics of Care Medicine is based on caring, the importance of which is reflected historically and in contemporary biomedical ethics. *Care* focuses on relationships; in clinical practice, this means relationships between caregivers and patients. Effective management also depends on relationships between managers and staff, and through them to patients. As the ethics of care evolves, it may become more applicable to management; at this point, however, it applies almost exclusively to clinical relationships.

The interest in the ethics of care beginning in the 1980s has been attributed to the feminist movement.[8] Its proponents argue that various interpersonal relationships and the obligations and virtues they involve "lack three central features of relations between moral agents as understood by Kantians and contractarians, e.g., Rawls—it is intimate, it is unchosen, and is between unequals."[9] Thus, the ethics of care emphasizes the attachment of relationships rather than the detachment of rules and duties.

A clear link to virtue ethics exists in that the ethics of care focuses on character traits such as compassion and fidelity that are valued in close personal relationships. It has been suggested that the basis for the ethics of care is found in the paradigmatic relationship between mother and child. It is claimed that this paradigm sets it apart from the predominantly male experience, which often uses the economic exchange between buyer and seller as the paradigmatic human relationship, and which, it is argued, characterizes moral theory, generally.[10]

A leading exponent of the ethics of care, Carol Gilligan,[11] argued that unlike traditional moral theories, the ethics of care is grounded in the assumption that

> Self and other are interdependent, an assumption reflected in a view of action as responsive and, therefore, as arising in relationships rather than the view of action as emanating from within the self and, therefore, "self-governed." Seen as responsive, the self is by definition connected to others, responding to perceptions, interpreting events, and governed by the organizing tendencies of human interaction and human language. Within this framework, detachment, whether from self or from others, is morally problematic, since it breeds moral blindness or indifference—a failure to discern or respond to need. The question of what responses constitute care and what responses lead to hurt draws attention to the fact that one's own terms may differ from those of others. Justice in this context becomes understood as respect for people in their own terms.

Similar to virtue ethics and the renewed interest in casuistry, the ethics of care is a reaction to the rules and systems building of traditional theories. Its proponents argue that the ethics of care more closely reflects the real experiences in clinical medicine and of caregivers, who are

expected to respond with, for example, warmth, compassion, sympathy, and friendliness, none of which fits well into a system of rules and duties. "Ethical problems are considered in a contextual framework of familial relationships and intrapersonal relationships combined with a focus on goodness and a reflective understanding of care."[12]

Virtue Ethics

Western thought about the importance of virtue can be traced to Plato, but more particularly to Aristotle.[13] Like natural law, virtue ethics is based on theological ethics but does not focus primarily on obligations or duties. "Virtue" is that "state of a thing that constitutes its peculiar excellence and enables it to perform its function well." It is "in man, the activity of reason and of rationally ordered habits."[14] Virtue ethics prescribes no rules of conduct. "Instead, the virtue ethical approach can be understood as an invitation to search for standards, as opposed to strict rules, that ought to guide the conduct of our individual lives."[15] As with casuistry, virtue ethics is receiving increased attention. MacIntyre's *After Virtue* and Foot's *Virtues and Vices*[16] reaffirmed the importance of virtue ethics as a moral philosophy with 20th-century relevance.

Some of this attention resulted from a perception that traditional rule-or principle-based moral philosophies deal inadequately with the realities of ethical decision making. That is to say, rules (as derived from moral principles) take us only so far in solving ethical problems; when there are competing ethical rules or situations to which no rules apply, something more than a coin toss is needed. This is where virtue ethicists claim to have a superior moral philosophy. Rule utilitarians and Kantian moral philosophies provide principles to guide actions, thus allowing someone to decide how to act in a given situation. By contrast, virtue ethics focuses on what makes a good person rather than on what makes a good action.[17] "Virtuous persons come to recognize both things that should be avoided and those that should be embraced."[18] Action comes from within and is not guided by external rules and expectations.

Contemporary authors Pellegrino and Thomasma[19] argue that virtue ethics has three levels. The first two are 1) observing the laws of the land and 2) observing moral rights and fulfilling moral duties that go beyond the law. The third and highest level is the practice of virtue.

> Virtue implies a character trait, an internal disposition habitually to seek moral perfection, to live one's life in accord with a moral law, and to attain a balance between noble intention and just action. . . . In almost any view the virtuous person is someone we can trust to act habitually in a good way—courageously, honestly, justly, wisely, and temperately.[20]

Thus, virtuous managers (or physicians) are disposed to the right and good that is intrinsic to the practice of their profession, and they will work for the good of the patient. As Pellegrino noted, "Virtue ethics expands the notions of benevolence, beneficence, conscientiousness, compassion, and fidelity well beyond what strict duty might require."[21]

Some virtue ethicists argue that, as with any skill or expertise, practice and constant striving to achieve virtuous traits (good works) improves one's ability to be virtuous. Other virtue ethicists argue that accepting in one's heart the forgiveness and reconciliation offered by God (faith) "would lead to a new disposition toward God (trust) and the neighbor (love), much

as a physician or patient might be judged to be a different (and better) person following changed dispositions toward those persons with whom . . . (they) are involved."[22]

As noted, the virtues are character traits, a disposition well entrenched in the possessor. The fully virtuous do what they should without any struggle against contrary desires.[23] Most of us are less than fully virtuous, however. We are continent—we need to control a desire or temptation to do otherwise than be virtuous. Another way to describe a virtue is that it is a tendency to control a certain class of feeling and to act rightly in a certain kind of situation.[24]

Plato identified only four cardinal virtues: wisdom, courage, self-control, and justice.[25] Aristotle expanded these four virtues in ways that need not concern us. Beauchamp and Childress identified five "focal virtues" that are appropriate for health professionals: compassion, discernment, trustworthiness, integrity, and conscientiousness.[26] Virtues appropriate for health services managers include those selected by Plato and by Beauchamp and Childress, and several more that can be added, including honesty, punctuality, temperance, friendliness, cooperativeness, fortitude, caring, truthfulness, courteousness, thrift, veracity, candor, and loyalty. The goal of the virtuous manager is to achieve a mean between a virtue's excess and its absence. For example, courage is a virtue, but its excess is rashness; its absence is cowardice. Another example is friendliness. In excess, it is obsequiousness; its absence is sullenness. Neither extreme is acceptable in the virtuous manager.[27] A way to understand the virtues is to identify the vices or character flaws managers should avoid. These include being irresponsible, feckless, lazy, inconsiderate, uncooperative, harsh, intolerant, dishonest, selfish, mercenary, indiscreet, tactless, arrogant, unsympathetic, cold, incautious, unenterprising, pusillanimous, feeble, presumptuous, rude, hypocritical, self-indulgent, materialistic, grasping, shortsighted, vindictive, calculating, ungrateful, grudging, brutal, profligate, disloyal, and so on.[28]

All people should live virtuous lives, but those in the caring professions have a special obligation to do so, which is to say that virtuous managers and physicians are not solely virtuous persons practicing a profession. They are expected to work for the patient's good even at the expense of personal sacrifice and legitimate self-interest.[29] Virtuous physicians place the good of their patients above their own and seek that good, unless pursuing it imposes injustice on them or their families or violates their conscience.[30] Thus, virtuous physicians place themselves at risk of contracting a deadly infectious disease to comfort and treat their patients, and they provide large amounts of uncompensated treatment even though doing so diminishes their economic circumstances. Similarly, virtuous managers place the good of the patient (through the organization) above their own. This means that they speak out to protect the patient from harm because of incompetent care, even though doing so risks their continued employment, and they work the hours necessary to ensure that needed services are provided, despite a lack of commensurate remuneration. Meeting the responsibility to protect the patient requires virtues such as courage, perseverance, fortitude, and compassion.

Virtues may come into conflict. For example, the virtue of compassion conflicts with the virtue of honesty when a patient asks a caregiver, "Am I going to die?" Moreover, the virtue of loyalty to the employing organization conflicts with the virtue of fair treatment of staff. Such conflicts cause an ethical dilemma. They may be resolved by asking questions such as

> Which of the alternative courses of action is more distant from the virtue that is relevant to it? Which of these virtues is more central with the role relationship that the agent(s) plays in the lives of the others with whom (they) are involved? Which of these roles is more significant in the life of the moral patient, the person to be affected by the agent's behavior?[31]

Answers to these questions enable the decision maker to choose a course of action that does no violence to their effort to be virtuous.

The concept of virtue and a moral philosophy based on it goes well beyond Western philosophical thought. Hindu ethics as discussed in the Hindu scripture the Bhagavad Gita identify duty, but duty coexists with virtue.[32] Confucianism exhibits attention to the virtues, but the virtues are present only in the context of filial piety—a pattern of interpersonal connectedness. This connectedness diminishes the extent to which individuals can be analyzed as autonomous entities. Thus, being virtuous for Confucius is to have traits that render trait-based explanations of behavior inadequate on their own.[33]

Summary

The moral philosophies described in this section span a wide spectrum. Health services managers are likely to be eclectic in selecting those that become part of the organization's philosophy and those that will influence the content of their personal ethic, as well as its reconsideration and evolution. Most important is that managers recognize that a basic understanding of moral philosophies is vital.

LINKING THEORY AND ACTION

Ethical theories are drawn from abstractions that are often stated broadly. Principles developed from these theories establish a relationship and suggest a course of action. Rules can be derived from the principles; the specific judgments and actions to be applied are the result. Figure 3 was developed by Beauchamp and Childress to demonstrate the relationship between ethical theories (moral philosophies) and actions implementing decisions.

Ethical theories do not necessarily conflict. Diverse philosophies may reach the same conclusion, albeit through different reasoning, by various constructs, or by focusing on divergent criteria (e.g., the rule utilitarian's use of ends versus the Kantian's use of duty). The principles discussed here, supplemented by various of the virtues, are considered crucial and should be reflected in the organization's philosophy and the personal ethic of health services managers.

Linking ethical theories and derivative principles permits the development of usable guidelines. To aid in that process, this discussion identifies four principles that provide a context for managing in health services environments: 1) respect for persons, 2) beneficence, 3) nonmaleficence, and 4) justice. Utility is sometimes treated as a distinct principle, but that construct is somewhat artificial and potentially confusing. Here, utility is included as an adjunct to the principle of beneficence.

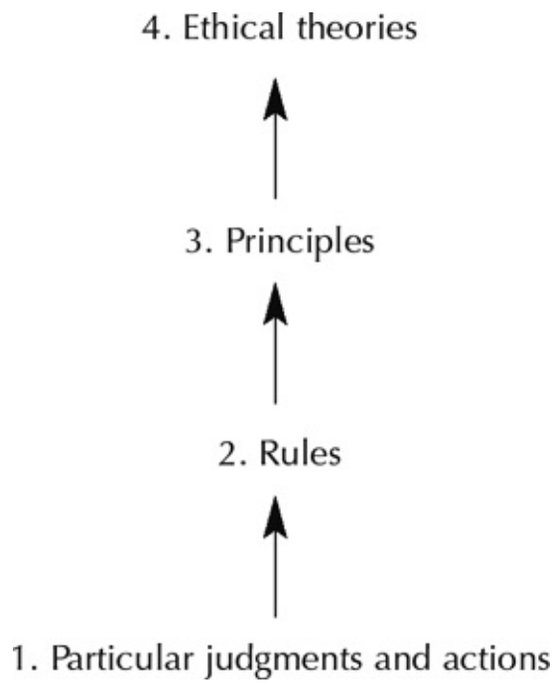

Figure 3. Hierarchy of relationships. (From Beauchamp, T.L., & Childress, J.F. [1983]. *Principles of biomedical ethics* [2nd ed., p. 5]. New York: Oxford University Press. Reprinted by permission.)

Respect for Persons

The theories discussed in this chapter support the conclusion that respect for persons is an important ethical principle. This principle has four elements. The first, autonomy, requires that one act toward others in ways that allow them to be self-governing—to choose and pursue courses of action. To do so, a person must be rational and uncoerced. Sometimes patients are or become nonautonomous (e.g., some persons with physical or cognitive disabilities). They are owed respect nonetheless, even though special means are required. Recognizing the patient's autonomy is the reason that consent for treatment is obtained, and it is a general basis for the way an organization views and interacts with patients and staff.

Autonomy is in dynamic tension with paternalism, the concept that one person knows what is best for another. Paternalism is an established tradition in health services. The earliest evidence of it is found in the Hippocratic oath, which is reproduced in Appendix B. It directs physicians to act in what they believe to be the patient's best interests. Stressing autonomy does not eliminate paternalism, but paternalism should be used in limited circumstances (e.g., when patients cannot communicate and there is no one to speak for them).

The second element of respect for persons is truth telling, which requires managers to be honest in all activities. Depending on how absolute a position is taken, this element prohibits fibs or white lies, even if they are told because it is correctly believed that knowing the truth would harm someone. The morality of insisting that patients be told the truth may also be problematic, depending on the circumstances. Some patients would suffer mental and physical harm if told the truth about their illnesses. In doing so, physicians would not meet their obligation of primum non nocere or "first, do no harm." The modern expression of this concept is nonmaleficence, which is discussed later in the chapter.

Confidentiality is the third element of the principle of respect for persons. It requires

managers as well as clinicians to keep what they learn about patients confidential. Morally justified exceptions to confidentiality are made, for example, when the law requires that certain diseases and conditions be reported to government. For managers, the obligation of confidentiality extends beyond patients. It applies to information about staff, organization, and community that becomes known to them in the course of their work.

The fourth element of respect for persons is fidelity: doing one's duty or keeping one's word. Sometimes, this is called "promise keeping." We treat persons with respect when we do what we are expected to do or what we have promised to do. Fidelity enables managers to meet the principle of respect for persons. Here, too, if exceptions are made, they cannot be made lightly. Breaking a promise must be justified on moral grounds; it must never be done merely for convenience or self-interest.

Beneficence

Like respect for persons, the principle of beneficence is supported by most of the moral philosophies described previously, although utilitarians would require it to meet the consequences test they apply. Beneficence is rooted in Hippocratic tradition and in the history of the caring professions. Beneficence may be defined as acting with charity and kindness. Applied as a principle in health services, beneficence has a similar but broader definition. It suggests a positive duty, as distinct from the principle of nonmaleficence, which requires refraining from actions that aggravate a problem or cause other negative results. Beneficence and nonmaleficence may be viewed as opposite ends of a continuum.

Beauchamp and Childress[34] divide beneficence into two categories: 1) providing benefits and 2) balancing benefits and harms (utility). Conferring benefits is firmly established in medical tradition, and failure to provide them when one is in a position to do so violates the moral agency of both clinician and manager. Balancing benefits against harms provides a philosophical basis for cost–benefit analysis, as well as other considerations of risks balanced against benefits. In this sense, it is similar to the principle of utility espoused by the utilitarians. However, here, utility is only one of several considerations and has more limited application.

The positive duty suggested by the principle of beneficence requires organizations and managers to do all they can to aid patients. A lesser duty exists to aid those who are potential rather than actual patients. This distinction and its importance vary with the philosophy and mission of the organization and whether it serves a defined population, as would a health maintenance organization. Thus, under a principle of beneficence, the hospital operating an emergency department has no duty to scour the neighborhoods for individuals needing its assistance. However, when they become patients, this relationship changes.

The second aspect of beneficence is balancing the benefits and harms that could result from certain actions. This is a natural consequence of a positive duty to act in the patient's best interests. Beyond providing benefits in a positive fashion, one cannot act with kindness and charity when risks outweigh benefits. Regardless of its interpretation, utility cannot be used to justify overriding the interests of individual patients and sacrificing them to the greater good.

Nonmaleficence

The third principle applicable to managing health services organizations is nonmaleficence. Like beneficence, it is supported by most of the ethical theories discussed previously (it must meet the consequences test to claim utilitarianism as a basis). Nonmaleficence means primum non nocere. This dictum to physicians is equally applicable to health services managers. Beauchamp and Childress[35] noted that although nonmaleficence gives rise to specific moral rules, neither the principle nor the derivative rules can be absolute because it is often appropriate (with the patient's consent) to cause some risk, discomfort, or even harm in order to avoid greater harm or to prevent a worse situation from occurring. Beauchamp and Childress included the natural law concepts of extraordinary and ordinary care and double effect in the principle of nonmaleficence. (Extraordinary and ordinary care are considered later in this chapter under the subheading "Application of the Principles and Virtues.") Nonmaleficence also leads managers and clinicians to avoid risks, unless potential results justify them.

Justice

The fourth principle, justice, is especially important for administrative (and clinical) decision making in resource allocation, but it applies to areas of management such as human resources policies as well. What is just, and how does one know when justice has been achieved? Although all moral philosophies recognize the importance of achieving justice, they define it differently. Rawls defined justice as fairness. Implicit in that definition is that persons get what is due them. But how are fairness and "just deserts" defined? Aristotle's concept of justice, which is reflected in natural law, is that equals are treated equally, unequals unequally. This concept of fairness is used commonly in policy analysis. Equal treatment of equals is reflected in liberty rights (e.g., universal freedom of speech). Unequal treatment of unequal individuals is used to justify progressive income taxation and redistribution of wealth: It is argued that those who earn more should pay higher taxes. This concept is expressed in health services delivery by expending greater resources on individuals who are sicker and thus in need of more services.

These concepts of justice are helpful, but they do not solve the problems of definition and opinion, which are always troublesome. Macro- and microallocation of resources have received extensive consideration in the literature, but there is little agreement as to operational definitions. Each organization must determine how its resources will be allocated. An essential measure of whether organizations and their clinicians and managers are acting justly is that they consistently apply clear criteria in decision making.

Summary

Philosophers call respect for persons, beneficence, nonmaleficence, and justice prima facie (at first view, self-evident) principles, or prima facie duties. None is more important; none has greater weight. Health services managers are expected to meet all four. A principle can be violated only with clear moral justification, and then negative results must be minimized. Virtue ethics holds a special place in the work of managers, and the virtues are applied to supplement and complement the prima facie duties.

MORAL PHILOSOPHY AND THE PERSONAL ETHIC

This examination of moral philosophies and derivative principles provides a framework for developing a personal ethic and subsequently analyzing ethical problems. Like philosophers, managers are unlikely to agree with all elements of a moral philosophy and make it their own. Most managers are eclectic as they develop and reconsider their personal ethic. In general, however, the principles and virtues described here are essential to establishing and maintaining appropriate relationships among patients, managers, and organizations, and they should be part of the ethic of health services managers and the value system of the organizations they manage. It should be stressed that the four derivative principles may appropriately carry different weights, depending on the ethical issue being considered. The principle of justice requires, however, that there be a consistent ordering and weighing when the same types of ethical problems are considered.

Application of the Principles and Virtues

How do the principles and virtues identified and discussed in the preceding section and their underlying moral philosophies assist in solving ethical problems in cases such as Baby Boy Doe? (see p. 16). The principle of respect for persons implies certain duties and relationships, including autonomy. Nonautonomous persons, however, must have decisions made for them by a surrogate. The parents of Baby Boy Doe, a nonautonomous person, had to make decisions on behalf of their son. Surrogates cannot exercise unlimited authority, especially when it is uncertain that a decision is in the patient's best interests. If the infant's and parents' interests differ, caregivers (including managers) are duty bound under the principles of beneficence and nonmaleficence to try to persuade parents to take another course of action. Such efforts by caregivers and managers should have been attempted for Baby Boy Doe.

Extending the principles of beneficence and nonmaleficence, it is acceptable for the organization to seek legal intervention and obtain permission to treat an infant against the parents' wishes. The moral compulsion to do so is especially great when the parents are not acting in the child's best interests, but this moral duty should be exercised only as a last resort. Courts intervene under the theory of *parens patriae* (parent of the nation) to permit a hospital or social welfare agency to stand *in loco parentis* (in the role or in place of a parent). Courts take this step reluctantly because of the common law tradition that gives parents control over reproductive and family matters, including decisions about children. As noted, although it is an element of beneficence, utility is not an overriding concept that permits trampling on the rights of the person, as happened to Baby Boy Doe.

Intervention has limits. Absent an emergency, treating the infant against the parents' wishes without a court order is unethical because it breaks the law. If persons caring for the infant cannot continue because of their personal ethic, they should be permitted to withdraw. Or they may engage in whistle-blowing or other actions to bring attention to the situation. In doing so, however, they must accept the consequences of their actions. The option to remove oneself from an ethically intolerable situation should be reflected in the organization's philosophy and policies.

In applying the principle of nonmaleficence, one must consider whether the ethically

superior choice would have been to shorten Baby Boy Doe's life through active euthanasia. This consideration raises the question of the moral difference between killing and letting die. Some argue that the identical results make them morally indistinguishable. The analysis cannot end there, however; to do so ignores critical aspects of medical decision making.

When caregivers apply the principle of nonmaleficence, they refrain from doing harm, which includes minimizing pain and suffering. Asking caregivers dedicated to preserving life to end it will cause significant role conflict. Furthermore, physicians and nurses in such roles are on a slippery slope that may lead to more exceptions and increasing use of positive acts to shorten lives that are deemed to be not worth living.

The concept of extraordinary care is a part of the principle of non-maleficence that developed from natural law. *Ordinary care* is treatment that is provided without excessive expense, pain, or inconvenience and that offers reasonable hope of benefit. Care is *extraordinary* if it is available only in conjunction with excessive expense, pain, or other inconvenience or if it does not offer any reasonable hope of benefit.[36] With no reasonable hope of benefit, *any* expense, pain, or inconvenience is excessive. Beau-champ and Childress[37] concluded that the "ordinary-extraordinary distinction thus collapses into the balance between benefits and burdens, where the latter category includes immediate detriment, inconvenience, risk of harm, and other costs." For Baby Boy Doe, there was hope of benefit, even though correcting the atresia would not reverse his mental retardation. Surgery would have given Baby Boy Doe a normal life for someone with his cognitive abilities. That benefit justifies the use of treatment involving significant expense, pain, and/or inconvenience.

Justice is the final principle to be applied, a principle that was previously noted to have rather divergent definitions. Rawls defined justice as fairness. Applied to the case of Baby Boy Doe, one could conclude that the result was just. Fairness is arguably compatible with an enlightened self-interest expressed by persons in the original position behind a veil of ignorance—the Rawlsian philosophical construct. Rational persons could decide that no life is preferable to one of significantly diminished quality, even though this arguably limits the liberty principle, which Rawls considered ultimately important.

For a Kantian or an adherent to natural law, the outcome in the Baby Boy Doe case is abhorrent because the infant was used as a means rather than as an end—the parents' apparent unwillingness to accept and raise a less-than-perfect child. Conversely, rule utilitarians would find the result acceptable. Other definitions of justice produce different conclusions. For example, if justice is defined as getting one's just deserts, it is clear that Baby Boy Doe fared badly. Applying an even cruder standard—that individuals equally situated should be treated equally—it is clear that if an adult had been in a similar situation, the necessary treatment would have been rendered. For Baby Boy Doe, the results of applying the principle of justice are uncertain.

The final regulations about infant care published by the U.S. Department of Health and Human Services (DHHS) in April 1985 focus on beneficence and nonmaleficence. In implementing the Child Abuse Amendments of 1984 ([PL 98-457], amending the Child Abuse Prevention and Treatment Act of 1974 [PL 93-247]), DHHS placed no weight on the parents' traditional right to judge what should be done for infants with cognitive and/or physical impairments and life-threatening conditions. The potential problem caused by parents who may

not fully understand the implications of the diagnosis (of both the impairments and the life-threatening conditions) and the effects of their decision is obviated by the regulations because medical criteria applied by a knowledgeable, reasonable physician are used. Quality of life criteria cannot be considered. The preliminary regulations to implement the law made specific reference to a case similar to that of Baby Boy Doe and stated that appropriate medical treatment had to be rendered. The final regulations contain no examples, however. Nevertheless, it is likely that DHHS will view narrowly any decisions to forego treatment of infants with impairments and life-threatening conditions. Specifics of the regulations are discussed in Chapter 10.

As with most governmental efforts to regulate ethical decision making, these regulations are likely to be modified in the future. From an ethical standpoint, it is more important to bear in mind the moral considerations that should underlie public policy than to be preoccupied with the semantics of a particular enactment.

Implications for Management

What are the implications of cases like that of Baby Boy Doe for health services managers? Such events place a heavy burden on caregivers. Whatever the decision, these cases split the staff. The resulting controversy diminishes morale. In addition, criticism may be leveled against management, governance, and medical staff by individuals who question the morality of the decision and the organization's role in it. In extreme cases, legal action may ensue.

It is crucial that the health services organization implement a view (a philosophy) about matters such as these that is reflected in its policies and procedures. This means the organization has explicitly formulated a course of action that it will take when confronted with such problems. Having a philosophy in place permits a deliberate response rather than one that is reactive, inadequately considered, or governed by (rather than governing) events. At the very least, the organization must consider these issues prospectively and within the constraints of its organizational philosophy.

Paradoxically, prior to the 1984 Child Abuse Amendments, the health services organization could legally do to Baby Boy Doe what the parents could not. Had the parents taken the infant home and allowed him to starve and dehydrate until he died, it is likely that they would have been charged with child neglect or some degree of homicide or manslaughter. However, the organization did not face the same liability. In fact, had it surgically repaired the atresia without parental consent it would have committed battery on the infant, for which it could have been sued for civil damages and for which the staff might have been charged criminally. Criminal charges are unlikely, but the hospital is legally obligated to obtain consent from the parents or legal guardian for a minor when no emergency exists.

CONCLUSION

This chapter helps the manager develop a personal ethic and stimulates the organization to formulate a philosophy. Few managers will disagree as to the importance of the principles of respect for persons, beneficence, non-maleficence, justice, and various other complementary virtues. However, not all managers will embrace unequivocally the principles and underlying

moral philosophies discussed here. It is even more unlikely that they will agree about their weighing or priority. Chapter 2 suggests a methodology that managers can use in solving ethical problems.

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