A TYPOLOGY OF ETHICS EDUCATION IN HEALTHCARE

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This study is a qualitative analysis of the author's previous publications, academic

and operational practitioners input, the literature, and accreditation requirements for

ethics education in healthcare.  Two research questions were addressed: 1. Is a typology

of ethics education in healthcare needed, and 2. Is more specificity of ethics education in

healthcare required?  Both research questions were answered in the affirmative.

The results indicated that a typology of ethics education in healthcare is needed

with the primary reason being the need for a focused manuscript that uses content validity

to illustrate the hierarchy of ethical reasoning in healthcare.  No one manuscript brings

together the six ethics education domains that were identified as required for appropriate

ethics education in healthcare. The second research question result indicated that there

are sparse educational objectives available in the context of cognitive and affective

educational domains, especially for the six ethics domains presented here: 1. Decision

ethics, 2. Professional ethics, 3. Clinical ethics, 4. Business ethics, 5. Organizational

ethics, and 6. Social ethics.  Due to the limited specificity of the ethics education

objectives identified in the literature, the author developed and presented a typology,

beginning with 270 ethics educational objectives, for use in healthcare instruction.

A discussion is provided on how healthcare can be improved by including more

specific ethics education objectives within healthcare programs.  Further

recommendations include the creation of a taxonomy based on the typology developed

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CHAPTER I

INTRODUCTION: FRAMEWORKS FOR AN ETHICS EDUCATION TYPOLOGY IN

HEALTHCARE

To educate a person in mind and not in morals is to educate a menace to society.
*Theodore Roosevelt*

Ethics education in health care has become synonymous with clinical ethics or

bioethics. There are significant numbers of books, journals, articles and manuscripts on

the topic of bioethics, due in part, to the genome project (Brannigan & Boss, 2001), and

the tremendous technology within healthcare. However, bioethics is only one very small

part of healthcare ethics. The larger sphere of healthcare ethics encompasses several

domains along a continuum from decision making to social ethics. Within each ethical

domain are at least two educational domains that are necessary to use in ethics education

planning for course objectives, namely the cognitive and affective educational domains

by Bloom (1956).

By combining a continuum of healthcare ethics with two domains from education,

a typology can be created on ethics education in healthcare. Presented below is the

problem addressed in this study along with the purpose and research questions.

Statement of the Problem: Current Ethics Education in Healthcare and Outcomes

The problem addressed in this study was the lack of a typology of ethics

education in health care as a centralized source for developing cognitive and affective

objectives for education, training and evaluation. Therefore, a typology of ethics

education in healthcare did not exist until now. The problem stemming from this

phenomenon is that authors and practitioners primarily focus on one specific competency

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area within healthcare ethics education or they concentrate on a specific domain. All too often, that competency area or domain has involved making decisions with clinical perspectives only. Although clinical perspectives are important, they are not the only perspectives that can be used for educating future professionals within healthcare.

As late as 2002, only one article attempted to bring together a continuum of ethics education domains (Schick, Porter & Chaiken, 2002). That article was based on a series of telephone conversations, practitioner input, current healthcare ethics syllabi and face validity discussions, and indicated at least five domains that exist for ethics education in health care. Further discussion of that article is presented below in the methodology section.

A significant reason for creating the domains for ethics education in health care is the ethical dilemmas created from the high technology and complexity of healthcare. There is a wide variation of individuals who have different perspectives on using that technology and addressing the complexity for each patient's care. For example, several health services administrators in significantly large integrated service organizations have explained to this author that the technology available may not be needed, even if it were available and brings in substantial revenue. In other words, excellent cognitive education for health care providers is provided, but sometimes affective aspects of education that instill values on the use or non-use of healthcare interventions are ignored. Also, healthcare educators may provide the cognitive and affective dimensions of ethics education, but predominantly within the clinical domain.

The following provides several reasons for the need to create a typology of ethics education in healthcare. Reasons include both academic gaps in education as well as social, organizational and patient level outcomes.

*Social, Organizational and Patient Ethical Problems in Healthcare*

Ethics issues in healthcare have existed since the inception of medicine. However, in the United States, several social demarcations have created the need for public discussion of ethical issues. Although not the first demarcation, the creation of Medicare and Medicaid has led to many controversial funds that pay for public mandated healthcare. One of those controversial issues is the right to have an abortion as allowed by Roe v. Wade in 1973. Other issues include the Health Maintenance Organization Act of 1973 that required specific services, but did not include others. Thus a resource issue, or rationing dilemma, was created.

According to Kuhse and Singer (1998), we have had a significant increase since the 1960s of ethical problems in healthcare. Through the 1980s and into the 1990s, many federal level commissions were created to help solve clinical ethics issues (Emanuel, 1991). Those ethical issues commissions were predominantly focused on clinical judgment and mistakes (Perry, 2002), without concentrating on the other ethics domains that are factors in healthcare outcomes. Other ethical issues evolved as healthcare technology increased (e.g., euthanasia) and clinical reimbursement rose significantly (Frederickson, 1993).

Contributing to the healthcare ethical problems are the social problems in education and in public policy. For example, the ethicist Josephson indicates "that families, schools and other institutions are failing to teach children about ethics and the

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negative consequences of unethical behavior" (Wekesser, 1995, p15). If ethics were taught in the elementary and secondary schools, we might improve not only healthcare problems, but reduce criminal activity (Wekesser, 1995; Benson, 1982). The same may be said for increasing the amount and specificity of ethics education in healthcare programs.

The fundamental social problem might not be in our educational system alone, but it may exist in the entire social fabric. Even with a movement toward a more virtuous business and social ethic (Woodward, 1995), we have a system of decision making based on moral relativism. That increase in relativism is supported by a study by the Ethics Resource Center (1995) where they found that lying to supervisors and falsifying records were significant ethical problems in organizations without clear ethical positions.

Another situation that has contributed to healthcare ethical problems is the value free nature of science in general. As Peck (1983) indicates

in the late seventeenth century…science and religion worked out an unwritten

social contract of non-relationship…religion agreed that the 'natural world' was

the sole province of scientists. And science agreed, in turn, to keep its nose out of

the spiritual. (p.40)

However, as the degree of healthcare sciences, and medical science in particular, has grown towards the area of increasingly more religion based social issues and interventions (e.g., abortion and cloning), the dichotomy of religion and science has diminished and become more intertwined. Thus a more specific form of ethics education is needed to disseminate the religious frameworks and consequences from the science based frameworks. Individuals who present themselves as patients have significant

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variations in their religious perspectives and those perspectives may conflict with science based healthcare. Although there are two issues of science-based ethics and religious-based ethics in healthcare, the author presents only a cursory overview of the later in the literature review. A more rigorous presentation of religious-based ethics is left for future research within a typology of ethics education in healthcare.

Corruption is an important part of the ethics outcomes described above and occurs regardless of science or religious-based ethics education in schools and higher education. The amount of corruption in society appears to be increasing, or at least the type of corruption that is ethically based. For example, Heidenheimer (1970) presents three types of corruption:

> black, white or grey [with] black corruption involv[ing] actions that are judged
> by both the public and public officials as particularly abhorrent and therefore
> requiring punishment. White corruption might be political acts [or administrative
> acts] deemed corrupt by both the public and officials, but not severe enough to
> warrant sanction. Grey corruption involves those actions found to be corrupt by
> either one of the groups but not both. (p.14)

With Heidenheimer's framework, we may have more white and grey corruption occurring in healthcare, especially with incidents like HealthSouth and Columbia described below.

A significant social problem in the United States is our dilemma with access to healthcare (Shi & Singh, 2001). With over 42 to 43 million individuals without health insurance (Robert Wood Johnson Foundation, 2002; Shi & Singh, 2001) and therefore healthcare costs at the highest level, with care in the emergency room versus a clinic for non-emergency situations, we have another resource use issue. Thomasma (2001) puts it

succinctly in terms of a right versus a privilege orientation towards healthcare in the United States; "virtually alone among advanced countries, the United States does not yet consider it a right for all citizens to have equal access to healthcare" (p. 147).

Solving all of the social healthcare ethical problems will not occur in the foreseeable future. However, we can start at the organizational and patient-level by improving our ethics education in healthcare. The following demonstrates the current situation in healthcare and the need to improve both organizational and patient-level ethical issues.

Current ethical issues are evident in healthcare organizations. Commonly known examples include ethically inappropriate accounting practices, such as HealthSouth (Bassing, 2003), and previous incidents of alleged fraud, such as HCA/Columbia (Kirchhiemer & Taylor, 2000). The reason for these organizational level healthcare ethical problems stems primarily from the abuse of power. Hoffman (2001) helps the reader understand how power can dominate healthcare decisions:

> abuse of power is at least as prevalent, if not more so, in healthcare organizations, as it is in other types of organizations. Examples include rudeness, profane languages, promise breaking, deception, dishonesty, arrogance, use of overly confusing jargon, and withholding information. (pp. 21-22)

The abuse of power is not only from unethical providers but also from those who hold the final authority, the administrators and board members.

Another outcome from the abuse of power is a loss of trust from patients towards care-providers, and care-providers towards those who are in charge. For example, Caplan (1997) indicates that there are several instances of "distrust" in hospitals and other

healthcare organizations. The distrust spills over into care and improper services that lead to sentinel health events. According to Brooks et al. (1990) a sentinel health event is an occurrence where "a bona fide quality of care breach [has occurred and could] … bring harm to a patient" (p. 184). According to a recent Institute of Medicine (IOM) report (2001), the amount of sentinel health events is significantly higher than previously thought, including medication errors and improper diagnostics and therapeutic interventions. Although the IOM report was mainly at the patient level, organizational factors that can be alleviated with increased ethics education could help reduce those problems.

Healthcare organizations are only representatives of the individuals who work in them. The structure of the organization may contribute to the outcome of care (Griffith, 2001), but it is the process of care that is at the very essence of healthcare. How well the process of care is provided is based on both the science and art of healthcare. There will never be a situation where healthcare is 100% sentinel event free, but the ethics education in healthcare could help reduce the problems found at the patient level. Improving upon the most predominate form of healthcare intervention with improved ethics education is one way to decrease sentinel health events, and the use of other forms of healthcare interventions with ethics based education is another.

The primary healthcare intervention within the United States is allopathic in nature. With the largest funds going to hospitals and physicians that are and who are allopathically based (CMS, 2003) we have a situation in the United States that is leading to ethical dilemmas in care. For example, alternative means of healthcare can be used to fight antibiotic resistant organisms (e.g,. homeopathy, naturapathy) but they only receive

little attention in the literature, in scientific funding, and in education. One specific example of our allopathic medicine failing and the ethical dilemma of continuously increasing public funding for potential future problems, is explained by Brook et al. (1990):

> prior to the achievement of universal precautions, it was commonplace to delineate patient isolation procedures by door placards that carefully outlined all the steps to be taken to reduce exposure. Universal precautions eliminated that practice. However, now that there are antibiotic resistant organisms present in our world, new isolation precautions are evolving. Rooms with negative pressure are required for patients who may have tuberculosis. Special door placards have been used to identify methicilin resistent staphylococcous aureus (MRSA). (p.177)

The MRSA may not be "conquered" with alternative medicines, but at least they could be given the same amount of funding to determine if they would work, an ethical problem that includes resource allocation as well as abuse of power on the part of providers who do not want to give up their dominance towards alternative means of care. Ethics education could help alleviate that dominance through better understanding of different professional means of care.

Another indication of the abuse of power is when providers provide care when not indicated. For example, Caplan (1997) indicates that patients could be put at risk when receiving fertility drugs. Another example is the study outcomes by Brook et al. (1990) whereby unnecessary surgical operations occurred, resulting in an ethical problem of non-maleficence. Brook and colleagues found negative outcomes for coronary interventions. Table 1 presents Brook et al. findings.

Table 1.

Overview of Unnecessary Operations in Healthcare

| Procedure | Appropriate | Equivocal | Inappropriate |
|---|---|---|---|
| | % | % | % |
| Coronary Angiograph | 74 | 9 | 17 |
| Coronary Artery Bypass | 56 | 30 | 14 |
| Pacemaker Insert | 44 | 36 | 20 |
| Carotid Endarterectomy | 36 | 32 | 32 |
| Endoscopy | 72 | 11 | 17 |

Note: From Brook et al., 1990

Although the data in Table 1 are more than 10 years old, individual healthcare providers still do, and will continue to make mistakes. Some interventions carry a significant amount of risk (e.g,. liver biopsies). However, Fremgen (2002) makes a poignant case about the nature of healthcare to better frame why outcomes found by Brook et al. exist; "there is ample proof in medical malpractice cases that in times of stress and crisis, people do not always make the correct ethical decisions" (p.2).

These examples of ethical problems in healthcare indicate at least three levels of issues. However, there are many more levels and a significant number of other cases that could be presented. For example, health research involves another level of ethical problems but that discussion is beyond the main focus of this introduction. One

additional area of individual-level ethical problems is the relationship of healthcare

providers to other providers, patients, family and the public.  Caplan (1997) presents an

issue with kindness that does not pervade the social fabric in healthcare:

> our society has grown so enamored of personal freedom and self-determination
>
> that any act of charity, kindness or beneficence seems extraordinary.  Would it not
>
> be better if society treated each individual with charity and beneficence as a daily
>
> occurrence rather than as an exception. (p.x)

Below are several indications of how a typology of ethical education in healthcare

can improve care for patients, redistribute resources in a more ethical manner and build

trust.  The implications or purposes for a typology are numerous and include the

following.

<center>Purpose: Clarification of Ethics Education in Health Care</center>

The purposes of this study include a higher degree of specificity of ethics

education in healthcare using the cognitive and affective domains and resulting

objectives, and improved healthcare goals obtained from ethics education in healthcare.

The ultimate goal from the creation of this typology is improved outcomes in healthcare;

*"We will be known forever by the tracks we leave" - Native American Proverb.*

The creation of a typology of ethics education in healthcare is needed because

there is a dearth of encompassing frameworks for ethics educators who provide education

to both clinicians and health service administrators, health services researchers and others

in the healthcare industry.  No one single work brings together a typology that ethics

educators in health care can use to create their syllabi for all six domains.

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While the typology presented below is meant to be encompassing, it does not mean that all domains should be used within a single ethics course in healthcare. Instead, the typology was created to help present what domains are most necessary if one were to present ethics education in either one course as a survey framework, or to thread ethics education throughout an entire curriculum as well as an ethics course. By using the typology below, educators can more fully bring together their own ideas with those domains most commonly known in ethics education.

Research Questions: Required Ethics Education in Healthcare

This study assessed two primary research questions; 1. Is a typology of ethics education in healthcare needed? and 2. Does the degree of specificity in healthcare ethics education need improvement? The methodology section presents the two questions in more detail.

*Defining Morals, Ethics, and Laws*

Several definitions are provided to help the reader better differentiate among the terms used throughout the study and better understand the research questions. Definitions are used in the literature for the following; morals, ethics, and laws. Unfortunately, the terms are used interchangeably far too often in the literature. Therefore, the author specifies the terms identified above.

Although not all of the literature cited would correspond with the definitions presented here, the terms most closely resemble the context in which they are used. Any discrepancies in terms and in specific literature cases are the result of the author's own interpretation.

The literature indicates three levels of morals: 1. Social or religious context, 2. Social and individual relationship, or 3. Individual level context. Below is the literature that supports the definition of morals.

According to Corey, Corey and Callanan (1993), morality is based on culture (e.g., social dogma) or religion. Bowie (1997) indicates that the social component of morality is a "set of standards [that is] acknowledged by the members of a culture" (p.1). The authors directly above present morality as a coming together of ideas and standards that individuals agree to be correct.

Boatright (1997) presents morality at the social level as standards of "conduct." Solomon (1996) further suggests that those rules are "inviolable" and point to a specific type of conduct. Flight (1988) and McCollough (1991) are more specific in their discussion when they suggest that morals are based on "right conduct." With Flight and McCollough there is a condition of morals that indicates a normative position, namely that social morals are positive and point to a specific pattern of ideas and action.

At the social level, Seth (1899) wants us to believe that "moral beings" must learn to be self-controlled, or in essence, act in a way that is socially acceptable. He indicates that without the self-control, society will "control without" or from a social context. Seth (1899) also points out that morality is based on social "reason" and logically society comes to specific actions that are accepted and not-accepted. This type of moral reasoning most closely resembles ethics, but without the theoretical component. A more theoretical framework has been added to ethics in the last century (McCollough, 1991; Solomon, 1996).

At the level of individuals interacting with society, several authors suggest a normative position. Purtillo (1999) wants individuals to have a "morality" whereby their relations between people are "in peace and harmony;" or in other words in a way that is socially acceptable for all individuals. Catalano (1995) indicates that the way to learn morals that are right is through the "socialization" that one experiences in life, hopefully in an environment or social context that positively impacts that individual to be "right."

Baier (1958) suggests that morals are accepted from society quite simply because moral reasoning is "superior" to all other reasons. With Baier there is an assumption that morals are positive aspects of living that individuals should live by. The positive aspects are actions that are socially acceptable such as paying our taxes, making morally acceptable decisions, and living without committing crime. Rachels (1999) further specifies our moral actions as those that are changed or "revised" based on the interests of others. Rachels helps society see how morals can evolve into ethics with the aspect of changing contexts or different points of view, and in the case of ethics with different theoretical perspectives.

At the individual level, authors are more specific as to how morals give us direction for living. Madsen and Sharitz (1992) indicate that morality is "appropriateness" and Shaw and Barry (1998) suggest that morality is proper "human conduct." Ferrel and Fraedrich (1997) point to a specific normative position when they say that morals mean what is "right and wrong." Flynn (2000) also indicates that morals are right and wrong, and also that they involve what is "good and bad, should and should not, and ought and ought not" (p. 3).

Seth (1899) gives us some historical perspective on how morals have changed from antiquity to the century preceding the past. He indicates that morals have changed from an emphasis on the political or social ideal to one that is "individualistic." With that change, there is more autonomy in individual interpretations of morals and less correlation between morals and ethics. Seth further elaborates on the individual orientation towards morals when he says that morals are an "awakening" towards what is or is not supposed to be. It may be that Seth's perspective during the previous two centuries has only intensified towards a more individualistic moral perspective.

The literature above provides a basis for a definition of morals as determined by the author: A set of ideas and actions that individuals believe are correct for living in their respective society. Below is a framework and definition for ethics.

McCollough (1991), Solomon (1996) and Dewey and Tufts (1908) indicate that ethics were derived from the Greek work "ethos" meaning custom or character. As the word ethics developed, it became to mean both a set of rules (custom) as well as the aggregate ideas of a group (character assimilation). Seth (1899) suggests that the word ethics is also based on the Greek word good (τομγαΘον) relative to customs and character of life.

Ethics is partly about what one ought to do, what is right, or what is the right conduct within some form of theoretical framework (Catalano, 1995; Corey, Corey & Callanan, 1993; Dewey & Tufts, 1908; Durant, 1962; Ferrel & Fraedrich, 1997; Garret, Baillie and Garret, 2001; Harris, 1999; Hoffman & Moore, 1990; Paul & Elder, 2003; Pfeiffer & Forsberg, 1999; Shaw & Barry, 1998; Singer, 1994; Spencer, 1895). Additional authors indicate that ethics is about knowing why society makes the decisions,

and hopefully to make the "correct" decisions for a "good life" (Beauchamp & Bowie, 1997; Edge & Groves, 1999; MacKinnon, 1998) and "justification" for that life (Solomon, 1996). The authors directly above stress that ethics is a means of helping with the ends of decisions.

Another perspective of ethics is pragmatic or applied whereby conflict is resolved, or at least is attempted to be resolved. As Hinderer and Hinderer (2001) indicate, ethics is "the study and practice of reasonably resolving situations [where] values or interests appear to conflict" (p.7).

Paine (1997) suggests that ethics helps "human interactions" and hopefully without conflict. Benjamin and Curtis (1981) believe that ethics should be used to help resolve questions and Thompson and Thompson (1981) believe that ethics should be used to help with problem solving.

Using the literature above as a framework, the definition for ethics as determined by this author and used in this study is: An aggregate of morals within a specific group used to solve conflicts, with reasons on why a solution was chosen.

Ethics are based in philosophy, while laws, on the other hand, are codified (Paul & Elder, 2003) and have civil and criminal consequences. Ethics and laws do overlap when the spirit of the law is in question. As O'Donnell (1960) indicates, laws are based in "epikeia" or equity; whereby ethics is concerned with the spirit of the law. A person may not be in violation of the law due to the strict interpretation, but that person may be in violation of an ethical framework, thus the spirit of the law.

Beauchamp and Bowie (1997) explain further about ethics and the law when they indicate "law is the public's agency for translating morality into social guidelines and

practices for stipulating punishments for offenses" (p.4).  An individual may be punished

for offenses of the law, but they are rarely punished for offenses against an ethical

framework (e.g., an ethical code).  However, there may be more ethically appropriate

behavior if there were punishments for "unethical" actions.

When the law is broken, individuals are held accountable for their offense by

some "authority" (Darr, 1997).   Garrett, Baillie and Garrett (2001) indicate that the

punishment is about how that offender affected the "public good."  In healthcare,

individuals who have the most significant risk for offending the public good are providers

of care.  As Flight (1988) indicates, physicians are most at risk for harming the public

good due to their "vicarious liability" or behavior of their employees or to those who

carry out their orders.  Even if the physician does not directly employ other healthcare

providers, they are typically in charge of a patient and by indirect means are still

responsible for the ultimate care, and care-providers of that care, to the patient.

Other providers who have ultimate responsibility for care include chiropractors,

nurses in some instances, especially nurse practitioners, physical and occupational

therapists, and health services administrators who are licensed (i.e., nursing home

administrators).  Health services administrators who are not licensed are also at risk for

ultimate responsibility of care if they are found to be negligent of keeping the health

organization structured appropriately for the care that is provided.

Flight (1988) provides a list of legal issues in healthcare that include:

abuse, fraud, search and seizure, rape, assault and battery, invasion of privacy,

defamation of character, false imprisonment, intentional infliction of emotional

distress, and negligence. (pp.28-39)

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There are a significant number of other legal issues in healthcare, but those above are especially important for direct care providers.

The definition used throughout this study for law, as determined by the author, is: A set of codified rules that may change, that limits actions, and the repercussions of going beyond those limits.

*A Framework and Definition of a Typology*

The author presents a typology in this study.  As opposed to a taxonomy that is empirically based, a typology does not have a specific test of significance.   Although the definition of a typology below fits Bloom's "Taxonomy" of educational objectives, where Bloom and his colleagues did not present empirical testing for their taxonomy, the author leaves the terminology for Bloom's taxonomy as it is.  Rather than correcting a long history of the literature on Bloom's taxonomy, when it is really a typology, the author will continue to refer to Bloom's typology as a taxonomy.

The author uses Bailey's (1994) definition for a typology as "generally multidimensional and conceptual … [and] formed without quantification or statistical analysis" (p.4).

Theoretical Framework for the Typology: Bloom's Educational Domains

The seminal research on a typology for ethics education in healthcare was the Porter and Schick study (2003) based on the Schick, Porter and Chaiken (2002) publication.  Bloom's (1956) educational domains were also chosen to help create the typology because Bloom provided educational objectives in two areas of instruction, both the cognitive as well as the affective, that are important components when teaching ethics education.

Bloom's taxonomy is used to indicate the hierarchy of cognitive and affective learning and teaching. In healthcare, the hierarchy is crucial to help providers and health administrators learn how to use ethics based decisions in increasingly complex and diverse settings and patient cases.

Bloom's taxonomy provides a total of 11 objectives at the first level of hierarchical learning in the cognitive and affective domains. If each of the six ethical domains were represented within those 11 objectives, there would be 66 objectives as a minimum framework for any healthcare provider to fully appreciate and begin to understand ethics in healthcare. A more rigorous study of ethics education for intermediate and executive healthcare practitioners would include all 45 objectives at the more specific hierarchical levels. Therefore, a minimum of 270 objectives would be required that included all hierarchical levels from the cognitive and affective domains, and within the six ethical domains. Even with 270 objectives, there would be only one objective for each cognitive and affective domain representing each of the six ethical domains. A "living" document would require more than one objective for each cognitive and affective objective within the six ethical domains.

Ethics Domains: Previous Research and Suggestions for Improvement

As discussed below in the methodology section, the final typology presented here was based on previous discussions with those who are in academia and the field, a presentation at a national conference, and a cursory literature review of ethics education in healthcare. The outcome for the typology was six ethics domains centered on the Bloom cognitive and affective educational domains. Those six ethics domains are

decision ethics, professional ethics, clinical ethics, business ethics, organizational ethics and social ethics (Porter & Schick, 2003).

The impetus for decision ethics is to improve healthcare. As healthcare providers and administrators have a better understanding of decision making based on ethical frameworks, those decisions are more apt to be within the social, organizational, business, clinical and professional parameters of accepted outcomes.

This study presents 24 ethical theories and 14 ethical decision making processes from the literature to help answer the two research questions. A simple three step ethical decision process is provided first by Fremgen (2002), with the final literature process found by Nash (1981) whom presents 12 steps.

Once the ethical theories and decision making frameworks are presented, a section is provided in the literature review on helping the professional become "more professional" and better understand ethics from the perspective of ethical codes. The ultimate goal of helping the professional become more professional is to improve healthcare outcomes, both in following the ethical codes and a better means of decision making relevant to other codes.

In the literature review, a discussion is also provided on the importance of professionalism in healthcare. Several instances are presented on how the individual healthcare provider and health administrators can serve best by serving themselves. For example, by having peer review through the different professional societies, the healthcare provider or administrator can improve their awareness of ethical issues and situations, and have a professional code of ethics to guide them.

The outcomes from improved professionalism and an awareness of the professional codes of ethics is a decrease in the outcome problems presented above, namely at the patient, organizational and social levels. Several professional codes are presented based on a framework of providers who treat the entire human (e.g., family physicians, nurses) rather than one body area or system (e.g., dentists). Discussion of professional codes for specialized care is left to further research.

Each of the professional codes presented are from the largest and most representative body or association for that respective profession. For example, the American Medical Association (AMA) represents the most significant number of physicians in the United States and therefore the AMA Code of Ethics (AMA, 2002) for allopathic physicians is used. Two additional examples are the American College of Healthcare Executives (ACHE) Code of Ethics for primarily acute care health administrators (ACHE, 2001) and the American College of Health Care Administrators (ACHCA) for long term care administrators (ACHCA, 2001).

Since clinical ethics is the largest proportion of the ethics literature in healthcare, only the major principles are discussed, namely beneficence, non-maleficence, justice (Perry, 2002; Hoffman, 2001) as well as equity, resource allocation and negligence. A discussion follows on a wide range of clinical issues that researchers are evaluating with ethical decision making processes to determine best outcomes for healthcare. In essence, a list of topics that can be assessed in the clinical realm using ethical decision making frameworks is presented, without an in-depth discussion on any one topic since that is beyond the scope of this study. An example is persistent vegetative state and how ethics

can help determine what to do for patients who are in that situation, but the entire range of alternative outcomes for persistent vegetative state patients is not presented.

However, a section on clinical ethics is presented that has the greatest probability of ethical conflicts in the future. That area is on human subjects in research and consent, including the human genome project and cloning, and evidence based medicine and experiments. Each of the areas above appears to be the fastest growing literature concerns in healthcare ethics today.

Whereas the relationship between provider and patient is a bona-fide and heavily acknowledged personal relationship, business ethics as a form of a relationship is not demonstrated very well in healthcare. When a patient enters a healthcare organization, there are two relationships that form, one with the provider who is ultimately responsible for the clinical aspects of the patient's care, and another between the business enterprise and the patient. Unfortunately, very few health administrators and those who help provide care for the provider acknowledge the relationship of the business with the patient. If there were more relationship building between those who work in the business with the patient, and in a one on one relationship, there may be a significant decrease in the ethical dilemmas that occur in healthcare.

The most difficult component of business ethics in healthcare today might very well be due to managed care. Although managed care does decrease healthcare expenses (Kongsvedt, 2001) it provides a degree of risk for the provider that was not previously there with a non-managed care framework. Caplan (1997) reiterates the dilemma between trying to save costs and the outcome of risk for the provider:

there is an increasing concern about the compatibility of business ethics with

health care ethics -   when those at the bedside are forced to make hard choices

about the allocation of resources. (p.143)

There is a significant increase in the amount of organizational level ethics

literature in the last decade.  Boyle, DuBose, Ellingson, Guinn, and McCurdy (2001)

illustrate how organizational ethics has developed into "a story about the moral lives of

individuals within health care institutions and about the moral life of the healthcare

institution as an institution" (p. 4).  An outcome of the organizational ethics literature is

an increased awareness and further specificity of the different forms of relationships

required within healthcare organizations.  For example, Beauchamp and Childress (1989)

indicate that two of the most important ethically related groups in healthcare

organizations are Institutional Ethics Committees (IECs) and Institutional Review Boards

(IRBs).  Both the IECs and the IRBs help make ethical decisions with input from various

individuals within the healthcare organization.

Two forms of community based ethics are commonly discussed either together or

interchangeably, and those are social and public ethics.  McCollough (1991) helps us

differentiate between the two social level ethics when he describes:

Social ethics [as] the systematic effort to develop ethical principles applicable to

society as a whole.  Public ethics focuses more narrowly on the political or public

realm and on the means of effecting change in policy. (p.60)

Both forms are used here to suggest that social ethics includes public ethics due to the

possibility of changing policy through social intervention.  Individuals who can change

social policy are typically those who regulate an industry or work within that industry.

Altenburger (1992) reminds us that just because society can do something does not mean it should and that "Ethical public officials must distinguish between what they have a right to do, and the right thing to do" (p.353). Carrying the illustration of can and should further means that society needs to investigate our situation within the framework of a larger "society," namely a global situation. Purtillo (1999) supports the global perspective of social ethics when she indicates that "Social responsibility involves all the ways in which you may feel that you should become involved in making the world a better place" (p. 301).

Over a century ago, Spencer (1895) indicated that a society can only grow as the social ethics are developed. It may be that the time is "ripe" to more fully develop our social ethics in the U.S. healthcare "system" and question if society indeed should provide the "best" as indicated by our high technology used in acute care services and "worst" of care where access is a tremendous problem, and should that continue? And, individuals need to assert themselves in a world that has growing pandemics of starvation, which leads to premature death, as well as HIV and AIDs. Scherer (1974) supports the notion of questioning how society lives when he asserts that "no one can live globally in isolation" (p. 82). Social ethics may help us solve our global dilemmas.

As social ethics are presented below, individuals need to recognize that society is a global unit of analysis as well as a national one. No longer are drugs manufactured only in the U.S. but the supply chain spans the entire globe. Also, the means of providing healthcare has many different forms including the quasi-market, quasi-government form of the U.S., and the National Health System of Great Britain. Ashley and O'Rourke

(2002) summarize best how social ethics in healthcare has transformed from an

individual oriented framework to a multi-input framework:

> for many years, healthcare ethics and the problems involved in the practice of
>
> medicine were considered the proper domain of healthcare professionals.  It is
>
> now clear, however, that they are the concern of all citizens because of their effect
>
> upon the common good of society. (p.ix)

CHAPTER II

METHODOLOGY: PROCESS OF ANSWERING RESEARCH QUESTIONS


Research Question 1: Is a Typology of Ethics Education in Healthcare Needed?

When first developing the typology presented here, this author explored the ethics education, training and evaluation literature as well as discussed healthcare trends that are related to ethical decision making, with practitioners in the field and academics who have previously worked in the field. The overarching conclusion during that time was that a typology of ethics education in healthcare was needed. A main premise for the need is that this author found no one focused source of ethics education in healthcare that uses the domains presented here and the hierarchical learning framework of Bloom's taxonomy.

In addition to this author and his colleague's previous articles that created the basic framework for this study, only one other researcher has used Bloom's taxonomy to help create ethics instruction in healthcare, namely in psychology (Vanek, 1990). However, Vanek's study was not a typology, but rather a means to help current instruction utilize Blooms taxonomy as a basis for objectives creation. She did not use ethics domains along with the cognitive and affective domains as presented here. Support for the ethics education typology in healthcare is presented below.

*Previous Content Validity: Input from Academics and Practitioners*

In addition to this author's own twenty plus years of healthcare experience, several others who worked with the author in academics and the field indicate that an

ethics education in healthcare was needed. Through discussion with leaders of several of the largest healthcare companies in the United States (e.g., Henry Ford Healthcare System), the author was told that too many of the newest health administrators and clinicians are "learning well" but they are not "acting well," namely that they are provided significant cognitive based education, but have poor affective education. Although the anecdotal evidence supported a need for the ethics education typology, the author wanted to improve upon that anecdotal information and determine if there was additional content validity in academics and the field. The author found support through three means: 1. Discussion of ethics domains for education with both academics and practitioners for a pre-typology stage of information that led to an article, 2. A formal national presentation of the typology in a draft form that received validity from participants (as indicated through 25 presentation evaluations that were ranked at the highest level on a Likert scale), and included several different professions, along with a suggestion for the sixth ethical domain, and 3. An additional article that was based on input from academics and practitioners as well as the literature, and lead to the six ethical domains presented here. Each of the three areas is discussed here.

While assessing evidence based outcomes in ethics education for a Robert Wood Johnson Foundation grant awarded to the Association of University Programs in Health Administration, the author and another colleague, Ida Schick at Xavier University, discussed the possibility of centralizing all of the possible ethical domains in one manuscript. The discussion was based on a clear lack of one point of reference to use for a variation of ethical domains and also within an educational framework that would benefit those who are teaching ethics education in healthcare. Upon further discussion

with both faculty and practitioners in the field, it became clear that ethics education in healthcare was primarily focused on clinical ethics at the expense of specific decision making, professional, business, organizational and social ethics education.

This author and Schick demonstrated what types of domains and objectives might be useful for those who teach ethics education in healthcare through an article that included another faculty member who taught ethics education in healthcare; Schick, Porter and Chaiken (2002) brought together additional faculty (n=6) and practitioners in the field (n=5) who provided input on that article to demonstrate an initial face validity for the domains and objectives presented here. Based on that initial article, the first two authors set out to demonstrate a more robust "typology" whereby a centralized source of ethics education in healthcare could be demonstrated.

Upon discussion with additional faculty and practitioners discussed below, this author and Schick (2003) published an article that created a typology of ethics education in healthcare along the same framework in this study. The two authors of the article brought together additional faculty from different disciplines including health services administrators and clinicians. The number of faculty and providers in the field who provided input for that article included nine and seven individuals respectively. Five disciplines were represented in the cohort who provided input: 1. Health services administration, 2. Nursing, 3. Allopathic medicine, 4. Public health and 5. Physical therapy.

In addition to the Porter and Schick (2003) article discussed above, this author presented a draft of the typology presented here to the 2003 National Conference of the Association of University Programs in Health Administration (AUPHA) in Nashville,

Tennessee.  At that presentation, all of the domains presented in this study were discussed with the exception of business ethics which was suggested as an additional domain that is necessary to fully consolidate all of the ethics education into one typology.  Both the cognitive and affective domains from Bloom's typology were also presented.

The presentation was well received by the audience (n=25 with mean=4.5 out of 5 as best according to a Likert Scale) and included several different disciplines: 1. Health Services Administration, 2. Allopathic Medicine,  3. Nursing, 4. Social work, 5. Physical Therapy, and 6. Occupational Therapy.  Taking the suggestion above of adding business ethics to the typology, this author believes that a full parameter of skills, knowledge and abilities that are necessary for healthcare situations is consolidated into the typology presented here.  In all, 55 individuals, including this author and the authors of the two articles discussed directly above, have assessed the typology presented in this study and concluded that it has face, and initial content validity.  The content validity means that individuals who teach or work in the field of healthcare believe that the typology is an appropriate representation of the necessary domains that are required in ethics education and to be necessary for improving healthcare outcomes.  In addition, the content validity is initially appropriate since there is a theoretical framework tied to the creation of the typology (Vockel & Asher, 1995), namely Bloom's taxonomy.

*Creation of Full Typology: Business Ethics Added to Typology*

As discussed above, the full typology presented here was not completely developed until during and after the presentation of a draft typology at the 2003 AUPHA national conference.  During that conference, it was evident that the original five domains in ethics education, along with Bloom's cognitive and affective educational domains,

were not sufficient for consolidating ethics education into one central manuscript. Based

on several suggestions during the presentation and subsequent discussion in informal

situations at the same conference, business ethics was added to the typology. While

business ethics can be incorporated into organizational ethics, the differences between

business and organizational ethics are greater than the similarities and therefore this

author separated the two domains. The literature helps further specify the differences in

the two business and organizational ethics domains.

*Previous and Current Literature Review: Typology Created*

Once the draft was completed and presented on the typology of ethics education

in healthcare at the national AUPHA conference, this author and Schick reviewed the

literature to determine if it was indeed appropriate for healthcare education. For the

Porter and Schick (2003) article, ten manuscripts were reviewed to help validate the

initial typology sans business ethics. Based on the cursory literature review in that

article, there is clear support for further exploration and specificity of the affective

portion of the typology of ethics education in healthcare. Also, there is a clear need for

the ethics education typology.

Research Question 2: Is Specificity of Ethics Education in Healthcare Needed?

After publishing the two articles above and the respective presentation, this author

wanted to determine the degree of ethics education specificity using a content validity

approach. For example, it was suggested during the presentation at the 2003 national

AUPHA conference described above that the degree of specificity in ethics education

requires improvement for those going into or even those who currently work in

healthcare and take continuing education programs. The degree of specificity and thus

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the answering of question two of this study will be achieved through three means: 1. A literature review that describes the necessary topics and objectives for each of the six ethics domains in the typology and also for the two educational domains by Bloom (i.e., cognitive and affective), 2. The use of accreditation standards within healthcare (e.g., medicine, nursing and health services administration), as a means of determining the degree of specificity required for ethics education prior to placement in the field, and 3. Through the specification of the cognitive and affective educational domains by Bloom (1956) and Krathwohl, Bloom and Masia (1964) at the main, sub-level and sub-sub-levels. Below are each of the three means of answering research question two.

*Literature Review: Depth of Typology Increased*

The previous literature provided direction on the degree of ethics education specificity in healthcare with the appearance that there is a concentration of bioethics literature rather than the other ethics domains discussed. While the other domains of the ethics education typology are discussed in the literature, the degree of specificity in terms of objectives for classroom planning is never discussed, at least to the knowledge of this author. Therefore the current literature was searched to determine if a high degree of specificity existed among the different ethics education domains. Once the literature was assessed for each ethics education domain, the topics presented was incorporated into objectives within the two educational domains.

Because the literature is not the sole source of information on what is available for ethics education topics, the author also explored the accreditation standards for practitioners working directly in healthcare. Educational outcomes are based on the accreditation standards that are required for programs that award degrees to those who

provide direct care or lead healthcare organizations. Those standards may or may not indicate ethics education as a requirement for practice in the field, and they may or may not be specific as to what ethics education objectives should or must be taught.

*Accreditation Standards: Outcomes Based Objectives*

The three largest professions in terms of sheer power and numbers in healthcare could arguably be allopathic and osteopathic medicine, nursing, and health services administrators. Without physicians, almost all hospitals, nursing homes, clinics and home health organizations would cease to function. For discussion purposes here, the author includes osteopathic physicians as part of allopathic physicians since osteopaths practice a major portion of their practice based on allopathic medications.

The reason those health facilities or organizations would cease to function is because physicians admit and ultimately are responsible for the clinical care of the patients and residents. The author acknowledges the tremendous impact other providers have upon the healthcare industry (e.g., chiropractors, dentists, podiatrists), but the ultimate power of care rests with the physician due to statutes, regulations and standards of care in the field. Therefore, since physicians weld the greatest clinical power and ultimately may have the greatest risk of ethical outcomes, the author will determine what ethics education is required according to the accreditation standards of domestic medical schools. International medical graduates may not receive the same undergraduate medical ethics education, but they must work alongside the domestic medical students in their residency years and therefore interactive effects should alleviate much of the problem of not assessing international medical ethics education accreditation standards.

Nurses ultimately have the responsibility for the holistic care of patients and residents. Other allied health providers are very important in the functioning of patients and residents (e.g., respiratory therapists), however, nurses have the greatest power in care planning for the entire needs of the patient. Therefore, the author explores the ethics education for nurses according to the same logic as medical accreditation by using the nursing accreditation standards.

In terms of ultimate responsibility for the entire operation of the facility from a licensure perspective, nursing home administrators are the only health administration professionals who are legally required to be tested and assured of their knowledge, skills and abilities before they can practice (Allen, 2003). Other health services administrators, such as hospital administrators, have the same ultimate responsibility as the sole nursing home administrator in a nursing home, but they tend to have a significant number of other administrators to help guide their decision making (Griffith, 2001). Both the nursing home and hospital administrator must have a required or market driven education respectively before they can be a practitioner. Each has a tremendous responsibility over budgets, hiring of personnel as well as input on the structure and process of care. Therefore, because of the power that health services administrators have in healthcare, and along the full continuum of care as well as in managed care, the accreditation standards for health services administrators ethics education will be explored to determine the level of specificity required in their didactic education.

Accreditation standards are used as a framework for determining the specificity of ethics education required prior to a practitioner working in the field. It may be that the accreditation standards are specific enough and no further discussion of the requirements

is needed.  It may also be that the accreditation standards are so minimal that the degree

of specificity is sorely needed to help improve evidence based ethics education in

healthcare, and at least in the three professions explored above.

Once the current literature review and accreditation standards were reviewed, the

results to each of the two questions were presented. The literature and accreditation

standards reviewed answered research question two by indicating if there was adequate

specificity in educational objectives to provide for appropriate content to cover all of the

ethics domains presented here.  More specifically, when physicians, nurses, and health

administrators are practicing in the field, do they have adequate cognitive and affective

knowledge, skills and abilities to cope with the ethical issues presented to them by the

activities and outcomes in healthcare?

*Bloom's Cognitive and Affective Domains as Theoretical Framework for Ethics*

*Education Objectives*

The author presents the first level of the cognitive and affective domains in Table

2 so that the reader can understand better how the literature is replete in providing ethics

education objectives.  If the first levels of the cognitive and affective objectives are

difficult to find in the literature or accreditation standards, it will be even more

problematic to find them at the more specific levels. To date, there is no literature that

this author could find that provides ethics education objectives for each of the cognitive

and affective domain levels and sub-levels, especially within the six ethics education

domains in healthcare as presented here.

Table 2

Bloom et al.'s Cognitive and Affective Domains - First Level Only

---

Cognitive Domain (There are two decimal points as originally provided by Bloom)

1.00 Knowledge

2.00 Comprehension

3.00 Application

4.00 Analysis

5.00 Synthesis

6.00 Evaluation

Affective Domain (There is only one decimal point as originally provided by Bloom)

1.0 Receiving

2.0 Responding

3.0 Valuing

4.0 Organization

5.0 Characterization by a Value or Value Complex

---

Note: Adapted From Bloom (1956)

　　　Since the literature and accreditation review indicated a need for further ethics education specificity, topics discussed in the current literature review and accreditation standards were included in a creation of the ethics education typology within the cognitive and affective educational domains at both the level and sub-level criteria.

Objectives were created that provide guidance on what students of ethics education in healthcare must, and should, know before they enter the field. That framework includes the levels (must level) and sub-levels (should levels) discussed above. To date, the only study that is known by this author to use the two cognitive and affective educational domains for ethics education objectives is by Porter and Schick (2003). This study elaborates further upon that study by creating objectives for the sub-levels that Porter and Schick did not provide, and improving upon the specificity of ethics objectives based on the topics found in the literature review.

In terms of explaining and justifying methodology, the methods above indicate a literature review and accreditation standards review to help explain the strategy used to answer the research questions, and within a qualitative research framework. Methods include content validity based on the Bloom taxonomy and the specificity that was provided. No empirical analysis was used because the author intended to create the typology first and leave future empirical analysis for validating and reliably testing the typology to create a taxonomy of ethics education in healthcare.

Using the Schram (2003) framework with specific questions within a qualitative methodology, the author presents here how the two research questions were answered:

- Research Question One: Methods of Answering
  - Initial Content Validity from Faculty and Practitioners in the Field (Done and discussed here)
  - National Presentation on the Typology and Input from a Variation of Faculty and Practitioners in the Field (Done and discussed here)
  - Initial Literature Review (Done and provided in Porter & Schick, 2003)

- Expanded Literature Review (Provided here)

- Accreditation Standards Review (Provided here)

- Research Question Two: Methods of Answering

  - Literature Review (Provided here)

  - Accreditation Standards Review (Provided here)

  - Creation of Educational Objectives using Blooms Taxonomy (Provided here)

Specific goals from the creation of the ethics education typology include:

- Creation of educational objectives that may be used as a guide for healthcare accreditation standards

- Discussion on means of disseminating those objectives to help future and current healthcare practitioners improve healthcare at the social, organizational and patient levels

- A framework for empirical assessment to create a taxonomy on ethics education in healthcare

CHAPTER III

LITERATURE REVIEW AND ACCREDITATION STANDARDS: OUTCOMES

BASED OBJECTIVES FOR ETHICS EDUCATION IN HEALTH CARE

By Fixing our Attention upon the Ideal, Ethics Tends to Raise the Level of the Actual (Seth, 1899)

The six ethical domains discussed above are presented in the current literature as a means of providing topics for the creation of cognitive and affective educational objectives. All six ethical domains are presented with some topics provided only as a cursory review since they are beyond the scope of this study (e.g., religious based ethics).

Decision Ethics Education: Basics for Healthcare Providers

The author found 24 ethical theories and associated philosophers along with 15 different religions that can be used as a basis for creating ethics education objectives. Each ethical theory and religion is presented in a table for future research by those who teach ethics education in healthcare. Each ethical theory has a prime directive that can be used as a framework for decision based objectives.

The author presents 14 different decision making processes that can be used as the ethical situation may require. All of the theories, religions and decision making processes help those who need to make ethical decisions, as well as help healthcare providers provide care that is more ethical. In addition, the theories, religions and decision making processes are foundational to the further development of ethics education even though the author does not connect all of them directly to the results below.

Table 3 indicates the different ethical theories found by the author within the context of four main themes: 1. Normative Ethics (Prescriptive Based Ethical Theories), 2. Teleological Ethics (Outcome Based Ethical Theories), 3. Relativistic Ethics (Procedural Based Ethical Theories), and 4 Communitarian Ethics (Process-Outcomes Based Ethical Theories).

Table 3.

Major Ethical Frameworks and Associated Ethical Theories

_____

| Normative Ethics (Prescriptive Based) | Teleologic Ethics (Outcomes Based) | Relativistic Ethics (Process Based) | Communitarian Ethics (Process-Outcomes Based) |
| --- | --- | --- | --- |
| Natural Laws | Virtue Ethics | Existentialism | Communitarianism |
| Formalism | Utilitarianism | Relativism | Normativism |
| Deontology | Positivism | Rationalism | Nominalism |
| Rights/Entitlement | Obligationism | Egalitarianism | |
| Authoritarianism | Distributive Justice | Contractarianism | |
| Descriptive Ethics | Egoism | Pragmatism | |
| Transcendentalism | | Intuitionism | |
| | | Feminism | |

Although several different frameworks exist in the literature on how to classify ethical theories (e.g., scholastic, stoic and pragmatic), a more organizational based framework is presented here. That framework flows from healthcare administration

literature that indicates health systems work in an input, process, outcome nature

(Griffith, 2001).  Therefore the structure for the ethical framework here is applied and

within a healthcare systems approach rather than a more traditional ethics framework.

The author found three main bases for the religions that could be used to create

objectives for ethics education in healthcare.  Those three bases are: polytheism (with

many deities), monotheism (with one deity) and non-deity.  Table 4 presents the major

religious bases and religions that could be used in an ethics education curriculum.

Table 4.

Major Religious Bases and Religions

_____

| Polytheism Based | Monotheism Based | Non-Deity Based |
| --- | --- | --- |
| _____ | _____ | _____ |
| Polytheism | Judaism | Animism |
| Hinduism | Christianity | Confucianism |
| Shintoism | Islam | Taoism |
| Native American | Nation of Islam | Neo-Paganism |
| | Buddhism | |
| | Hare Krishna | |
| | Bahai | |

[Note: Sources; Curtis, 1994; Dewey & Tuft, 1908; Edge & Groves, 1999;  Grant, 1960;

Hoffding, 1906; Lewis, 1947; Peck, 1983; Red Jacket, 1805; Seth, 1899; Singer, 1994;

Toropov & Buckles, 2002; Visotsky, 1996.]

*Normative Ethics: Prescriptive Based Theories, What Must Be*

Ethics may be normative in nature, whereby a specific action or thought is supposed to occur regardless of the situation. The process or outcome of the situation is not used to help formulate a decision process, there is just a given on what is required to occur, a situation that should be done (Darr, 1997) or "must" occur.

According to Olen and Barry (1996) natural law is based on given "rights." Where natural law is specified in terms of duty, we have deontology ethics as indicated below. The universal imperative of duty is a deontology framework, while the natural law universal imperative is natural rights.

The natural law prime directive is: All ethical decisions must ensure that individuals' natural rights are provided within universal frameworks, given limited resources.

Immanuel Kant proposed that formalism is based in the "conscience" of individuals and that moral decisions must be purely interior (Ashley & O'Rourke, 2002; 4). Whereas natural rights are provided from nature, formalism is based in the individuals own morals that are within specified parameters of correct social acceptance.

The formalism prime directive is: All ethical decisions must be based on fixed morals that do not flow from consequences.

The ethical theory of deontology stresses the use of "rules of right and wrong for reasoning and problem solving" (Towsley & Cunningham, 1994; pp. 5-6). Immanuel Kant is best known for his ideas on deontology. Where deontology is strongest is on using rationalism to make decisions. However, deontology also has at least one

significant weakness as described by Seth (1899); "the error of Kant is that the real is sacrificed for the ideal" (p.161).

To clarify how health administrators and providers in healthcare must use the resources of others and still be within the framework of deontology is to specify the relationship of individuals through duty.  Hoffman and Moore (1990) help to specify the relationship of duty by indicating how Kant believed on this issue: "Kant holds that one ought to perform right actions not because they will produce good results, but because it is our duty to do so" (pp.14-15).  Kant emphasizes the ideal, whereby a bad result may occur, and that it may be ethical, if and only if the actions leading to the bad result were duty bound.  McCollough (1991) emphasized the strong Kantian notion of duty over outcomes, when he indicated that "[Kant placed] unconditional stress on the notion of obligation or duty" (p.55).

The deontology prime directive is:  All ethical decisions must be based on specific principles within the framework of treating individuals as ends only.

Another form of "must" ethics is rights or entitlement theory that stresses individuals have "legal, civil and natural rights" (Solomon, 1996; p. 125).  Based on natural rights ethics, the rights/entitlement ethics indicates more broadly based rights for individuals.  Those rights are more important than duty, as indicated by Benjamin and Curtis (1981) when they present how rights based ethics is framed versus deontology ethics; "rights based ethics is 1. Rights, 2. Duties, and 3. Goals to rights, as opposed to deontologists who believe in 1. Duties and [than] 2. Rights" (pp.31-35).

The prime directive for the rights/entitlement ethics is: All ethical decisions must consider patients or residents to have broadly based rights that they must be provided in order to obtain and sustain quality care.

Flynn (2000) indicates that authoritarianism "is the will, the analysis or the declaration of a person in authority, which makes an action ethical or unethical" (p.6). While the decision may or may not be ethical from the basis of the definition used in this study, it is ethical in the mind of the decision maker. That decision may be based on the educational background of the individual, the experience or position of the individual, or both.

The prime directive for authoritarianism is: All ethical decisions by individuals who have powerful positions in healthcare must recognize their power and keep in mind that they serve the patient regardless of their own education or position.

Rather than a complete prescription of what "must" be done for ethical situations, descriptive ethics gives us a prescriptive approach on the study of an ethical situation. Beauchamp and Bowie (1997) indicate that "descriptive approaches [are] the scientific study of ethics" (pp.6-7). An empirical method of assessment is prescribed for ethical situations that are prescriptive in nature, since science is an exact form of decision making rather than an art form.

The prime directive for descriptive ethics is: All ethical decisions must use an empirical assessment.

To connect with all others is a framework that transcendentalist ethicists use when solving ethical situations. Durant (1962) describes transcendentalism as going "beyond the senses or experiences" (p.188). Taka (1997) gives us another form of

transcendentalism as a "philosophy that every phenomenon is an expression of the great

life force, and is ultimately connected with the universe" (p.556). If we are to act or

make decisions that are ethical, we must conceive of how those actions or decisions

reflect upon the universe. When an action or decision is right, the universe will be better

off. And if an action or decision is wrong, the universe will be worse. Both outcomes

are similar in nature to deontology where there is a duty to the universe.

The prime directive for transcendentalism is: All ethical decisions must use the

directive to disregard your happiness, and do your duty as a positive reflection upon the

universe.

*Teleological Ethics: What Should or Can be as an Outcome*

Whereas deontology theorists have indicated that one "must" do something

regardless of the outcome, teleological theorists look more at the outcome that can occur

than the process. The process is still important, but it is the consequence that is most

important. Relativistic theories look more at the process than the outcome, and

communitarian ethics look at both the process and outcome with the same proportion.

Teleologists look at the "utility" of the outcomes (Catalano, 1995) as a framework

for decision making. For example, in virtue ethics, the utility of using a specific or

multiple virtues are important in the outcome.

The first known Western philosopher to espouse a form of teleologic ethics was

Socrates (469-399 B.C.) who indicated that ethics is part of wisdom, knowledge and

"virtue" (Runes, 1955). Thus virtue ethics was framed by Socrates, although the essence

of that theory was more fully developed by Plato (427-347 B.C.), who was a student of

Socrates - and later Aristotle (384-322 B.C.), who specified what virtues are in the

context of daily living.  Although Aristotle, Plato and Socrates were not always in agreement, it is virtue ethics that they helped to create.

The prime directive for virtue ethics is: All ethical decisions should be based on a virtuous framework.

A major teleological theory is utilitarianism that is based in the general framework of consequentialism that stresses maximizing "overall good consequences" from the actions taken (Kamm, 1992; p. 11).  Purtillo (1999) further stresses that utilitarianism "places the focus on consequences of actions….[with the] root from the idea of utility" (p.48). Purtillo (1999) also helps us understand the differences between deontology and teleology theories such as utilitarianism when she presents the issues most important to the respective theories; "Deontology is duty driven and has means that count, while teleology is goal driven and has ends that count" (p.48).  As a consequence theory, utilitarianism has a final outcome of the best for the most or "the greatest good for the greatest number" (Edge & Groves, 1999; p. 21; Garrett, Baillie & Garret, 2001; pp. 2-3; Towsley & Cunningham, 1994; pp. 5-6).

The prime directive of the utilitarian theory is: All ethical decision making ought to take into consideration the greatest good for the greatest number and balance the short and long term consequences.

The earliest known writer of the positivism ethical theory was Hobbes in 1651 (Singer, 1994) who believed that natural laws for positive outcomes were the basis of ethical decision making.  Later, Comte (1798-1857) wrote that positivism should be based on "laws of phenomena" and the consequences of observations (Runes, 1955).

Modern positivism has its basis in civil law, whereby the law directs how ethical

decisions are made (Ashley & O'Rourke, 2002; McGann, 1971).

The prime directive of positivism is: All ethical decisions ought to based on the

prevailing law with knowledge that the law may require a change.

Although obligationism may be a part of distributive justice as described below, it

is presented as a separate theory due to its connection with beneficence.  Catalano, (1995)

describes obligationism as an "attempt to resolve ethical dilemmas by balancing

distributive justice with beneficence" (p.11).  Although both distributive justice and

beneficence are intertwined, the author separates them here as the distribution of scarce

resources (distributive justice) and doing good (beneficence).

The prime directive of obligationism is: All ethical decisions must balance

distributive justice and beneficence with the knowledge that outcomes may not be the

best in the long run, but that they are the best for that time.

The ethical theory of distributive justice helps frame decisions on what is the best

distribution of "social benefits and burdens [outcomes]" (Beuchamp & Bowie, 1997;

610).  Edges and Groves (1999) purport that distributive justice must include the

following when making use of scarce resources;

> 1.  To each an equal share, 2. To each , according in need, 3. To each, according
>
> to effort, 4  To each according to contribution, 5. To each, according to merit, and
>
> 6. To each, according to ability to pay. (p. 48).

Pay is an important economic consideration in healthcare, due in part to the elasticities of

demand that are different from other industries (e.g., small changes in quantity lead to

high changes in price in healthcare), and that the individual and organization are both important components to the distribution of scarce resources.

The prime directive of the distributive justice theory is: All ethical decisions ought to be conducted with the knowledge of limited resources and that those resources will be distributed to individuals without a limiting effect or creating a burden upon others.

Egoism is the last teleologic or outcomes based theory discussed because it deals with the individual at the opposite spectrum than virtue ethics. Whereas virtue ethics indicates that individuals ought to decide on a virtuous orientation towards others, and the other telelogic theories take into consideration other individuals when outcomes are decided upon, egoism is an individual based theory. Several authors indicate that egoism is based on self-preservation, self-interest, self-promotion, or a weighing of self-good over evil (Baier, 1958; Beauchamp & Bowie, 1997; Catalano, 1995; Ferrell & Fraedrich, 1997; Hoffman & Moore, 1990; MacKinnon, 1998; Rachels, 1999; Shaw & Barry, 1998).

The primary directive of the egoism theory is: All decisions ought to be self-oriented with reflection on the outcome of achieving universal unity.

*Relativistic Theories*

As discussed in the above theories, the process of ethical decision making is important, but is not a primary component in teleologic theories. Theories that focus on the process of ethics are relativistic in nature and are discussed below.

A standard for every person does not exist according to existentialists. As a basis for realism, existentialists believe that ethical decisions are made in "new circumstances" (Ashley & O'Rourke, 2002; p. 3). How individuals perceive beyond their own senses is

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the realist approach, whereby each person uses the "discovery, transmission and use of knowledge" within the framework of their own time and cohort (Gutek, 1988). As indicated by Thomas Aquinas, self-expression is valued only for the individual making the decision and without possible influence from other sources, except possibly some form of divine intervention (Gutek, 1988).

The prime directive of the existentialism theory is: All decisions ought to be made with the affected individual's own thoughts and perogatives as part of the decision process. And that individuals effected by the decisions, have the freedom to be part of or not part of the decision making process.

Based on existentialism, relativism and situationalism are based on circumstances and cases (Fletcher, 1966). As Hoffman and Moore (1990) indicate, ethical relativism is a "position that there is no one universal standard or set of standards by which to judge an action's morality" (p.5). In essence, relativism and situationalism purport that there is no universal standard or moral orientation (Darr, 1997; MacKinnon, 2001; McGann, 1971; Thompson & Thompson, 1981) because morals and ethics are individually or society based (Beauchamp & Bowie, 1997).

The prime directive for relativism/situationalism is: All decisions ought to be made with respective individual and/or societal frameworks, and that no one standard is valid for all ethical situations.

Several issues are addressed by the rationalism ethics theory. The first issue is how reasoning leads to rationality and appeared to be the prime orientation of the rationalism theory until the mid 1900s. The second issue is science as the means of rational decision making and was the prime orientation of rationalism until Kohlberg's

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theory of moral development, and the development of relationships as the prime orientation of the rationalism theory in the late 1900s.

According to Seth (1899), rationalists "refuse to see anything absolute or permanent" (p.23), in their orientation towards ethical decision making. What Seth presents is that there are two forms of life, one that is good based on pure reason and the other that is good based on sensibilities.

The prime directive for rationalism is: All ethical decision making ought to use reason, science and individual relations as frameworks for decision alternatives.

According to Edge and Groves (1999) and Beauchamp and Bowie (1997), egalitarianism emphasizes "equal access" to services. Towsley and Cunningham (1994) further specify egalitarianism as "equal distribution of equal opportunities" (pp.75-76), whereby individuals not only have equal access, but they have the same opportunities within the services as others do. Neilsen (1985) also supports the Towsley and Cunningham perspective when he indicated that the "quality of conditions" within the services must be equal for all individuals.

For individuals in healthcare, the egalitarianism theory purports that equality is paramount. We do not have an egalitarianism framework to date, because not all individuals have equal access with equal services. It may be that individuals do have access to forms of care with unequal costs, such as emergency visits for the uninsured for a cold or flu, but that is equal access without equal services. A more equal form of care would be providing interventions for the uninsured individual with a cold or flu in a clinic rather than an emergency room. With the above form of care, both the individual receiving the care would have equal access and equal services and the individuals paying

for that care would have more equal form of resource distribution in the form of lower taxes.

Where egalitarianism can be incorporated into the healthcare framework is within the ethical decision making process, at least at the patient level. Individuals making ethical decisions may need to assess if the egalitarianism framework is appropriate for their situation. The egalitarian theory stresses the process of decision making and is a basis for the nominalism ethical theory discussed below.

The prime directive of the egalitarianism theory is: All ethical decision making ought to consider equal access, distribution of opportunities and quality of conditions for individuals who may be affected by the decision process.

Solomon (1996) and MacKinnon (1998) indicate that Thomas Hobbes (1588-1679) was the first individual to speak of a contractarian ethical framework when he wrote the "Leviathan." Hobbes speaks of the "self-interest" of individuals as a guiding force in the relationship of individuals. Because of this self-interest, individuals would best be served by having specific rules on the conduct of relationships. More specifically, Rachels (1999) indicates that Hobbes believed that a "social contract" was important for strong relationships and should be built upon "1. Equality of need, 2. Security, 3. The essential quality of human power, and 4. Limited altruism" (pp. 143-145).

The prime directive for the contractarianism theory is: All ethical decisions ought to ensure a contractual situation that is based on either a covenant or written document among respective parties to ensure mutual benefit.

Beginning with Francis Bacon (1561-1626) and defined by Dewey in the early 1900s, pragmatism is an ethical theory that uses secular thought and experiential or experimental observation to make decisions (Durant, 1962; Runes, 1955). Pragmatism is similar to utilitarianism due to happiness as an outcome, but pragmatism is different than utilitarianism because happiness is also part of the process of the decision. As Seth indicates (1899) pragmatism includes "happiness [when it] is permanent and universal. It results only when the act is such as one as will satisfy all the interests of the self-concerned" (p. 209). When the act of decision making does not include happiness as well as after, than there may not be permanence to the happiness.

The prime directive for the pragmatism theory is: All decision making ought to include shared experiences and interdisciplinary perspectives to reach solutions for complex problems.

Whereas pragmatism uses experiential inferences to help make decisions, intuitionism stresses the feelings of individuals as the most important component to take into consideration during the decision process. Ashley and O'Rourke (2002) indicate that emotions, as described by Hume, are important to consider as intuitive factors; "for discerning moral good and evil that is not rational, but rather is emotional, [is] the result of feeling" (pp. 2-3).

When individuals confront ethical situations, there are a considerable amount of emotions involved. For example, the ethical issue of prolonging life with the use of extreme interventions is always filled with emotions since the family and friends hope for a return to better times, even if that situation is not very probable. Intuitionism helps us confront our emotions and intuition on what is right and wrong and how to "form data

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[from] intuition" (Runes, 1955). Our instincts are usually correct, but it is at the individual level where they are more correct than at the aggregate level. The individual level is more accurate because the variation from each individual is cumulative at the aggregate level and more apt to be incorrect.

The prime directive of the ethical theory of Intuitionism is: All ethical decisions ought to take into consideration the intuition or emotions of the individuals involved, but the weight of those emotions should be less at the aggregate level.

Similar to the emotions of the intuitionism theory, the feminism ethical theory stresses relationships in the decision making process. Building on relationships is important to the caring component of healthcare and Hinderer and Hinderer (2001) stress this situation when they describe the feminist ethic as "a pattern of ethical reasoning emphasizing … relationship and caring" (p. 96).

The prime directive of the feminist ethical theory is: All decision making ought to include the caring needs of individuals under consideration as a major focus of the alternative outcomes.

*Communitarian Ethics*

The combination of process and outcomes is inherent in the communitarian ethical theories below. While previous ethical theories had components of process and outcomes, the communitarian ethical theories support the use of process and outcomes at the same level.

According to Beuchamp and Bowie (1997) communitarian ethics "emphasize group goals, collective control and participation in communal life" (p. 610), with no particular emphasis of process over outcomes or vice versa. This ideology of process-

outcomes is relatively recent in terms of balancing both with the same weight (Lodge, 1977).

While the process-outcomes ethical framework is important to use for decision making, the difficult part is in the deliberation. Emanuel (1991) indicates that "each citizen is committed to sustaining the community not just for himself, but for his fellow citizens and for the future generations" (pp. 156-157). If the deliberation within the process of decision making is not supported by a wide variation of individuals, than the "community" will only represent those few who do participate. The important aspect of the deliberation if only a few do participate is to recognize that the sacrifice of the individual is not acceptable. McCollough (1991) supports the non-sacrifice of individualism when he indicates that "a view of the common good that embraces the good of the person in the community does not entail the sacrifice of the individual to the community" (p.41). Runes (1955) also supports the non-sacrificial aspects of the communitarian ethical theory when he indicates that the individual "has not only a personal but also a supra-personal sense of responsibility" (p. 1090).

The prime directive of the communitarian/universalism ethical theories is: All ethical decision making ought to include deliberation that can include a significant variation of individuals who are part of the process of decision making as well as the outcomes, or who are affected by the process and outcomes.

All individuals require a "normal" environment that is unique to their specific needs (Wolfsenberger, 1980). Normativism ethics supports the perspective by Wolfsenberger and also supports the notion that "categories of disease vary from culture to culture and historical period to historical period" (Caplan, 1997; p. 16). Whereas one

individual may be accommodated quite well in one country, the same treatment may not

be acceptable in another country.

Seth (1899) indicated that normativism should stress self-actualization for the

individual (ενεργεια).  Not until the individual receives the needed care does a normal

environment occur, and within the range of what that individual feels is "actualizing."  A

case in point is where cognitively impaired residents receive "normal" care only when

specialized care for their needs are addressed, they have a specialized environment for

their unique habits and specialized continuum of services are provided with providers

who have specialized training (Porter, 1999).

The prime directive for normativism ethics is: All ethical decisions ought to

include the rights and needs of individuals who are effected by the decision and the

outcome includes a "normal" process of care, or non-care if the individual wishes.

Only one literature source could be found by the author for the nominalism ethical

theory.  Seth (1899) wrote that "nominalism [is] the belief in the individual"  (p. 329).

Individuals reach a nominal point when perfect actualization is obtained (εντελεχεια)

(Seth, 1899) rather than the level of self-actualization in normativism.

This author expands on nominalism ethics because it is an important framework

for decision making.  Using nominal type of data, where no one category is in a

hierarchical relation to another such as ordinal or interval data (Vockel & Asher, 1995),

the nominalism ethical framework is based on the notion that no one individual is

"worth" more than another.  Individuals who are assessed for healthcare interventions

should be assessed with the nominalist approach whereby the decisions for one person

should be the same range as for any other person, the range allows for individual freedom in choice.

Whereas the egalitarian theory stresses the process of decision making with some thought to outcomes and distribution, the nominal ethical theory considers both the process and outcomes as equally important. When the decision process is conducted, individuals who are part of the process must realize that each individual has an equal weight into the decision, as well as the individual or phenomena under consideration. But the outcome of the process is equally important and all individuals who are part of the process and the individual or group effected by the process must have an equal share in the outcomes.

An example of a nominal process-outcome occurs when resource consumption, such as salaries, are considered for distribution and all individuals who are in the process of the decision are also the recipients of those outcomes. Although physicians are indeed more educated than nurses, there should be a more nominal approach to the distribution of remuneration rather than a skewed approach that is inherent in current reimbursement strategies. The physician is "paid" over and above the nurse relative to the weight of the extra education.

Types of care distribution is also an important consideration when using the nominal ethical theory. When distribution of limited resources is considered for interventions such as organ transplant, no one individual should be considered over another due to socio-economic or "celebrity" status. While difficult, the decision makers must adhere to the duty of all, partially deontological oriented, and keep their thoughts of who may be "better" to themselves, as well as to whom the intervention will be provided.

The outcome is that all individuals will have the same equal consideration in the decision process - egalitarian approach - but also that the outcome will allow for equal access.

The prime directive for nominalism ethics is: All ethical decision making ought to ensure that no one individual is treated hierarchically than another in both the process and outcome of care.  And that the range of available services is considered and provided to all individuals regardless of ability to pay or ability to understand those services.

*Ethical Decision Making*

The process of using the ethical and religious frameworks to help with ethical decision making is an art and not an exact science.  With so many variables that could be part of the decision making process, such as family, friends, resources, the situation and characteristics of the individual under study to name a few, a significant variation exists on how to conduct the ethical decision process.  However, ethics committees can start with processes that help guide them through the ethical decision making.

Below are 14 ethical decision making processes that help frame three durations of time to make the decision; 1. Short time duration meaning there is an immediate need to have alternatives and could be as short as 30 minutes or less, to several hours, 2. Medium duration meaning there is a definite need to make a decision in the next few days or the consequences could lead to dire outcomes without alternatives (e.g., death or prolongation of the body without "life"), and 3. Long term duration meaning there are possibly short-term answers but a more complex alternative is required to solve the problem rather than take care of only the symptoms.  Table 5 provides the 14 decision making processes within the framework of short, medium and long-term duration.

Table 5.

Ethical Decision Making Processes; Duration, Author and Number of Steps

| Author(s) | Number of Steps |
|---|---|
| Short Term Duration | Short Term Duration |
| Fremgen (2002) | 3 |
| O'Connell (2001) | 4 |
| Benjamin & Curtis (1981) | 5 |
| Gow (1985) | 5 |
| Flight (1988) | 5 |
| Medium Term Duration | Medium Term Duration |
| Edge & Groves (1999) | 6 |
| Purtillo (1999) | 6 |
| Hinderer & Hinderer (2001) | 6 |
| Boyle, DuBose, Ellingson, Guinn, & McGurdy (2001) | 6 |
| Corey, Corey & Callanan (1993) | 7 |
| Paul & Elder (2003) | 8 |
| Long Term Duration | Long Term Duration |
| Worthley (1997) | 9 |
| Pfeiffer & Forsberg (1999) | 9 |
| Nash (1988) | 12 |

*Short term duration ethical decision processes.*

The shortest ethical decision making process found by the author was by Fremgen (2002). Fremgen "cuts to the chase" and makes the decision process based on legal standing but still allows for individual feelings. Fremgen (2002) describes his decision process as:

1. Is it legal, 2. Is it balanced, and 3. How does it make me feel? (p.9)

Ethics committees could use this framework for situations that require immediate decision such as life and death circumstances (e.g., cardiac arrest versus death).

The second shortest decision making duration is by O'Connell (2001) with four steps:

1. Review the facts, 2. Identify the ethical values at stake, 3. Evaluate the relative weight of conflicting values, 4. Generate a consensus about a morally preferable course of action that is consistent with your organization's mission and values. (pp. 102-103)

O'Connell does not ground his decision process in law, but instead bases it in ethical values and within the mission of the organization. For example, if an organization does not provide abortions, than the individual presenting herself at the emergency room that requires an abortion or the mother will die, will definitely need to use this above decision process to help with the alternatives of care.

O'Connell's decision process also helps with situations that must weigh non-profit versus profit missions, as consequences of the circumstances. Whereas non-profit organizations are required by law to provide services to the community at their own expense, or pay the taxes they are otherwise not required to pay, for-profit organizations

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are not required to provide services to the community.  However, for profit organizations

may want to provide services to the community, albeit less than the non-profit level of

services, if the for-profit is to have "goodwill" within the community.  O'Connell's ethical

decision process may thus help both the non-profit and for-profit healthcare organization

on weighing the "amount" of services provided to the community.  If an emergency

situation presents itself and it provides goodwill to the community, independent of costs,

than the O'Connell decision process may be appropriate to use.

The three decision processes that follow include five steps each.  As the longest of

the "short duration" ethical decision processes, they provide frameworks that give some

latitude for emergency type situations.  Instead of using Fremgen's decision process that

is for the most acute situations, the last three of the short duration processes are for those

that are still acute but not requiring an intensive intervention.

Benjamin and Curtis (1981) provide the most conceptual of the last three short

duration ethical decision processes:

> 1.  Determining and obtaining relevant factual information, 2. Aiming at
>
> conceptual clarity and drawing relevant distinctions, 3. Constructing and
>
> evaluating arguments, 4. Developing a systematic framework, 5. Anticipating and
>
> responding to objectives. (p.9)

Because the steps are conceptual in nature, such as "conceptual clarity" that might require

several factors taken into consideration, this process is multifactorial in its application.  It

might be used in any part of the continuum of healthcare, from acute situations to chronic

with complex situations, but requiring a short time duration in decision making.

Gow (1985) gives us a predominantly individual level process of ethical decision making because it concerns individual's moral beliefs:

1. Objective Moral precepts, 2. Critical analysis of moral precepts, 3. Discussion of alternative action and consequences, 4. Rational - irrational / moral - immoral decisions, and 5. Support of existence of moral precepts. (p. 169)

All individuals involved in the Gow process of ethical decision making need to consider their own moral beliefs as they help make a decision for the person or people affected by the decision outcomes.  Of course, the person or people affected must also provide their own moral beliefs, with the final outcome weighing more of the affected party than the individuals who help with the ethical decision making.

The final five-step ethical decision making process is provided by Flight  (1988) and is directed at both medical and legal issues as separate from the ethical framework:

1.   When making an ethical decision, first identify the ethical component isolating it from the medical and legal issues, 2. Determine the influence of alternative ethical decisions on the medical and legal issues, 3. Evaluate the expected short term and long term outcomes for each alternative, 4. Determine who has the responsibility for making the decision, and 5. Clarify your role in the decision making process (p.185-186).

We see here that the roles of the individuals who are part of the process are very important and should be considered when deciding on the final outcomes.  Whereas a physician may be given significant weight in most medical-ethical issues, the physician may not be that heavily weighted for another situation, such as hospice where the family

and friends interests are just as or more important than the physician since most medical care at that point is palliative rather than curative.

*Medium term duration ethical decision processes.*

The five following ethical decision making processes range from six to eight steps respectively. A demarcation was apparent between eight and nine steps relating to the transition from medium to long term duration of decision making. That demarcation was based on a more specific approach to values clarification in long term versus medium term duration decision making. While values clarification is important in all levels of decision making, be it short, medium or long, it is more reflective in nature at the long term level.

Edge and Groves (1999) presents a six step ethical decision making process that includes an examination of "credible" options:

1. Identify characteristics of the problem, 2, Gather facts of the case, 3. Examine options with initial credibility, 4. Weigh and evaluate potential options, 5. Make decisions and act, and 6. Assess and evaluate results. (p.36-37)

It is important to stress that the examination of options with credibility may take a long term approach, but the author includes the process here because of the possibility for a medium duration assessment. If the number of credible options are not significant, than the Edge and Grove process may indeed be a medium duration decision process.

Purtillo (1999) also provides a six step ethical decision making process:

Step 1. Gather relevant information, 2. Identify type of ethical problem, 3. Analyze problem using ethics approaches, 4. Move to practical alternatives, 5. Make action, 6. Evaluation of results. (p. xiii)

The Purtillo process is very similar to the Edge and Grove process when individuals must assess practical alternatives rather than credible ones. Where one must decide upon practical alternatives, the credibility may be weak. Also, a credible alternative may not be practical. Therefore, the use of both the Purtillo, and Edge and Groves ethical decision making processes are suggested when confronted with a complex ethical situation that requires both assessment of practical and credible outcomes.

Hinderer & Hinderer (2001) present another six step ethical decision making process as:

1. Problem identification, 2. Values identification, 3. Options identification,

4.Consequence identification, 5. Option selection, 6. Documentation. (pp. 42-45)

The emphasis placed by Hinderer and Hinderer upon the ethical decision making process is on values and documentation. While values are important, it is also important to document those values in the event that outcomes are not as desirable for one individual as they are for another (e.g., when wills are involved in hospice cases).

Boyle, DuBose, Ellingson, Guinn, & McGurdy (2001) present the last of the six step ethical decision processes:

1. Identify question, 2. Gather facts, 3. Clarify concepts, 4. Size up alternatives and consequences, 5. Find justification for action, 6. Seek integrity preserving compromise. (p. 23)

Their emphasis is on justification for actions that is similar to the Purtillo, and Edge and Groves practical and credible positions respectively, as well as on integrity of the outcomes. It may be difficult in some situations to find a compromise among the alternatives that meets an integrity level where all facilitators can agree. Boyle et al.

however, gives support that individuals should at least "seek" to find an integrity level all facilitators can live with, but more importantly what the affected party can live with.

Corey, Corey & Callanan (1993) indicate that there are seven steps in an ethical decision making process:

1.  Identify the problem or dilemma, 2. Identify the potential issues involved, 3. Review the relevant ethical guidelines, 4. Obtain consultation, 5. Consider possible and probable courses of action, 6. Enumerate the consequences of various decisions, 7. Decide on what appears to be the best course of action.

(p.11)

Several key points in the above process include "obtain consultation" that is so important in complex ethical issues.  Using an interdisciplinary team approach may not always be possible, even in medium and long term duration ethical decision making, but it is a framework that should be attempted.  When a variation of ideas are presented rather than one, a more robust decision process is created and usually with a more valid and reliable outcome for the situation at hand.

Paul & Elder (2003; 14-15) provide a seven step decision making process that is helpful for ethical issue decision making:

1.  [What is the] Purpose, 2. [What is the ethical] Question, 3. [Gather] Information, 4. [Make] Inference, 5. [Discuss] Essential concepts, 6. [Make clear] Assumptions, 7. [Reviews] Implications, 8. [Include several] Point[s] of view. (pp.14-15)

While the original language is succinct, it is made more relevant to ethical decision making here, including the concept of an "ethical" question.  Rather than a generic

viewpoint, one must specify what ethics is at the outset, and one strategy is to follow the definition provided in this manuscript.

    *Long term duration ethical decision processes.*

    Worthley (1997) identifies nine steps in his ethical decision making process;

        1. Get the facts, 2. Specify stakeholders, 3. Describe feelings, 4. Clarify values

        involved, 5. Imagine options, 6. Describe controls, 7. Articulate consequences of

        options, 8. [Make] Decisions, 9. Choose response. (pp.231-232)

Worthley's process indicates both feelings and values are important factors in the decision making process. Both facilitators of the decision making process and those who are affected by the decision should have their feelings and values known. Without everything "out in the open" it may be interpreted that there are "hidden agendas" among those who help with the decision process. However, once the feelings and values are known, it is still the person that is affected that needs to have the final say in the decision outcome. Even if providers do not agree, as a professional, they are bound to "agree to disagree" since the covenant that they have with their patient is first and foremost the most important part of their care.

    Pfeiffer and Forsberg (1999) also present a nine step ethical decision making process:

        1.  Review the case, 2. State the main ethical problem, 3. List the main possible

        solutions to the case, 4. State the important and probable outcomes, 5. Describe

        the likely impact of each main solution, 6. Explain the values upheld and those

        violated in each solution, 7. Evaluate each main solution and its outcomes, 8.

Decide which solution is best, 9. Defend the decision against objections and

weaknesses. (p.33)

The Pfeiffer and Forsberg steps include a weighing of values "upheld" and those

"violated." By discussing values as part of the decision outcomes and that may be in

conflict with the individual or phenomena under consideration, there is a "full parameter"

type of assessment for the first time among the different decision processes presented.

The full parameter means that all "error" terms are assessed, to use a framework from

structural relations quantitative assessment (Bollen, 1989).

The use of a full parameter assessment is important to all individuals that are

involved with the decision process. Both facilitators and the affected party(s), as well as

the individuals who may be affected, such as taxpayers and individuals directly affected

due to the redistribution of limited healthcare resources, are at stake of possibly being

affected by the interaction effects of the factors involved in the decision process above.

Without a full parameter assessment, the decision process is only linear or unidirectional

towards the focal point of the decision process. It may be that the full parameter

assessment leads to curvilinear or other non-linear decisions, whereby one outcome is

possible given the factors involved and the actual outcomes, or the decision may be the

complete opposite with the same factors, but different outcomes.

The most significant full parameter decision making process found in the

literature is provided by Nash (1981). Although the Nash framework is not an ethical

decision making process per se, it is adaptable to an ethics based decision process:

1. Have you defined the problem accurately, 2. How would you define the

problem if you stood on the other side of the fence, 3. How did this situation

occur in the first place, 4. To whom and to what do you give your loyalty as a

person and as a member of the corporation, 5. What is your intention in making

this decision, 6. How does this intention compare with probable results, 7. To

whom could your decision or action injure, 8. Can you discuss the problem with

the affected parties before you make your decision, 9. Are you confident that your

position will be as valid over a long period of time as it seems now, 10. Could you

disclose without qualm your decisions or action to your boss, your CEO, the

board of directors, your family, or society as a whole. 11. What is the symbolic

potential of your action if understood or misunderstood, and 12. Under what

conditions would you allow exceptions to your stand. (pp. 79-90)

Nash uses symbols to represent "potential" actions as well as the factors from preceding

decision processes.  The use of symbols may be a powerful factor for some patients or

residents, while they may be minimal factors for others.   For example, in cognitive care,

the use of pictures or other symbols for those who have severe dementia, allows that

individual to remember where their room is, while a simple number may not.

The use of ethical prime directives and a patient's or resident's religious beliefs are

important components for any of the decision making processes above.  Different

circumstances will require different combinations of prime directives and religions to

arrive at a "coalescence" of facilitators in conjunction with the respective patient/resident

or proxy.  For policy or procedural ethical decision making, facilitators should recognize

how their decision may be incongruent with specific patients or residents.

Below is a section on professional ethics that will help facilitators and providers recognize their obligations to patients and residents beyond the clinical domain. Following the professional ethics section are clinical ethics, business ethics, organizational ethics and social ethics literature reviews to further help answer the research questions.

<center>Professional Ethics Education</center>

According to Schick, Porter and Chaiken (2002), professional ethics must be based upon a coherence of ethical theories as well as the organizational ethics that professionals work within.  Bayles (1989) presents at least four fundamental ethical problems for professionals that relate to both the ethical theories and organizational ethics:

> 1. Availability of services to all, 2. The relationship between clients and stakeholders and the potential conflict between these two and among stakeholders, clients, and professionals, 3. The effects on others based on a professional's conduct on behalf of clients, and 4. A professional's status as an employee. (p.151)

Although a significant number of other ethical problems exist for professionals, it may be that these four problems represent the majority of time spent on ethical issues.

When professionals are educated during their didactic coursework, the inculcation of both cognitive and affective objectives may be highly significant among the different professions.  For example, it is the author's experience that the amount of clinical education is most significant for physicians where there is also a greater proportion of affective education occurring versus the affective education found in didactic

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coursework. However, for health service administration graduate students, the amount of clinical education, as presented in internships or residencies, is significantly less than in medical education, with the result that affective education may be significantly less than in medical education. Therefore, it may be that most affective learning occurs in internships and practical experience rather than in the classrooms.

Medical education and health services administration graduate education are probably the two ends of the spectrum, at least in terms of potential clinical residency training and thus affective education. In addition to medical education and health services administration graduate education, the author presents additional professional programs such as nursing to help demonstrate the wide variation of professional education and thus the different frameworks towards ethical issues in healthcare.

To further clarify the different perspectives of professional orientation towards ethical issues in healthcare, the author discusses the different respective professional codes below. Each code is representative of a significant profession in healthcare.

*Professionalism in Healthcare*

The degree of autonomous decision making and within small groups of teams is very high in healthcare. Several factors contribute to this phenomena including the high expertise required to provide medicine as well as the high amount of technology provided during healthcare interventions. And, because there is so much autonomy related to healthcare with a concentration of patient and resident responsibility, there is a need to provide a high degree of professionalism. Below are discussions of how professionalism is related to the creation of a profession and the specific codes that professions follow to ensure ethical decision making is appropriate.

According to Emanuel (1991) there are two ethical "characteristics" of a profession:

> 1. That it is dedicated to ethical ideals, and 2. That it serves a subject, a client, for whose benefit the ethical ideals are pursued. (p. 14)

The characteristic of ethical ideals are not unique to any one profession, but the different professions will have different ethical ideals. For example, there are differences between allopathic physicians and nurses towards specific types of care. For example allopathic physicians tend to be more exclusive towards other forms of care, although that perspective is changing with newer allopathic physicians, compared to the wholistic orientation of nurses.

> Garrett, Baillie and Garrett (2002) further elaborate on what a profession is:
>
> A profession - involves the following elements: 1. A dedication to a particular way of life and a particular expertise, 2. A deep involvement in activities important to the functioning of society, and 3. A commitment to place service to society and often the individual ahead of personal gain. (p. 16)

Each of these elements is supported to different degrees among the different professions. For example, between physicians and health administrators, the time commitment is similar in terms of total hours dedicated to a particular health organization or facilities, but the two professional types have different means of commitment. Physicians may only be at a hospital or nursing home for a short period of time per period, or they may be there for extended periods. But, the total time of all of the periods will be most similar to health administrators who are at one facility most of the time in one period.

Where there is a great variation among healthcare professions is with element number three above.  Professions that have committed their practitioners towards "service above self" have instilled a more normative type of economic orientation than one that is prescriptive towards a specific type of contract with patients, specifically reimbursement issues rather than care issues (Jacobs & Rapoport, 2001).  Each individual within a profession may or may not agree with the "ethics" of the profession towards reimbursement or care, but the total sum of one healthcare profession is different from other healthcare professions.  An example is the orientation of physicians towards reimbursement issues compared to nurses.  There is a greater proportion of discussion of reimbursement by physicians than nurses, and that may be due to the reimbursement of physicians that is significantly higher than nurses.   Secondly, physicians have more control in determining reimbursement than do nurses.

In addition to reimbursement of the individual practitioner, the type of payments for other healthcare interventions (e.g., pharmaceuticals) is a topic of discussion significantly higher for physicians than nurses.  Each of the reimbursement issues above demonstrate that healthcare professions have their own unique ethical orientation towards healthcare issues.  These differences support the need for interdisciplinary teams when deciding on ethical issues since without the other orientations discussed in the decision process, one profession will dominate healthcare.  That dominance may not be in the best interest of the patient or resident, especially when proxies for the patient or resident are not available, or individual autonomy is not known (e.g., no living will), or cognitive impairment is present.

When professions represent professionals, the type of value system that is represented is very important towards the type of care provided in healthcare. Individuals who are educated within a particular profession have both cognitive and affective objectives presented to them, and that individual may or may not accept them. Ashley and O'Rourke (2002) support the unique kinds of cognitive and affective education within a profession when they indicate that:

> professionals place value, first of all, upon systematic knowledge and intellect [along with] technical skill and trained capacity [and] putting this conjoint knowledge and skill to work in the service of others; helping. (p.73)

In addition to obligations towards patients and residents, the healthcare administrator has the greatest degree of obligation towards other healthcare professions. While physicians are the "captain of the ship" for healthcare, and nurse administrators are typically in charge of patient management, healthcare administrators must ensure that all employees are cared for and within the context of providing the best care for the patients or residents. Thomasma (2001) supports this ethical element of caring for employees when he presents that:

> all healthcare executives have an ethical and professional obligation to employees; some of the objectives encompass 1. Creating a workforce environment conducive to understanding employee ethical conduct and behavior, 2. Ensuring that individuals may freely express their ethical concerns without prejudice to their jobs, 3. Producing mechanisms for discussion of such concerns, and for addressing and redressing them, so that employees know where to turn for support, 4. Establishing procedures for the resolution of ethical dilemmas through

consensus building or other methodologies, 5. Committing the institution to ethical standards in the community, even in the midst of competition that might threaten to erode some of those standards in the interests of expediency, and 6. Working with other healthcare institutions to help formulate a national policy about healthcare access, so that the survival of the institution is not at stake when care is given to the poor or needy. (p. 80)

How health administrators and other healthcare professionals deal with keeping ethical standards high for both employees and patients requires a determination that is not self-serving, especially in the face of easy gains. When the professional has the ability to gain from high autonomous decisions, it sometimes means that individuals face a dilemma of being self-critical or self-serving. Paul and Elder (2003) help explain this growing phenomena of "keeping on track" with what is right compared to those who have self-oriented positions;

[the] uncritical person [is] 1. Unconcerned with the development of intellectual abilities, 2. Manipulated by self-serving critical persons and easily indoctrinated, 3. Person being victimized or blindly led into victimizing others, 4. Good hearted, but self-deceived. [while a] Self-Serving Critical Person; 1. Develops intellectual abilities to serve one's selfish interests without regard to rights and needs of others, 2. Manipulates less sophisticated people, 3. Results in those people being harmed, 4. Unethical self-righteousness and self-deceived. [and a] Fair-Minded Critical Person; 1. Develops intellectual abilities to serve one's interests while respecting rights and needs of others, 2. Acts as forthright as possible, 3. Results

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in people being treated reasonably and fair, and 4. Ethical, empathic and just. (p.

6)

It is the duty of those who educate healthcare providers to instill both cognitive and affective objectives that support a "Fair-Minded Critical Person" orientation.

When individuals start to take advantage of those they care for, work with, or are in charge of, they either have not had appropriate education of ethical cognitive and affective objectives, or they have had the appropriate education and have chosen not to abide by those objectives. It may also be that the code of ethics that a profession follows is not enforced when infractions occur and thus the market is weak on keeping further infractions from occurring.

When infractions occur, several outcomes are possible. Situations may be handled with verbal, written or terminal decisions, or in the extreme with lawsuits. According to Kubler-Ross (1975) it is especially difficult for professionals to sue another because it "is a very risky business in offering the patient sense of teamwork, a sense of confidence, and a sense of inter-professional communication" (p. 18).

The decisions above from verbal discussions to lawsuits may not be necessary if professionals more fully understood the great responsibility they have along with the autonomy they enjoy. Backer, Hannon and Gregg (1994) support the notion of responsibility along with autonomy when they stress that:

> professional autonomy lies within the individual, whom has the freedom and
> responsibility to make assessments and decisions about patient care based on
> professional skill and knowledge. (p.51)

As the degree of technology increases in healthcare, that autonomy also increases because patient knowledge does not keep up with the technology change. From an economic perspective, the assumption of perfect knowledge for services or goods on the part of the patient may be most problematic in healthcare due to the technology and expertise required to provide that healthcare. Therefore healthcare professionals have an extra burden of responsibility to patients and residents that other professions may not have.

Along with the significant autonomy and responsibility of care by healthcare professionals comes a significant amount of autonomy and responsibility of knowing and abiding by ethical ideals within that profession. Both care and ethics are reciprocal which makes it all that more important that providers understand the cognitive and affective objectives that are the foundation of their profession. The different professions have different care and ethics relationships (Gewirth, 1986), but the fundamental issues of beneficence, access, equity and resource allocation are similar among the professions (Herlihy and Golden, 1990).

While the cognitive and affective objectives that are taught to healthcare providers create a foundation for high quality of care and ethics in the field, it is the code of ethics of the profession that continues to support that foundation. Below is a discussion of the ethical codes of the following professions; allopathic physicians, chiropractors, nurses, physical therapists and occupational therapists, and health administrators.

*Ethics Codes: Concrete Statements for a Profession*

Education and continuing education cannot always instill the appropriate ethic into professionals, and thus a code is created to ensure that the respective profession follows that ethic. According to Pellegrino (2001) ethical codes are a "collation" of morals. Arrow (1973) indicates that ethical codes are only "useful" if they are "accepted." And how they are accepted may hinge on the individuals who are creating that professional code and the conduct of the individuals represented (Shaw and Barry, 1998).

How ethical codes are constructed depends upon the particular profession and the individuals in that profession. Some codes may be more contractual in nature, or collegial, or some other form. Edge and Groves (1999) provide four models of ethical codes "1. Engineering model, 2. Priest model, 3. Collegial model, and 4. Contractural model" (p 103).

Each model may be represented to some degree within the different professional ethical codes, or they may be the only framework within one ethical code. Future research may investigate how the ethical codes are constructed to determine if there is an effect upon the outcomes of care by that profession. However, the structure may not be so important as the issues that the codes address. Since the concerns of a profession continue to change, the codes should not be static. Change should be encouraged if the profession changes it orientation towards issues (Corey, Corey and Callanan, 1993). Knowing the history of ethical codes keeps us from making the same mistakes.

As an indication of the history of ethical codes within specific professions, Beauchamp and Childress (1989) provide some insight into the professional codes of

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health administrators (both acute and long term care) as well as allopathic physicians and nurses.  Further elaboration of chiropractic, physical therapy and occupational therapy professional codes follow the Beauchamp and Childress history.

Beauchamp and Childress (1989) indicate that the American College of Healthcare Executives (ACHE) has had their code of ethics since 1939.  Initially it was linked to the code of ethics for hospitals developed by the American Hospital Association (AHA).  The American College of Health Care Administrators (ACHCA) has adopted a code of ethics for affiliates who are primarily managers of long term care facilities.

Ethics codes in medicine dates from the 18th century B.C. and the Code of Hammurabi, which established a payment schedule for treatment by physicians and veterinarians.  Harsh punishments were prescribed if a patient was harmed.  A physician could lose his hand if the patient's life was lost as a result of treatment.  A quite different code developed from the teaching and work of Hippocrates (circa 460-370 B.C.).  The Hippocratic oath contains a long, largely obsolete section describing expected relationships between physician and their teachers and students.

The American Medical Association (AMA) was founded in 1847 with the ethics code created soon thereafter.  Codes for nurses promulgated by the American Nurses Association (ANA) were first adopted in 1950.

Although now part of a mainstream form of healthcare interventions, the profession of chiropractic had a "rocky" start with other healthcare professions, especially allopathic and osteopathic physicians.  It was not until the federal level AMA v. Wilk case that physicians and chiropractors had to have an "ethical" relationship.

The current chiropractic code of ethics is founded on two divergent chiropractic philosophies. Whereas "straight" chiropractors believe in only spinal adjustments, the more liberal chiropractic philosophy of "mixing" believes in using other healthcare interventions along with spinal adjustments. Although the author recognizes both chiropractic philosophies, he concentrates on the chiropractic association that represents the majority of chiropractors, the mixers.

According to the American Chiropractic Association's ethical conduct policy (ACA-House of Delegates, 1982), chiropractors follow a non-personal "monetary gain." The ethical position is based on a deontological framework of duty to the patient. When using either spinal adjustment or other alternative means of healthcare interventions (e.g., nutritional supplements), the chiropractor is supposed to ensure that the intervention is beneficial to the patient or suggests other means of improving the problem presented.

As representatives of allied health rather than a full systems provider of healthcare, physical and occupational therapists have their own codes of ethics. Although the two codes are different in terms of their structure, they both enumerate several ethical issues of care, including beneficence, nonmaleficence, and duty (American Occupational Therapy Association, 2000; American Physical Therapy Association, 2000).

Several of the professional codes of ethics discussed above are presented more in depth in the accreditation code of ethics section. Whereas codes of ethics are important for the professional to follow, the outcomes of healthcare are the true indicator of how ethical frameworks are followed. Below are the crucial clinical ethics literature, which is the most predominate literature type of healthcare ethics found by the author.

Clinical Ethics Education

Current clinical ethics could be best summarized as a condition of anomie. With increasing technology and medical education surpassing social standards of acceptable practice, the anomie of unrest and disruption has become part of the healthcare provider's interaction with patients. There may be too much emphasis upon the clinical and not the health of patients as indicated by Toombs (2002):

> the focus of clinical interaction, and the theme of clinical dialogue is not simply the pathology of the biological body but rather it is the particular patients' experience of the disruption of the body. (p. 39)

An holistic approach to healthcare that includes ethical discourse must be part of the providers interaction with patients; *"in clouded and weak moments of the spirit, seeks to hold fast to that which it experienced and thought in its bright and powerful moments." Hoffding (1906; 117)*

For patients, the clinical ethics expertise of providers is most asymmetrical in terms of the ethics domains known. Few healthcare providers have ethics education in their didactic instruction due to the requirements of teaching clinical skills before graduation. It may be that the clinical providers only ethics education is clinical or biological based. Therefore, the patient and the provider may have the same amount of ethics education, other than clinical, as taught through religious or experiential frameworks. According to Gruber (1998) the clinician should understand their limitation of ethics knowledge and try to improve upon that situation, especially in the chronic areas of healthcare:

the call for a new bioethics is in part a call for a better understanding of the human and social significance of chronic illness.  In chronic cases, the physician helps the patient to integrate the illnesses and its effects into his or her life. (p. 395)

The author presents below those clinical ethics issues that are most current and potentially most problematic in the future.  In addition to the major principles and issues in healthcare, a section is provided on the type of ethics education provided in current clinical education.  A final section of clinical ethics is presented on the issues of healthcare research and the possible implications from the results of such research.

*Major Principles and Issues in Healthcare*

The major principles of clinical ethics discussed here are autonomy, beneficence, nonmalifience, justice, equity, resource allocation, and negligence.  Those seven issues have a significant effect upon the outcomes of healthcare, through the availability or providing of healthcare services, the accessibility or means of obtaining healthcare, and the attainability or payment for healthcare.

According to Corey, Corey and Callanan (1993) autonomy is:

self determination or the freedom of clients to choose their own direction.

Beneficence, refers to promoting good for others. Nonmaleficence means

avoiding doing harm, which includes refraining from actions that risk hurting

clients. Justice refers to providing equal treatment to all people. (p. 9)

Balancing each of these issues is difficult for clinicians, especially when conflicting ethical and religious frameworks are evident in the planning of care; conflicts may exist due to patients, family or friends ideas, as well as patients and providers conflicts.

However, one means of focusing these issues is to have the patients' beliefs known prior to healthcare interventions through a living will or advance directive, and especially if there are cognitive deficits known to be apparent in the family.

In addition, equity and resource allocation are paramount issues when dealing with limited healthcare resources (Herlihy & Golden, 1990). Equity is a framework whereby patients do not have their healthcare "blocked," and resource allocation is a means of "equitable" distribution of services. Several ethical theories help guide the clinician on how to balance these two issues with those directly above (e.g., distributive justice ethics). An example of an equity and resource allocation problem that has been discussed and decided on is the issue of state level healthcare reimbursement. Oregon, through its residents who voted on a referendum, has decided to overtly limit particular healthcare interventions based on age and other casemix variables.

The final major principle and issue discussed here is negligence. As defined by Harris (1999) negligence "[is] duty, breach of duty, causation and damages" (p. 171). A great deal of literature is available in law and malpractice that indicate how clinicians can improve their care by avoiding the four components of negligence. Another perspective is to add more ethical education that includes the domains discussed here to help alleviate the potential for negligence in healthcare. Corey, Corey and Callanan (1993) support the increased need for ethics education in healthcare that goes beyond clinical ethics when they discuss malpractice issues:

> Malpractice is the failure to render professional services or to exercise the degree of skill that is ordinarily expected of other professionals in similar circumstances. (p. 129)

The skill of clinical care includes more than clinical education, but also the ethics education on the use of those clinical skills. If the ethics perspective of clinical education were to increase, the amount of malpractice cases could be reduced.

The author recognizes that each clinical profession has unique perspectives on patient care and appropriate relationships towards that care. For example, Backer, Hannon and Gregg (1994) indicate that nurses tend to "take charge" and that social workers insist on a more "confidential nature" of clinical services. However, deParre (1998) stresses that all decisions are inherently "moral," or appropriate for a particular professional framework, no one framework is more or less moral than another. In addition, Emanuel (1991) stresses that physicians and other providers (e.g., nurses) have different missions:

> medicine is devoted to health and the relief of suffering of sick patients, while nursing is personally devoted to caring for the very same patients. This does not mean that caring is not an end of medicine. It is; caring, however is not the primary end of medicine, but the primary end of nursing. (p.17)

Therefore, the amount and type of ethics education for all clinicians should be standardized at a baseline of understanding, specifically the decision processes (i.e., using ethical and religious frameworks), professional ethics issues, clinical ethical issues presented here, and business - organizational - social ethics as presented below.

In addition to the major principles and issues discussed above, there are a significant number of bioethical issues that are confronting and will continue to confront healthcare in the future. The author will not discuss each of the topics presented below due to time constraints, but it is important to discuss the educational and healthcare

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research issues as presented below.  Where the bioethics issues are most important to ethics education is to include those issues as topical areas that need to be incorporated in the cognitive and affective objectives for an ethics education curriculum.  Therefore, during the discussion section of this study, the author will include several of the bioethic topics in the cognitive and affective objectives.

*Bioethics topics potentially confronting healthcare providers.*

The bioethics topics listed here are in no particular order.  Each topic is as important to one provider as another topic is to another provider and their patients or residents.   An ethics education curriculum would be best served if it included a significant number of these topics for student independent research or as group discussion.  The clinical topics identified in the literature include the following; Caring and distributing limited resources to Alzheimer's and related disorders, severe multiple sclerosis, massive burns, paralyzing injury, Parkinson's, and the interventions as a result of living wills, do not resuscitate orders, advance directives, durable powers of attorney (Caplan, 1997; Emanuel, 1991), physician-patient relationships, selection of medical interventions, restoring the health of sick individuals, relieving suffering, promoting the health of the general community (Emanuel, 1991), human cloning, prenatal diagnosis and decisions to carry, new reproductive technology, abortion, competencies and consequences, domestic violence and healthcare consequences, bioethical dilemmas in emergency medicine, deinstitutionalization, older people and access, genetic testing, human experimentation and universal consent, AIDS and research with limited resources, withdrawal of fluids and nutrition, physician assisted death, euthanasia, brain death, rationing of healthcare, equality and inequality of healthcare (Monagle & Thomasma,

1998), truth telling, justice and fairness, a patients right to know, adherence to the mission statements, adherence to professional codes of ethical conduct, management role and responsibilities, legal implications, organizational implications, (Perry, 2002), [dearth of] empirical studies in medical ethics, mental health and DNRs, prenatal diagnosis, confidentiality, genetic screening, genetics, newborns and end of life, abortion, referral of treatment, AIDS, moral reasoning, competence, IRBs, organ donation, truth telling, third party decision making, allocations, transplantations, intensive care units, reproductive technology, compulsory treatment, discrimination , access to care, sexual abuse, substance abuse, insurance, maternal fetal relationships, rationing, surrogacy, home care and poverty, sex selection (Sugarman and Sulmasy, 2001), assisted reproductive cloning, caring for compromised newborns, applications of genetic science, experimental medicine, euthanasia, treatment of the terminally ill, paternalism and autonomy, roles of the courts, governments and professional societies in health care ethics (Flynn, 2000),

Additional bioethics issues as presented by the respective authors are; Harris (1999; 20) "genetics and global justice;" Kuhse and Singer (2001) killing and letting die; Callahan, (2001) terminating life sustaining treatment of the demented; Buchanan (2001) advance directives and the personal identity problem; Gbadegesin (1998) bioethics and cultural diversity; Crosthwaite (1998) gender and bioethics; Chadwick (1988) gene therapy; Murphy, (1988) mapping the human genome; Brook (1998) medical screening and the end of life; McMahan (1998) brain death, cortical death, and persistent vegetative state; Stoffell (1998) voluntary euthanasia, suicide and physician assisted suicide; Myser (1998) bioethics education, genetics, sexism, strikes and collective bargaining, placebos and deception; Benjamin and Curtis (1981) nurse autonomy, professional obligations,

individual responsibility, strikes; Thompson and Thompson (1981) infanticide, abortion IUD (use), sterilization, contraception, ordinary v. extraordinary neonatology, child abuse, adolescent sexuality, adolescent care, assault and battery, false imprisonment, dealing with incompetent practitioners.

*Education of ethics in medicine: from dogma to science.*

Evidence Based Medicine (EBM) and Evidence Based Healthcare Management (EBHM) are two themes (Griffith, 2001) among the many different healthcare related educational frameworks to emerge in the last decade. Using a scientific approach to outcomes education, both EBM and EBHM can incorporate an ethics curriculum that is significantly different from the ancient and current means of teaching ethics in healthcare. Whereas ancient healthcare education taught ethics from a religious dogma framework, current ethics education can better incorporate the variation of ethical frameworks to better represent the variation of patient beliefs. The incorporation of different ethical theories and decision making objectives within an educational curriculum that includes the typology here would significantly increase the variation of ethical knowledge in healthcare.

Below is an historical representation of how ethics education was taught in the clinical domain compared to the current framework. It is provided here to demonstrate that if we do not know from whence we come, we may repeat it (e.g., overemphasis on the clinical ethics domain).

The first Doctorate of Philosophy (Ph.D.) awarded was from the faculty of divinity in Paris about the year 1145 (Atkinson, 1945). That doctorate was based in philosophy with a religious framework and ethical issues as a topic area. Prior to the

time of that first Ph.D., an Aristotelian curricula was followed in most Western instruction that was not based on degrees but disciplines, and included ethics as part of the instruction (Gutek, 1988).

The first Medical Doctorate (MD) degree awarded in the U.S. was from Columbia University in 1770 (Eels, 1963). However, it was not until 1861 that the Ph.D. was awarded in the U.S. from Yale and the first Doctorate in Public Health (Dr.P.H.) from Harvard in 1911 (Eels, 1963). Each of these three degrees may be the most predominate types that clinical instructors hold in the U.S., as determined by this author through an analysis of the respective Internet Websites of the faculty providing instruction for those degrees.

While it is important to know what types of degrees are held by clinical instructors, it is even more important to know if any of those individuals teach ethics education and most importantly what types of ethics is taught beyond clinical ethics. Research could demonstrate that there is a consensus on what should be taught in ethics education, as assessed here in terms of a typology. Future research could determine what is actually taught and the difference between what should and is taught. If there is a discrepancy between what should and is taught in ethics education in healthcare, society may be better off by going back to the disciplines and indicating the need for use of the typology presented here, as one means only of improving ethics education. In relation to the ethics education typology here, the dissemination of it in current curricula at the doctoral level will help improve the ethics education at the provider level. The provider level will be helped through the instruction of the professors holding those doctorates.

*Healthcare Research: Human Subjects and Ethical Implications*

The growing literature on clinical guidelines, especially through EBM and EBHM, should lead to a new era of science based healthcare. According to Caplan (1997), there should be more use of such information, especially EBM, as a means to "grade the care provided to patients" (p.91). What types of grading mechanisms used to assess clinical outcomes is left for future research, but it is important to stress that some form of outcome assessment beyond patient satisfaction will eventually lead to improved care and "caring" in healthcare. Ethics education must be a predominant form of that EBM.

In addition to the EBM and EBHM used to improve care, the data that go into EBM an EBHM must be conducted with care. Again Caplan (1997) helps us understand that it is important to stress how the data were obtained, assessed and used within "moral means." Without such rigorous procedures of peer review research in healthcare, we could have another Nazi concentration camp situation that lead to the Nuremburg Code (Agich, 1998).

The best means of ensuring that healthcare research is conducted within ethical means is to have patient or family consent on the appropriate research. Also, individuals conducting healthcare research must be certified, in addition to the didactic education taught at the doctoral level. One means of certification is through the requirements of the National Institutes of Health (NIH) for all individuals to complete a program on human participant protection education for research (NIH, 2001), as conducted by the author for this study.

Informed consent is a paramount issue for clinicians and those who conduct

research with human subjects.  According to Purtillo (1999) a patient who is:

subjected to an experimental procedure and his or her personal freedom

recognized, he or she must be allowed to grant consent to the procedure. (pp. 196-

199)

Without informed consent, patients have their rights infringed upon and are not

contributing to their own medical decisions (Harris, 1999).  Corey, Corey and Callanan

(1993) stress that consent also includes:

voluntariness [which] means that the person giving consent is acting freely in the

decision making process. (pp. 87-88)

If coercion or incomplete information is provided to the patient (Catalano, 1995) to make

a fully informed decision, than several ethical frameworks are not being utilized (e.g.,

deontology with duty to the patient).

In addition to full disclosure of the disease and consequences of clinical

interventions, O'Donnell (1960) stresses that:

the human subject must be made aware of the full extent of the risks involved in

the [regular interventions or] experiment and he must freely consent to the entire

procedure. (p. 117)

Beyond the individual providers and organizations, federal guidelines exist on the proper

use of consent forms in healthcare.  Agich (1998) discusses specific consent form use

under:

Federal regulations (45 CFR 46 - 116) [that] require consent forms for research

generally involv[ing] the following: 1. The subjects involvement must be

identified as research, and a description of the research and its purposes must be provided, 2. The risk must be described, 3. The benefits must be described, 4. If the investigation is clinical, then diagnostic and therapeutic alternatives must be described, 5. A description must be given of the confidentiality of research records and data, 6. An explanation must be given of the availability or unavailability of compensation or treatment for injury, 7 identification must be made of whom to contact for answers regarding the conduct of the research and the subjects rights as well as who to contact in the event of any injury, and 8. An explanation must be given of the subject's rights to refuse participation and to withdraw from the study. (p. 230)

While clinical ethics education is an important part of the ethics education in total, it primarily focuses on the relationship of the clinical provider and patient. Another important part of ethics education is the relationship of those who work in healthcare organizations on the "business" side of the care.

<div align="center">Business Ethics Education</div>

While healthcare is a service comprised of professionals providing highly technical and deeply personal interventions, there is a significant portion of healthcare that is a business. According to Machan (1990), business is "the institutional expression of … the good deeds people engage in while carrying out prudent endeavors" (p. 99). Following the major principles outlined above in clinical ethics, the good deeds of healthcare may be impacted both positively and negatively by the business component of healthcare.

The author presents business ethics in healthcare as those interactions among individuals who support the direct clinical care. As opposed to organizational ethics where an aggregate of individuals are represented by the organization to individuals and society, business ethics is an individual based unit of analysis. And, the first individual who should set the finest example of business ethics within the healthcare organization is the chief executive officer (Griffith, 2001).

How the chief executive officer interacts with both internal and external constituencies is dependent upon a personal focus of that individual. For example, Worthley, 1997) discusses the different foci that individuals may have when relating to others:

> [the individual has a] locus of analysis with ethical criterion. Individual and egoism = self interest. Individual and benevolence = friendship. Individual and principle = personal morality. Local and egoism = company profit. Local and benevolence = team interest. Local and principle = company rules/ procedures. Cosmopolitan and egoism = efficiency. Cosmopolitan and benevolence = social responsibility. Cosmopolitan and principle = laws and professional codes. (p. 206)

Each of the locus of analysis has different consequences. For example, a cosmopolitan and benevolent leader has a great deal of understanding and commitment towards environmental issues (social responsibility). However an individual does not have to be focused within one of Worthley's types - that individual may use different foci for different situations.

One means of using different foci or locus of analysis is to ensure that a code of ethics is in place that addresses individuals, the healthcare organization and society. Ferrell and Fraedrich (1997) provide a question to leaders to help with the ethics in the business: "[does] the company have a code of ethics that is reasonably capable of preventing misconduct?" (p. 186). In essence, the code of ethics helps ensure proper conduct and avoid many if not all of the major clinical ethical issues.

Not only is the foci important for sound ethical leadership, but there must be an orientation of that foci grounded in outcomes based vision. Crapps (1986) indicates that a good business ethic is founded upon a: "healthy moral development [of leadership that] moves from fear oriented to goal oriented controls" (p. 271). For example, a leader who continuously dominates the process of care as well as the structure may find few who are motivated to whatever vision, if there is one, that the leader and business has set. Rather than intimidate, the leader could give a vision with expectations and provide ethical guidance on meeting that vision (Beauchamp & Childress, 1989).

Leaders in healthcare must not only lead, but they must also manage. Paul and Elder (2003) provide a list of required ethical management styles that are important to the success of a healthcare business:

1. Going beyond what is obligatory to improve the lives of others; generous, unselfish, charitable, altruistic, philanthropic, humanitarian, benevolent, 2. Dealing with people objectively in order to be fair; understanding impartial, equitable, unbiased, dispassionate, objective, 3. Relating to people in ethically appropriate ways; civil, polite, courteous, respectful, forbearing, tolerant, tactful, 4. Being forthright and honest, honest, truthful, integrity, loyal, faithful,

trustworthy.5. Relating to people in commendable ways; friendly, obliging, cordial, kind, gentle, gracious, tender, warm, warm-hearted. 6. Being willing to forgive in order to alleviate suffering; forgive, pardon, absolve, exonerate, compassionate, merciful, 7. Acting out of a concern to behave ethically; scrupulous, honorable, upright, open-minded, evenhanded, 8. Acting out of a concern for the feelings of others; sympathetic, empathetic, understanding, compassionate, and considerate. (p. 19)

Maintaining a high ethical base, and knowing the different ethical frameworks provided above, requires vigilance and sacrifice on the part of the leader. It is not easy to make the right decisions in the face of the easy ones, especially when the leader may not be the one with the final or fiduciary authority. Baier (1958) indicates that a change agent can be within any level of organization and:

is a person who is determined to do whatever is morally right and to refrain from doing whatever is morally wrong. It is an outstanding characteristic of morality that it demands substantial sacrifices. (pp. vi-1)

One sacrifice might be that the individual cannot "agree to disagree" with the business climate of an organization and must leave the organization in order to sustain their own moral beliefs.

Going beyond one's self and knowing when to maintain ethically sound behavior in others is a fine art acquired from both education and experience. Ross, Wenzel and Mitlyng (2002) support the need for maintaining ethical standards in others when they indicate that:

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the leader should pay attention every day to the ethical behavior of all of the

members of his or her staff and serve as an example beyond reproach. (p. 353)

The leader is, however, not the only individual in the healthcare business who must

maintain an appropriate business ethic. All individuals in the business, including

clinicians, must know what the business ethics are in their healthcare organization.

Business ethics can be presented from many different perspectives. The difficulty

for all employees in a business is that they may not know the ethical framework to which

they are expected to uphold, and that situation goes back to strong leaders who must

ensure that the vision and ethics are known throughout the business.

In addition to principles, the healthcare business has responsibilities. Shaw and

Barry (1998) provide several business responsibilities as:

1. Business should give safety the priority warranted by the product, 2. Business

should abandon the misconception that accidents occur exclusively as a result of

product misuse and that it is thereby absolved of all responsibility 3. Business

must monitor the manufacture [and service] process itself, 4. When a product [or

service] is ready to be marketed, companies should have their product safety staff

[or risk managers in services] review their market strategy and advertising for

potential safety problems, 5. When a product [service] reaches the marketplace,

firms should make available to consumers written information about the products

[services] performance, and 6. Companies should investigate consumers

complaints. (pp. 466-468)

How leaders ensure that the ethical principles and responsibilities are obtained and sustained can be supported by using the different ethical, religious and decision making ethical processes, and at times that are appropriate.

Although not an ethical theory, the ethics of neutrality is a means of ensuring appropriate ethical principles and responsibilities, and that may be in conflict with a leader's own convictions. According to Thompson (1988) the use of "ethics of neutrality" may lead to "administrators" who:

> act neutrally in the sense that they should follow not their own moral principles but the decisions and policies of the organization. Three sets of outcomes may be brought against the ethics of neutrality; 1. Because the ethic underestimates the distinction that administrators exercise, it impedes the accountability of administrator as citizen, 2. That office holding implies consent to the duties of office as defined by the organization, and 3. It limits their course of actions to two - obedience or resignation. (p. 30)

If the leader is able to balance when to ensure their own convictions or morals to guide the ethics of the business, along with the appropriate amount of neutral ethics, than the healthcare business usually has a steady state of care processes. However, when the inappropriate mix of individual morals and neutral ethics are used, the healthcare business is in conflict, and either the business must be set straight or the leader is set "packing." Knowing how to balance should not be based on experience alone, but rather using education as a means to understanding the development of business ethics and to not repeat problems from the past.

The evolution of business ethics has significantly increased since the 1960s and has grown out of a religious base. DeGeorge (1987) presents how business ethics has changed in the latter part of the previous century into:

a guiding behavior in the world of business. The study of business ethics in North America has evolved through five distinct stages 1. Before 1960, 2. The 1960s, 3. The 1970s, 4. The 1980s, 5. The 1990s [and beyond]. Until 1960; ethical issues related to business were often discussed theologically. The Protestant work ethic encouraged individuals to be frugal, work hard and attain success in the capitalistic system. The 1960s: the rise of social issues in business. This period witnessed the rise of consumerism, activities undertaken by independent individuals, groups, and organization to protect their rights and as consumers. Activities that could destabilize the economy began to be viewed as unethical and unlawful. The 1970s; business ethics as an emerging field. Corporate social responsibility. Business became more concerned with their public images, and as social demand grew, many businesses realized that they had to address ethical issues more directly. The 1980s; consolidation. Methods for discerning best practices and tactics to link organizational practice and policy to successful ethical compliance. Codes of conduct had to be understandable with details provided on more subjective areas. The 1990s; institutionalization of business ethics. Codifying into law incentives for organization to take action, such as developing internal ethical compliance programs to prevent misconduct. (p. 7)

Where is business ethics in healthcare heading ? Visotzky (1996) helps answer that question when he asks:

what price did morality cost? Was life a matter of simply avoiding situations

where the currency of morality was tested too severely? Were there hard and fast

rules, or did situations change the ethics we held dear? (p. 26)

Each of those questions can help leaders determine their own vision and to choose what

ethical theories, religious frameworks and decision making ethical processes that are

important to their respective healthcare organization.  And, it is that organizational level

that the leader and all employees must ensure has an ethical framework, otherwise the

shifting sands of technology and reimbursement will surely and possibly sorely make the

future for that organization.

<div align="center">Organizational Ethics Education</div>

Using an analogy of the definition of ethics as the aggregate of individuals'

morals, organizational ethics is an aggregate of the different group ethics and individual

morals within an organization.  With a significant amount of variation among groups in

terms of ethical codes and individual values within a healthcare organization, the

organizational ethics can at best be focused but still varied and chaotic in the worst

situation.

Worthley (1997) helps readers understand the different levels of ethics when he

discusses power levels as:

macro (organizational) micro (individual) and subtle micro (individuals and

indirect). (p. 165)

Those different levels of power coincide with the different levels of business and

organizational ethics in healthcare.  Whereas the individual may represent what the

business should do in terms of ethical vision, the organization may not as a whole go in

that direction, it may be headed in an entirely opposite direction if the aggregate is different from the leader.

How to build organizational ethics that are focused yet allow for variation may best be described by Paine (1997) when he provides four tasks that must be accomplished:

> Task one - developing the ethical framework, task two - aligning the organization with leadership and supervision, hiring and promotion, performance evaluation and rewards, employee development and education, planning and goal setting, budgeting and resource allocation, information and communications, audit and control. Task three - leadership by example. Task four - addressing external challenges. (p. 99-103)

And Hoffman and Nelson (2001) support those tasks by indicating that in addition to strong business ethics from the leader there must also be a "planning" and "ongoing monitoring" process in the organization to improve the ethical decision making.

Another supporter of the Paine, and Hoffman and Nelson frameworks is Griffith (2001) when he presents how a "well run" organization is conducted within a virtuous framework:

> 1. Moral leadership is essential, 2. Sound systems and procedures encourage virtuous acts, 3. Behavior that is not virtuous must be identified and discouraged, 4. workers should be empowered to the greatest extent possible, 5. The organization should offer moral counsel and support, 6. The organizations visible incentives, nonmonetary and monetary should be based on reward more than blame, 7. Standard methods of persuasion should be used for moral issues, 8.

Leadership should be selected and promoted [based on] moral and nonmoral competence. (p. 7)

Griffith also points out that the virtuous organization has to be held accountable for its actions beyond the business ethics of the leaders, a difficult situation when malpractice cases are usually decided on who has the deep pockets.

In addition to ensuring individual business ethics are appropriate for the organization, the organization must ensure that there is a minimal amount of power abuse, or none if possible. With power comes the "dual edged sword" of possible abuse, and ethics can help decrease that abuse. Hoffman (2001) helps leaders and all employees take note on how to decrease power imbalance, a very important note when the service is to vulnerable clients or patients:

1. Recognize the inadequacy of well-intentioned rhetoric, including organizational value statements unaccompanied by explicit programs to reinforce them, 2. Develop and implement a code of conduct for management, staff and physicians, 3. Perform periodic ethics audits that include questions about abuse of power, 4. Prepare a casebook with descriptions of unacceptable behavior and constructive interventions and use it in management orientation and training sessions. 5. Conduct educational programs to promote candid discussion of those issues. 6. Establish and encourage the use of a hotline to report inappropriate behavior. 7. Sanction improper behavior promptly, 8. Encourage the referral of physician problems to the medical staff's physician advising committee, 9. Emphasize the importance of sensitivity to the values of patients, families, and staff in routine employee performance appraisals. (p. 22)

Organizational ethics committees can help implement these strategies as indicated below. The first step towards having appropriate ethics committees is providing an organizational ethic.

According to Caplan (1997) organizational missions provide an awareness of the access to healthcare and the distribution of caring within a healthcare organization:

> When patients have no health insurance or cannot meet the requirements for copayment, they have reason to wonder when the doctors say all that can be done, has been done. (p. 91)

If indeed the mission is non-profit, than the healthcare organization can be trusted when they say "no more." The difficulty in for-profit healthcare organizations is keep the trust when they say "no more" and patients know that more is available.

Trust is created in healthcare organizations, beyond the leaders and providers, in part by ethics committees. The public can better trust a healthcare organization if it knows as a whole that not one individual is trying to create trust, but rather the entire organization. Monagle & Thomasma (1998) help illustrate this trust building when they present the basic roles of the ethics committees as:

> 1. Education, 2. Multidisciplinary discussion, 3. Resource allocation, 4. Institutional commitments, 5. Policy formulation, and 6. Consultation. (pp. 460-461)

Veatch (1983) provides examples of how ethics committees can focus their orientation towards building trust:

> 1. Autonomy model - implements decisions of competent patients whose wishes are known, 2. Social justice model - grapples with broad issues such as

organizational health care policy, resource allocation, and cost effectiveness, and

3. A patient benefit model - makes decisions for patients who are unable to make

decisions for themselves.  (p. 77)

Hinderer and Hinderer (2001) indicate further that more is needed in terms of improving

or even establishing institutional review boards and ethics committees (IRBs and IECs).

Individuals who are on ethics committees must be knowledgeable not only of the

healthcare topics but the ethics frameworks that may be used to make appropriate

decisions.  Nelson (2001) provides several recommendations on improving ethics

committees by indicated that those committees:

should be populated by individuals who possess some level of knowledge in: 1.

Moral reasoning and ethical theory, 2. Common bioethical issues and concepts, 3.

Healthcare systems, including knowledge of managed care and governmental

systems, 4. Clinical context, 5. Your healthcare organization, including the

organization's mission statement and structure, 6. Your healthcare organization's

policies, 7. Beliefs and perspectives of the local patient and staff population, 8.

Relevant codes of ethics and professional conduct and guidelines of accrediting

organizations, and 9. Relevant health law. (p. 208)

Without organizational leadership and organizational commitment from all

employees for sound, valid and reliable ethical frameworks and committees, the type of

healthcare provided will be low quality with reciprocal effects upon employees.  Boyle et

al. (2001) indicate that "ethical problems" can result in a wholesale fashion (e.g., greed,

cover-up, misleading).  How and to what degree those issues arise can be improved or

reduced by having organizational ethics better known throughout the entire organization.

Kellar (1988) makes a distinction between internal and external ethical decision making when he indicates that:

public and private acts which relieve individuals of responsibility for acts

undertaken in their public role fails because individuals generally gain some

personal benefit from performance of their public or organizational role. (p. 24)

Whereas individuals may gain from ethical decisions unconsciously, it is the worst kind of ethical decision making when the outcomes are known and the ethical decision process is overtly warped to gain those personal benefits. Several professional codes discussed earlier prohibit their professionals from having those personal gains (e.g., American College of Healthcare Executives for health administrators). Bowman and Menzel (1998) further stress that ethics in organizations must be fully known by all employees and include knowledge on the following;

duties, organizational efficiency, conflicting rights, competitive costs, risk

sharing, punitive damages [when wrong decisions are made], institutional

shareholders, stakeholders, management, justice. (p. 77)

At least three programs were found in the literature on how to improve organizational ethics in a healthcare organization. Perry (2002) presents a process of improving organizational ethics as recommended by the Ethics Resource Center in Washington, D.C.:

1. Assess organizational values and vulnerabilities to misconduct, 2. Create

opportunities for management to discuss organizational values or risks, 3.

Develop and communicate clear standards of conduct, and 4. Refine management

systems and practices to support the ethics programs. (p. 189-191)

A second strategy for improving organizational ethics is presented by Whitley and

Heeley (2001):

> To develop an ethics program…some strategies you might consider include: 1.
> Adopting a continuous quality improvement approach to communicating and
> living your organization's mission and core values, 2. Training senior executives
> to incorporate ethical considerations into daily activities and interactions with
> staff, 3. Educating staff, through large group presentations and small group
> discussions, on the ethics plans, 4. Developing tools and techniques for including
> ethics as a criterion for hiring and promotion, and 5. Including ethics on every
> meeting agenda throughout the organization. (p. 202-203)

And, a third means of improving organizational ethics is presented by Carroll (1991) as

indicated through:

> corporate social responsibility; 1. Philanthropic: be a good corporate citizen.
> Contribute resources to the community, improve quality of life. 2. Ethical; be
> ethical. Obligations to do what is right, just and fair. Avoid harm. 3. Legal; obey
> the law. Law is society's codification of right and wrong. Play by the rules of the
> game. 4. Economic; be profitable. The foundation upon which all others rest. (p.
> 68)

Each of those three means of improving organizational ethics are representative of

different means of improving healthcare in general. However, no matter how much the

organizational ethics are known, it is still individuals who must ensure that organizational

ethics are sustained, improved upon and increasingly known to all employees. Ross,

Wenzel, and Mitlyng (2002) conclude best on organizational ethics as a means to improve healthcare when they stress:

how leaders act shows the importance they place on organizational ethics.

References to the organization's ethics, as a basis for decision making, builds

credibility and support for ethical behavior in the organization. (p. 131)

Aggregating individual morals and creating professional environments, developing strong ethically sound clinical interventions, ensuring that valid business and organizational ethics are in place are the framework for appropriate social ethics. Below is a presentation of how social ethics is founded not only in the individual and organizational ethics units of analysis, but also at the community ethics level of analysis.

Social Ethics Education

Social ethics as presented here, is comprised of two levels, the national and global. However, each level has two components as described by Sommers (1993):

Social morality is only half of the moral life; the other half is private morality.

Through education 1. Schools should have behavior codes that emphasize civility,

kindness, self-discipline, and honesty. 2. Teachers should not be accused of

brainwashing children when they insist on basic decency, honesty and fairness. 3.

Children should be told stories that reinforce goodness. In high school and

college, students should be reading, studying and discussing the moral classics.

(p. 3-13)

Of course, along with morality, the description of values, ethics and law should also be discussed in both high school and college and how they relate to conduct; "Conduct cannot be made good or bad by law; but its goodness or badness is to the last determined

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by its effect as naturally furthering, or not furthering, the lives of citizens. Ethics becomes nothing else than a definite account of the forms of conduct that are fitted to the associated state" (Spencer, 1895; p. 53).

At the national level, and especially in the U.S., there is no one ethical code or "ethos" to follow. As presented above, there are numerous ethical theories, religions and ethical decision processes that are used, and allowed due to our freedoms, in the U.S. and therefore in healthcare organizations. Solomon (1996) presents how this "pluralism" in the U.S. affects individuals and society:

> We live in an ethically pluralistic society. This means that there are no single codes of ethics. We should … look at the ideals of a particular society or what inspires and ultimately motivates its most admirable members. What is missing on our ethics, in other words, is a sense of an ethos, an already established and agreed upon way of living in which values are shared. (p. 6-131)

Although one could argue that the U.S. was founded on Judeo-Christian beliefs, there were several other religions that were here before the European settlers (i.e., Native Americans) and since that time, several other religions and ethical theories have changed the "ethos" that is part of the American social fabric. Within that fabric, healthcare organizations have employees and independent providers with their own ethical positions, as well as the patients that are cared for who have their own ethical perspectives on care. The result is a significant variation of ethical thought in the society and thus in the healthcare organization. Without knowing those ethical theories and religions, the care provided in healthcare organizations may not be meeting the variation of ethical thought in society, a social inequality of thought and care.

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DeVitis and Rich (1996) support the variation of U.S. social ethics in healthcare when they discuss a service orientation:

service ethics in America is an abiding faith in human potentiality in solving rational problems… by communitarian mosaics of social responsibility. (p. 66)

Supporting this mosaic of social responsibility, Lodge (1977) indicates that:

traditional ideology of the United States [is] 1. Individualism, 2. Property rights, 3. Competition - consumer desire, 4. Limited states, 5. Scientific specialization and fragmentation [is changing to a] New strategy; 1. Communitarianism, 2. Rights and duties of membership, 3. Community need, 4. Active, planning states and 5. Holism [or] interdependence. (p. 145-149)

The increase in communitarianism within healthcare may or may not be true depending on who is receiving care, those who have health insurance that is the best, quickest and cheapest (e.g., low copayments) or those without health insurance (at over 42 million) who have to rely on handouts, the use of expensive emergency room care for minor illness or no healthcare at all.

How to improve the communitarian "ethos" in the U.S. includes a redefining and increased knowledge of what morality and ethics are, through both education and on the job.  McCoullough (1991) notes that society can improve the knowledge base of ethics through business:

industrial society is a communal society not only because of the frictional interdependence of its members but also because of the moral quality of their mutual relations. (p. 44)

However, the basis of ethics education, especially in healthcare, can improve most significantly if it is inculcated in the didactic and clinical components of healthcare education with orientation towards the roles that healthcare providers will be ethically responsible individuals (Kamm 1992). That inculcation must also use both cognitive and affective domains in the educational process rather than relying solely or disproportionately on the cognitive domain alone.

Different schema exist on changing the social ethics in U.S. healthcare. Emanuel (1991) presents four possible health schemes that utilize a variation of ethical theories:

1. This is roughly the current system. 2. This system would eliminate life saving care for the elderly but provide more palliative care for their chronic diseases, 3. This system would focus medical care on conditions in which there is real chance for an independent autonomous life, a chance to pursue projects, and plans and 4. This system would focus medical care in the most cost-effective manner not on the basis of particular diseases or disabilities. This is akin to the British NHS. (p. 94)

Each of the schema beyond number one above would require social input and a vote on how to arrive at the respective framework, with a significant amount of discussion beforehand. However, the current schema does not fit the social desires of those who are without healthcare and society must take some position, even if it is to announce that the current scheme is the social "way," and do it with full acknowledgement rather than a de facto approach that we are currently under in the U.S.

How can the U.S. society come to a conclusion on the social policy for healthcare? Bougle (1970) provides insight on how we might start to decide what social policy we want towards U.S. healthcare:

> The group interest always comes first. It is this which commands individuals to act contrary to their desires, to master and sacrifice themselves. It is the measure, the beginning and the end of all morality. (p. 25)

Until a measure is made to fully disclose the plight of those without healthcare, the "group interest" will not be known in the U.S. and the plight will continue.

Beyond the U.S. social healthcare "ethos," or lack thereof, the largest social domain is at a global level. Kung (1990) indicates that we must have not only a responsibility within our society but also at a "planetary" level. Of course, if each of the ethics directly above would be in place, we would have a significant decrease in the needs for healthcare. For example, if non-violence was in place, the amount of genocide and effects upon not only acute but behavioral healthcare would subside (e.g,. use of psychological and psychiatric care).

> Beyond a religious declaration, Donaldson (1997) indicates that there are: fundamental international rights; 1. The right to freedom of physical movement, 2. The right to ownership of property, 3. The right of freedom from torture, 4. The right to a fair trial, 5. The right to non-discriminatory treatment, 6. The right to physical security, 7. The right to freedom of speech and association, 8. The right to minimal education, 9. The right to political participation, and 9. The right to subsistence. (p. 555)

Donaldson provides insight on how we might provide less healthcare and redistribute limited healthcare resources to those most in need. If there was at least a decrease in the amount of torture at the global level, there would be less acute care interventions and behavioral care and more resources for prevention (e.g., polio vaccines).

Changing the U.S. social policy towards healthcare may take several years or decades, and it may take even longer to change at the global level. With a significant amount of variation in ethnic and racial composition at the global level, the change in attitude may take generations, however we may be able to change behavior to some degree in this generation. By simply knowing the different perspectives, we can decide which is most appropriate. For example, Corey, Corey and Callanan (1993) indicate that there is:

> ethnicity of identity that stems from common ancestry, nationality, religion or race. Minority group category of people who have typically been discriminated against or subjected to unequal treatment and oppression by society. A comparison of the western and eastern systems [helps us understand the different ethical perspectives]: West: Primacy of individual, Democratic orientation, Nuclear family orientation, Emphasis on youth, Independence, Assertiveness, Nonconformity, Competition, Conflict, Freedom, Morality in Person. East: Primacy of relationships, Authoritarian orientation, Extended family orientation, Emphasis on maturity, Interdependence, Compliance, Conformity, Cooperation, Harmony, Security, Morality in relationships. (p. 241)

Bringing the two divergent frameworks together means severe discourse, and this dichotomy alone does not do justice to the many different perspectives that exist at the global level.

In addition, the two frameworks may not work together while they are "merged." For example, Callanan, Meulen and Topinkova (1995) indicate that:

> the introduction of such a two-tiered system in health care [private pay and quasi-socialized healthcare] is often criticized as a danger to solidarity and quality, which are basic values for European health care systems. (p. 81)

It may be necessary to keep one system in place at the national level, while the global level determines first what direction to take. After a global perspective has taken shape, then the U.S. healthcare system would have a significant reason to follow the rest of the globe. Or it may be that we are already at the point of a global perspective of universal healthcare, which currently exists in all industrialized countries except the U.S.

Raising the social conscience to a global perspective may take several generations if we continue at the current rate of ethics education. However, Scherer (1974) indicates that a "Global consciousness" could occur much sooner if we all had:

> 1. A personal awareness or knowledge of something, 2. That is shared with others and 3. Relates to the globe as a whole. (pp. 8-9)

That "something" is a situation where a significant proportion of the global population has very little access to healthcare, as indicated by our own national level statistics. We may need to start, however, with those very individuals who have no access. According to Altman, Reinhardt and Shields (1998) we may need to start with:

the difference principle, [whereby] society is better off only when it makes its least well-off people better off.  If societies believe that equal access to either health care services or equal access to good health is necessary in the name of social justice, then there is a clear cut justification for universal health insurance. (p. 391)

The author has presented the literature supporting the need for a typology of ethics education in healthcare, as indicated by the amount of literature that is separate and not focused in one manuscript.  Also, there are no indicators of the hierarchy of ethics education objectives that Bloom's taxonomy helps create.  Thus, the connection with Bloom's taxonomy is important in respect to creating the typology here and the literature reviewed.

In addition, the specificity of the ethics education in healthcare may be best in the cognitive educational domain with the number of clinical domain topics.  But it is clearly less specific in the affective educational domain and especially within the business, organizational and social ethics domains.

Directly below, the author presents how the specificity of ethics education is minimal within the requirements for accreditation of healthcare education programs.  As indicated, the three most arguably powerful professions are discussed in healthcare, in terms of scope of practice (i.e., physicians), the numbers of providers (i.e., nurses), and the ultimate responsibility for the daily operations of healthcare organizations (i.e., health service administrators).

Healthcare Accreditation Programs - An Overview

Each healthcare provider or administrator is either required by law or the market to obtain some form of didactic education as well as possibly pass a licensure examination before they can practice.  In the case of physicians, they have the most stringent licensure requirements and thus have the most regulated educational requirements within healthcare.  Accordingly, medical graduates must be from an accredited medical college in order to sit for their respective licensure examination. International medical graduates must pass other examinations and programs that are essentially the same in terms of domestic clinical education.

There are two major forms of physicians in the United States that are allowed to have admitting privileges in all 50 states, namely allopathic physicians with either a Medical Doctorate (MD) degree or Doctorate of Osteopathy (DO) degree.  Those two physician types share many of the same accreditation requirements for their respective degrees, therefore the author chose the one predominate form of allopathic education to study here, which is the MD degree (as indicated by the shear number of programs at 127 versus only 28 for the DO degree).

*Allopathic Medicine: Ethics Education Accreditation Requirements*

According to the Liaison Committee on Medical Education (LCME) there is a specific requirement for ethics education in medicine.  That requirement by the LCME (2003) states:

A medical school must teach medical ethics and human values, and require its students to exhibit scrupulous ethical principles in caring for patients, and in

relating to patients' families and to others involved in patient care: Each school

should assure that students receive instruction in appropriate medical ethics,

human values, and communication skills before engaging in patient care

activities. As students take on increasingly more active roles in patient care

during their progression through the curriculum, adherence to ethical principles

should be observed and evaluated, and reinforced through formal instructional

efforts. In student-patient interactions there should be a means for identifying

possible breaches of ethics in patient care, either through faculty/resident

observation of the encounter, patient reporting, or some other appropriate method.

'Scrupulous ethical principles' imply characteristics like honesty, integrity,

maintenance of confidentiality, and respect for patients, patients families, other

students, and other health professionals. The school's educational objectives may

identify additional dimensions of ethical behavior to be exhibited in patient care

settings. (p.13)

The above ethical education requirement is the most prescriptive of those reviewed.

*Nursing: Ethics Education Accreditation Requirements*

Unlike physicians, nurses have only one form of licensure outcome and that is a

Registered Nurse (RN). Although Licensed Vocational or Practical Nurses (LVN or

LPN) provide a significant amount of nursing care, it is the RN who is ultimately

responsible for nursing care planning and daily care operations.

Nurses have several types of education, with the oldest type as the diploma nurse

that was historically based in a hospital setting. Few diploma programs still exist, with

the majority of programs at the Associate or Bachelor degree level (NLNAC, 2003).

Similar to physicians, nurses have two main accrediting bodies for the different types of nursing programs in the United States: 1. The National League of Nursing Accrediting Commission (NLNAC), and 2. The Commission on Collegiate Nursing Education (CCNE). The former was chosen to assess since it has the most specific ethical requirements found by the author.

According to the NLNAC (2003), the core competencies for ethics education in nursing programs are:

Exhibit ethical behaviors in all professional activities [that will]

- Embrace a personal ethic of sound responsibility and service

- Provide counseling for patients in situations when ethical issues arise

- Participate in discussions of ethical issues in health care as they affect communities, society and health professions. (p. 86)

Those ethics education guidelines, although minimal, are far more specific than those found in health services administration accreditation requirements.

*Health Services Administration: Ethics Education Accreditation Requirements*

Although there may be as many as 200 or more health services administration programs in the United States (Personal communique, Jeptha Dalston, President of the Association of University Programs in Health Administration, June 2003), there are only 85 that are approved for membership into the Association of University Programs in Health Administration (AUPHA). The AUPHA is the sister organization for the Accrediting Commission on Education for Health Services Administration (ACEHSA) that is the only body approved by the Department of Education to accredit graduate programs in health services administration in the United States. And there are only 65

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programs in the AUPHA that have received accreditation from the ACEHSA (ACEHSA, 2003).

According to the ACEHSA (2003), the ethics education accreditation requirements are minimal and indicate that health services administration programs must have:  Legal and ethical analysis applied to business and clinical decision making, (p. 5) Obviously, there is a significant difference among the three ethics education accrediting requirements assessed here, with the medical ethics education as the most prescriptive and the health services administration accrediting requirements as the least specific. Therefore, with little incentive from accreditation standards for ethics education in healthcare, a more focused and hierarchical method is suggested to help alleviate the ethical problems found in healthcare.

<div align="center">A Call for More Ethics Education Specificity</div>

As indicated in the literature review and the accreditation review here, there is a clear lack of focus and a hierarchical relationship of the ethics education objectives. In all of the literature reviewed there is no indication of a single source that provides a logical and basic framework or foundation for the study of or development of ethics education in the healthcare field.  In addition, this accreditation review indicates a clear lack of specificity in ethics education requirements for those who are entering the healthcare field.  The author therefore believes that there is a call for more specificity in the ethics education in healthcare and discusses that conclusion in the results chapter below.

CHAPTER IV

RESULTS AND THEORETICAL FRAMEWORK FOR ETHICS EDUCATION

TYPOLOGY

This chapter focuses on the material reviewed to answer the two research

questions. Both research questions indicated a positive result, namely that there is a need

for an ethics education typology in healthcare and that more specificity in ethics

education is needed. An ethics typology of objectives is also provided due to the

affirmative answer for research question two.

Research Question One: Is There a Need for an Ethics Education Typology?

From the author's own experience and interaction with those who also have over

20 years in healthcare, as well as the literature and accreditation reviews, there appears to

be a convincing need for a typology of ethics education in healthcare. Several indicators

provided a basis for the need: 1. There is not one manuscript that brings together the six

domains required for an adequate knowledge base of ethics education in healthcare, with

the exception of the Porter and Schick (2003) article, 2. No one compendium of

manuscripts brings together the six ethics domains and the cognitive and affective

educational domains so that educators can use it for creating ethics education objectives

in medical, nursing or health services administration graduate programs, and 3. The

ethics education accreditation requirements for medicine, nursing and health services

administration graduate programs are sparse, therefore creating little incentive for ethics

education instructors to follow a framework for ethics education other than their own research.

Each of the three indicators above provide adequate incentive for creating a typology of ethics education in healthcare, and the three of them combined provide significant reason for creating the typology. The reasoning demonstrated by the combination of the three indicators is founded on the face validity request for the typology, a construct valid framework that uses Bloom's taxonomy, and the limitations on a hierarchy of objectives whereby those entering the healthcare field are ensured of having adequate preparation in ethics decision making as well as while they are in the field (e.g., continuing education). More importantly, the literature and accreditation standards are so widely disparate among the healthcare professions, and the lack of direction for creating the ethics objectives is clear, that any attempt to improve healthcare outcomes that are ethically related without a typology would be nefarious and difficult.

Research Question Two: Is There a Need for Increasing Ethics Education Specificity in Healthcare?

As indicated in the previous two chapters, there is a need for increasing the specificity of ethics education in healthcare. Several indicators point to that conclusion: 1. The literature does not provide specific educational objectives for ethics education in healthcare that cover the cognitive and affective domains, with the exception of the Porter and Schick (2003) article and indirectly in the Vanek (1990) dissertation, and therefore it is difficult to prepare and create ethics education objectives from the topics identified with the result of a bias towards bioethics objectives covered in different healthcare programs, 2. No one compendium of manuscripts provide ethics education objectives in

the six domains of ethics education, 3. There is no logical form or typology around which to organize the instruction of and the study and development of a comprehensive system of ethics education in healthcare, and 4. The accreditation requirements for medicine, nursing and health services administration graduate programs provide no specific ethics education objectives, with the exception of medicine where specific clinical objectives are provided. Even within medicine, where one domain of clinical ethics education objectives are required and provided, that is still only one-sixth of the domains required to adequately understand ethics education, at least within the typology presented here.

As a result of the indicators above, the specificity of the ethics education in healthcare is minimal at best, although an occasional program may provide a significant amount of ethics education due to a professor's autonomy to include ethics education beyond one or two domains. With the degree of ethics education objectives at a minimal degree of specificity, it is clear that there is a need to further specify the ethics education in healthcare. Therefore, the author attempted to increase the specificity of ethics education in healthcare by providing 270 objectives along the framework of the six ethics domains and two educational domains discussed previously.

*A Typology of Ethics Education in Hierarchical Form*

Based on the Porter and Schick (2003) framework of six ethics education domains, the specificity of ethics education in healthcare is improved here through the creation of cognitive and affective objectives for all of the levels, sub-levels, and sub-sub-levels. Those objectives are based on the topics and issues presented in the current literature and accreditation standards reviewed.

Porter and Schick provided one objective for each of the ethics domains within the first level of cognitive and affective educational domains, except for the business ethics objectives. They provided a total of 55 objectives, and those 55 objectives are reprinted here with permission and are noted with an asterisk (*). Appendix A provides the approval for the use of the Porter and Schick objectives here.

The author further specifies the Porter and Schick framework by providing one objective for each of the six ethics domains within each of the 45 levels and sub-levels found in the cognitive and affective educational domains - for a total of 270 objectives. Further refinement and research is suggested beyond the 270 objectives provided here by including all of the topics and issues for each of the six ethics domains within the context of the 45 levels and sub-levels of the cognitive and affective educational domains. Clearly, that research would be ongoing and a "living" typology similar to the biological typology of kingdom, phylum, class, order, family, genus, species and sub-species that biology courses include at the undergraduate level. An additional suggestion based on that biological framework, is to include the typology presented here for every undergraduate and graduate level program in healthcare. The number of objectives would reflect the level of degree (i.e., doctoral level with highest number of objectives).

A hierarchical presentation of the cognitive and affective levels, sub-levels, and sub-sub-levels are provided in Table 6 so the reader can better follow how the narrative hierarchy of the objectives are presented. Each level, sub-level, and sub-sub-level objectives reflect a variation of topics found in the literature review; one topic could be followed for each hierarchical level when creating more objectives per level, or the framework here could be followed when further developing the "living" typology.

Table 6 and the subsequent narrative and objectives in Tables 7 and 8 that follow, are

based on the original Bloom et al. work whereby the levels, sub-levels, and sub-sub-

levels are numbered according to the original taxonomy.   Rather than follow a more

current hierarchical framework such as the American Psychological Association (2001),

the author presents the objectives in their original hierarchical order.

Table 6

Bloom et al.'s Cognitive and Affective Domains with All Levels

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Cognitive Domain

| First Level | Sub-Levels | Sub-Sub-Levels |
| --- | --- | --- |
| 1.00 Knowledge; | 1.10 Knowledge of Specifics | 1.11 Knowledge of Terminology |
| | | 1.12 Knowledge of Specific Facts |
| | 1.20  Knowledge of Ways and Means; Dealing with Specifics | 1.21 Knowledge of Conventions |
| | | 1.22 Knowledge of Trends and Sequences |
| | | 1.23 Knowledge of Criteria |
| | | 1.24 Knowledge of Methodology |

|                          |                                    | 1.31 Knowledge of         |
| ------------------------ | ---------------------------------- | ------------------------- |
|                          | 1.30  Knowledge of Universals       | Principles and            |
|                          | and Abstractions in a Field        | Generalizations           |
|                          |                                    | 1.32  Knowledge of         |
|                          |                                    | Theories and              |
|                          |                                    | Structures                |

2.00 Comprehension; 2.10  Translation

2.20  Interpretation

2.30  Extrapolation

3.00 Application;     None

4.00 Analysis;        4.10  Analysis of Elements

4.20  Analysis of Relationships

4.30  Analysis of Organizational

Principles

5.00 Synthesis;       5.10  Production of a Unique

Communication

5.20  Production of a Plan, or

Proposed Set of Operations

5.30  Derivation of a Set of Abstract

Relations

6.00 Evaluation;      6.10  Judgments in Terms of Internal

Evidence

6.20  Judgments in Terms of External

Evidence

Affective Domain [Author's Note: Hierarchy Change]

1.0 Receiving;  1.1  Awareness

       1.2  Willingness to Receive

       1.3  Controlled or Selected Attention

2.0 Responding;  2.1  Acquiescence to Respond

       2.2  Satisfaction in Response

3.0 Valuing;   3.1  Acceptance of a Value

       3.2  Preference for a Value

       3.3  Commitment

4.0 Organization;  4.1  Conceptualization of Value

       4.2  Organization of a Value System

5.0 Characterization

 by a Value or

 Value Complex 5.1  Generalized Set

       5.2  Characterization

_____

Note: Adapted From Bloom (1956); Krathwohl, Bloom & Masia (1964)

Bloom Revisited: Cognitive Objectives for Ethics Education in Healthcare

The following tables 7 and 8 present the 270 cognitive and affective objectives

created by the author to initiate a typology on ethics education in healthcare.  Table 7

presents the cognitive objectives within the six ethics domains, while table 8 presents the

affective objectives within the six ethics domains.

Table 7.

Bloom et al.'s Cognitive Domains with All Levels and Objectives in the Six Ethics

Education Domains (Original Porter and Schick objectives reprinted here with permission

and noted with an asterisk *).

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Cognitive Domain

First Level

1.00    Knowledge; 1.00 Decision Ethics: Define "ethical dilemma" as presented

by the instructor or book*  1.00 Professional Ethics: Describe the elements

contained within a professional code of ethics and its purposes*  1.00

Clinical Ethics: Define informed consent and list the elements of an

informed consent form*  1.00 Business Ethics: Define business ethics

within a healthcare setting as presented by the instructor 1.00

Organizational Ethics: Define organizational ethics in healthcare settings

as determined by the instructor or course book*   1.00 Social Ethics:

Define distributive justice as presented by the instructor or course book*

Sub Level

1.10    Knowledge of Specifics; The degree of specifics at this level is

general, with the sub-sub-levels providing more precision than the

objectives here: Knowledge of Specifics - 1.10 Decision Ethics:

"table continues to p. 138"

Indicate two major ethical decision making processes for

alleviating an ethical dilemma 1.10 Professional Ethics: Describe

professional relations between a patient and two providers  1.10

Clinical Ethics: Indicate the difference between beneficence and

nonmaleficence 1.10 Business Ethics: Indicate the unit of analysis

for business ethics in healthcare 1.10 Organizational Ethics:

Differentiate organizational and business ethics in healthcare  1.10

Social Ethics: Define social ethics using healthcare as a right

versus a privilege.

Sub-Sub-Levels

1.11 Knowledge of  Terminology; 1.11 Decision Ethics:

Define communitarian ethics as presented by the

instructor  1.11  Professional Ethics:  Define

professionalism as indicated by two professions in

healthcare 1.11 Clinical Ethics: Distinguish between

informal consent and self-determination 1.11 Business

Ethics: Define fiduciary responsibility in non-profit

settings 1.11 Organizational Ethics: Distinguish

between goodwill and community service 1.11 Social

Ethics: Define availability, accessibility and

affordability in healthcare.

1.12 Knowledge of Specific Facts; 1.12 Decision Ethics:

Indicate three decision processes with the author and

respective number of steps involved 1.12 Professional Ethics: Distinguish between allopathic and nursing care outcomes in relation to the respective ethical codes 1.12 Clinical Ethics: Present the requirements for obtaining human subject review approval in a clinical setting 1.12 Business Ethics: Indicate the first individual who should set the finest example of business ethics in a specific healthcare organization 1.12 Organizational Ethics: Indicate three means of improving organizational ethics and indicate references for the means 1.12 Social Ethics: Indicate the two levels of social ethics and the respective components.

Sub-Level

1.20    Knowledge of Ways and Means, Dealing with Specifics; 1.20 Decision Ethics: Describe the relationship between monotheistic and polytheistic religions and the impact of the difference upon short term ethical decision making steps 1.20 Professional Ethics: Distinguish between the relationship of physicians and patients, and physicians and other providers when creating ethical committees  1.20 Clinical Ethics: Indicate the relationship between genome therapy and NIH funding in terms of IRB requirements 1.20 Business Ethics: Distinguish financial ethical accountability

and goodwill in the community 1.20 Organizational Ethics:

Indicate how a for-profit healthcare organization can provide the

same quantity of services as a non-profit healthcare organization

1.20 Social Ethics: Indicate the relationship of human rights and

AIDS intervention funding.

Sub-Sub-Levels

1.21 Knowledge of Conventions; 1.21 Decision Ethics:

Indicate three golden rules from either polytheistic or

monotheistic religions, or both 1.21 Professional

Ethics: Indicate the allopathic means of care and how

that may not be ethically appropriate for all patients

care needs 1.21 Clinical Ethics: Differentiate between

access to all and affordability by many 1.21 Business

Ethics: Indicate how the CEO of a healthcare facility

can ensure a stable workforce without creating a

financial deficit 1.21 Organizational Ethics: Present a

healthcare organizational mission and how it

establishes the organizational ethic 1.21 Social Ethics;

Differentiate between right to healthcare and

healthcare as a privilege.

1.22 Knowledge of Trends and Sequences; 1.22 Decision

Ethics: Indicate how medicine and religion have

become more intertwined when it comes to ethical

decision making 1.22 Professional Ethics: Compare and contrast the ethics codes for physicians, nurses and health services administrators 1.22 Clinical Ethics: Indicate the possible historical impact of the Jewish holocaust upon gene therapy 1.22 Business Ethics: Indicate how the backward bending supply curve for physicians effects CEO decisions in healthcare organizations 1.22 Organizational Ethics: Indicate the historical consequences of DRGs upon ALOS and what types of organizations were ethically sound in keeping the ALOS appropriate 1.22  Social Ethics: Indicate the percentage of GDP spend upon healthcare in the U.S. and the consequences upon the uninsured.

1.23 Knowledge of Criteria; 1.23 Decision Ethics: Provide one short term, medium term and long term decision making process with a possible intervention for each 1.23 Professional Ethics: Indicate ethics education accreditation standards for physicians, nurses and health service administrators 1.23 Clinical Ethics: Indicate an interdisciplinary executive membership group for an IRB  1.23 Business Ethics: Indicate the appropriate organization that would sanction a health administrator for ethics violations  1.23 Organizational

Ethics: Present how a teaching healthcare facility must comply with NIH research requirements  1.23  Social Ethics: Explain the major components of the United Nations Human Rights Act and implications upon a specific country.

1.24 Knowledge of Methodology;  1.24 Decision Ethics Indicate how polytheistic and monotheistic religions may provide different outcomes for long term ethical decision making and the means to alleviate those different outcomes 1.24 Professional Ethics: Indicate human research protocols for care planning purposes 1.24 Clinical Ethics: Present research methodology protocols for an IRB  1.24 Business Ethics: Indicate individual consequences for ethics violations by the ACHE, ANA or AMA  1.24 Organizational Ethics: Distinguish between a living will and a guardian and the relationship between the two 1.24  Social Ethics: Indicate how the separation of church and state effects healthcare outcomes rather than a church-state affiliation.

Sub-Level

1.30 Knowledge of Universals and Abstractions in a field; 1.30 Decision

Ethics: Indicate the major types of religions and ethics theories that can be used as a framework for ethical decision making 1.30 Professional Ethics: Describe the personal consequences for non-beneficent care towards patients 1.30 Clinical Ethics: Indicate how maleficence is problematic for care planning 1.30 Business Ethics: Indicate how deontology may lead to different personal decision making than utilitarianism in a healthcare setting  1.30 Organizational Ethics: Provide two ethical theories that may be used in a healthcare organization that is non-profit 1.30  Social Ethics; Indicate the consequences of millions of uninsured patients upon the costs of national healthcare.

Sub-Sub-Levels

1.31 Knowledge of Principles and Generalizations; 1.31 Decision Ethics: List five religious frameworks that can be used within ethical decision making 1.31 Professional Ethics: Compare and contrast between professionalism and a code of ethics in relation to acute and long term care healthcare facilities  1.31 Clinical Ethics: Compare and contrast morals, ethics and law as they pertain to clinical care 1.31 Business Ethics: Indicate how generally accepted accounting principles are helpful for a CFO of a healthcare organization  1.31 Organizational Ethics: Compare and

contrast business versus organizational ethics in healthcare  1.31  Social Ethics: Present the social implications from for-profit versus non-profit healthcare organizations in terms of potential healthcare screenings.

1.32  Knowledge of Theories and Structures; 1.32 Decision Ethics: Present three decision making ethics frameworks and how they are affected by non-deity religious beliefs held by a patient 1.32 Professional Ethics: Indicate the structure of an IRB in terms of individuals serving on the committee with at least seven members  1.32 Clinical Ethics: Indicate the clinical ethics issues involved in the genome mapping project  1.32 Business Ethics: Indicate individuals who may be change agents for implementing an ethics framework in a healthcare facility  1.32 Organizational Ethics: Provide two proxies to an IRB if the IRB is not established 1.32  Social Ethics: Indicate how communitarian ethics helps increase access to healthcare.

First Level

2.0     Comprehension; Not only do students have the knowledge, but they must

demonstrate comprehension of that knowledge. 2.0 Decision Ethics:
Define "ethical dilemma" in the student's own words* 2.0 Professional
Ethics: Enumerate and describe the elements in a professional code of
ethics in the student's own words*  2.0 Clinical Ethics: Define informed
consent in the student's own words*  2.0 Business Ethics: Describe the
implications of not following an IRB's recommendations  2.0
Organizational Ethics: Define or describe organizational ethics in a
healthcare setting in the student's own words* 2.0  Social Ethics Define
distributive justice in the student's own words.*

Sub-Levels

2.10    Translation; 2.10 Decision Ethics:  Indicate how one may need to
        use both deontological and utilitarian frameworks in the same
        healthcare facility 2.10 Professional Ethics: Present how the ethical
        education standards may be improved using an ethics education
        typology 2.10 Clinical Ethics: Provide a case study on the use of
        Roe v. Wade to indicate diversity of thought in clinical
        interventions 2.10 Business Ethics: Define the process of how an
        individual's moral beliefs may be created into an ethical position
        2.10 Organizational Ethics: Describe an organizational mission
        based on Christian and Jewish beliefs 2.10  Social Ethics: Define
        the right to healthcare within a market based healthcare
        framework.

2.20    Interpretation; 2.20 Decision Ethics: In the student's own words

indicate four ethical decision making processes, including one

from each of the following and one from a compilation of the

following: short term, medium term and long term ethical decision

processes 2.20 Professional Ethics: Describe to the level of an

eighth grade education how physicians must abide by non-

maleficence 2.20 Clinical Ethics: Explain from the student's own

moral position how the genome project will change medical

interventions in the next decade 2.20 Business Ethics: Take a

position on Roe v. Wade and indicate how that case affects direct

care and the financial viability of the facility 2.20 Organizational

Ethics: Define a non-profit framework and how that fits a nominal

ethics theory more than a for-profit framework 2.20  Social Ethics:

Define social ethics in the context of Fremgen's three step process

for decision making.

2.30    Extrapolation; 2.30 Decision Ethics: Indicate how Nash's twelve

step process can be expanded to create a state or national

healthcare policy 2.30 Professional Ethics: Provide a case study

where components of three ethical codes are brought together to

form a unified code of ethics for a healthcare organization 2.30

Clinical Ethics: Indicate how beneficence and non-maleficence

may provide confusing frameworks for providers 2.30 Business

Ethics: Provide a case study where an individual CEO's moral

position is different than the mission of the healthcare organization

and how that CEO can continue to work in that organization 2.30

Organizational Ethics: Provide an example of a benchmark health

facility that has been a change agent for an ethical policy in similar

organizations 2.30 Social Ethics: Indicate a situation where one

country has changed the social ethics of another country, and if the

student agrees with that change.

First Level

3.00 Application; In addition to having comprehension, students need to apply

their knowledge when confronted with a dilemma.  3.0 Decision Ethics:

Distinguish between a personal dilemma and an ethical dilemma, using

examples* 3.0 Professional Ethics:  Using a professional code of ethics,

identify appropriate values and ideals* 3.0 Clinical Ethics: In a case study,

indicate if an informed consent is required* 3.0 Business Ethics: In a case

study, indicate how utilitarianism would be used to decline healthcare

coverage  3.0 Organizational Ethics: Use a case study to indicate how

organizational ethics affects a healthcare operation*  3.0  Social Ethics: In

a case study, determine whether justice alone or justice complemented by

other principles apply.* No sub-levels exist in the cognitive domain for

3.0 Application.

First Level

4.00 Analysis; Going beyond application, students must learn how to analyze

their situations to improve the environment, with 4.0 Decision Ethics:

Identify the essential components of an ethical dilemma in an example

provided by the instructor and explain the relationship of the elements*

4.0 Professional Ethics: Using [a] professional code of ethics, explain the

source of the elements and their relationship to its principles and ideals*

4.0 Clinical Ethics: In a case study, identify the elements of informed

consent and explain the relationship of one element to another*  4.0

Business Ethics: Explain the relationships of organizational ethics as the

aggregate of business ethics  4.0 Organizational Ethics: Identify the

professional, clinical and social ethics that affect organizational ethics

outcomes* 4.0  Social Ethics: In a case study, identify the kinds of

material justice and other principles that apply.  Explain the relationships

among the principles.*

Sub-Levels

4.10    Analysis of Elements;  4.10 Decision Ethics: Explain the

        relationship of religions and professional codes as frameworks for

        making ethical decisions 4.10 Professional Ethics: Provide the

        elements of two professional codes of ethics and the overlapping

        components  4.10 Clinical Ethics: Explain the relationship of the

        four components of a valid malpractice case and the implications

        for clinical providers 4.10 Business Ethics: Explain the

        relationship of the medical doctors code of ethics and the CEO's

        fiduciary responsibility to the health facility 4.10 Organizational

        Ethics: Provide a case study that describes the relationship of the

members of an IRB and an HSRB 4.10 Social Ethics: Prepare a policy statement on the relationship of a right to healthcare along with a free market and for-profit health system.

4.20    Analysis of Relationships; 4.20 Decision Ethics: Critique the relationship of using a long term ethics decision making process in an emergency situation 4.20 Professional Ethics: Indicate how the relationship of the APTA and AOTA can improve both profession's code of ethics 4.20 Clinical Ethics: Indicate how the relationship of managed care organizations may reduce costs but impact access to care  4.20 Business Ethics: Provide a case study that indicates the relationship of discharge planners and a waiting period for Medicare covering nursing home stays 4.20 Organizational Ethics: Indicate the impact of community health facilities upon regional hospitals with one recommendation on improving that relationship 4.20  Social Ethics: Indicate the process of bringing more community based health organizations into a national social policy without disrupting the financing of provider based healthcare.

4.30     Analysis of Organizational Principles; 4.30 Decision Ethics: Indicate the relationship of a feminist based ethics theory within an all male prison health clinic  4.30 Professional Ethics: Provide a case analysis on implementing licensure requirements for hospital administrators based on a nursing home administrator framework

4.30 Clinical Ethics: Indicate how a church based health facility that relies upon its greatest funding from Medicare, can decline abortion cases 4.30 Business Ethics: Provide a case study on the relationship of management engineering and marketing department managers as change agents for organizational ethics committees 4.30 Organizational Ethics: Provide a peer reviewed reference that indicates how ethics education can be used within healthcare facilities and provide improvement upon the article recommendations 4.30  Social Ethics: Provide a case study on how the World Health Organization should use both public health and health services administration theories to improve the AIDs pandemic.

First Level

5.00 Synthesis; In addition to analytical techniques, students must learn how to synthesize issues and create new means of improving their environment, 5.0 Synthesis and objectives are provided here; 5.0 Decision Ethics: Create a narrative from the student's own experiences or from other sources that include an ethical dilemma* 5.0 Professional Ethics: Create a code of ethics for graduate students* 5.0 Clinical Ethics: Based on the student's experience or from another source, develop a case study that necessitates informed consent* 5.0 Business Ethics: Bring together an interdisciplinary committee to improve an IRB and provide an agenda and timeline for the improvement 5.0 Organizational Ethics: Indicate the

causal factors that affect organizational ethics outcomes* 5.0  Social

Ethics: Develop a case study where justice is the dominant principle that

applies in solving the problem.*


Sub-Level

5.10  Production of a Unique Communication; 5.10 Decision Ethics:

Create a multidimensional polytheistic religion that will fit a

continuum of healthcare facility casemixes and associated problems

on end of life care  5.10 Professional Ethics: Use a non-allopathic

framework to improve the allopathic physicians code of ethics 5.10

Clinical Ethics: Indicate how virtual reality software will decrease

the ethical issues for animal vivisection in medical education  5.10

Business Ethics: Create a benchmark moral position that includes a

polytheistic, monotheistic and non-deity religious framework for

ethics committee members 5.10 Organizational Ethics: Form an

HSRB that can be used in any acute or long-term care health

organization and indicate the professionals involved along with the

relationship of those professionals 5.10  Social Ethics: Provide a case

study where a national healthcare system has waiting times that are

no longer than a FFS based system.

5.20  Production of a Plan, or Proposed Set of Operations;   5.20 Decision

Ethics: Provide a case study that implements a decision based policy

using at least one short, medium, and long term ethical decision

process to alleviate uninsured healthcare in one healthcare facility

5.20 Professional Ethics: Indicate the framework for a universally accepted code of ethics for all healthcare providers  5.20 Clinical Ethics: Create a theoretical framework that includes both physically and cognitively impaired residents within an ethically valid environment 5.20 Business Ethics: Provide an ethical framework that creates lower long term costs and higher quality of care outcomes that a healthcare administrator can implement 5.20 Organizational Ethics: Create an ethical theory that distributes limited healthcare resources to all who need those resources within one healthcare facility  5.20  Social Ethics: Using at least three peer-reviewed resources, create a national ethical policy that alleviates the dilemma of rationing healthcare for the elderly.

5.30  Derivation of a Set of Abstract Relations; 5.30 Decision Ethics: Indicate how the relationship between non-deity religions and the Roe v. Wade case affects short term ethical decision making 5.30 Professional Ethics: Provide a case study on the relationship of ethics education in nursing and rehabilitation care, as provided by physical and occupational therapists 5.30 Clinical Ethics: Indicate how the cloning of human stem cells may be thought of by some individuals as an analogy to the Jewish holocaust 5.30 Business Ethics: Indicate an ethical issue that is an analogy to the disproportionately high level of  education required for nursing home

administrators on cognitive care and the amount provided 5.30

Organizational Ethics: Provide a case study on the relationship of a

pragmatist ethical framework and non-profit structure upon

healthcare outcomes 5.30  Social Ethics: Indicate how AIDS cases

might be decreased by using an entitlement ethical theory as a basis

for national policy.

First Level

6.00 Evaluation; 6.0 Decision Ethics: Give reasons for identifying one action in

the ethical dilemma as superior to others* 6.0 Professional Ethics: Explain

the relationships of the elements in a [a professional] code and determine

its foundation and values*  6.0 Clinical Ethics: Using [a] case study…

indicate the factors that cause the need for informed consent* 6.0 Business

Ethics: Indicate ten causal factors that influence the decision making of a

health facility CEO to provide negative cost benefit care in the long run

6.0 Organizational Ethics: Using the causal factors [in 6.0 Clinical Ethics]

indicate how organizational ethics can improve healthcare operations* 6.0

Social Ethics: Explain why justice is [a] dominant principle in [a] study

and the causal factors that make justice the dominant principle.*

Sub-Levels

6.10 Judgments in Terms of Internal Evidence; 6.10 Decision Ethics:

Using the Nash decision making process, and a case study, create

an ethics committee, describe the participants, and the means to

alleviate the issues of a PVS patient without private funds for that

care 6.10 Professional Ethics: Present a situation where a physician has not broken the law, but has committed an ethical offense, and the means to rectify the problem within a healthcare facility 6.10 Clinical Ethics: Indicate how a nurse can inadvertently break HIPAA regulations based on the nurse's moral beliefs, and the means to improve the situation 6.10 Business Ethics: Provide the student's own moral position on how a for-profit organization can provide bad debt care to those who have no financial ability to pay for care 6.10 Organizational Ethics: Using a nominalist ethical theory, indicate how a health facility can provide care for both a premature infant and a geriatric patient in hospice 6.10 Social Ethics: Provide in the student's own words how the use of rationing healthcare services based on age is unethical and indicate what ethical theory is used for the answer.

6.20 Judgments in Terms of External Criteria; 6.20 Decision Ethics: Based on EMTALA regulations, indicate an ethical decision making process that could support the EMTALA regulations for an ER situation in a for-profit hospital 6.20 Professional Ethics: Provide a case study where a nurse could be held accountable to the ANA's Code of Ethics, but where the nurse broke no local, state or federal laws 6.20 Clinical Ethics: Provide a case study where an IRB would deny a request for an outside agency to conduct research on patients within a hospice setting 6.20 Business

Ethics: Using the normative ethical theory, provide a case study where a nurse executive would be required to resign due to the nurse's moral beliefs that are in significant contrast to the healthcare facility mission 6.20 Organizational Ethics: Provide a case study where a health facility could legally create a monopoly situation, but would be in contrast with the ethics of the physicians who have admitting privileges 6.20  Social Ethics: Indicate those areas where the U.S. healthcare framework is out of compliance with the United Nations Declaration of Human Rights.

Bloom Revisited: Affective Based Objectives for Ethics Education in Healthcare

The affective domain has five levels starting with 1.0 Receiving through  5.2 Characterization.  Table 8 provides the affective domain objectives within the six ethics education domains.

Table 8.

Bloom et al.'s Affective Domains with All Levels and Objectives in the Six Ethics Education Domains (Original Porter and Schick objectives reprinted here with permission and noted with an asterisk *).

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Affective Domain

    1.0     Receiving; Students must first attend to their studies and actively accept the information provided to them in a manner that conveys actual attention to the instructor.  1.0 Decision Ethics: Recognize conflicting principles,

values and ideals in an ethical dilemma* 1.0 Professional Ethics:

Recognize the importance of a code of ethics and adherence to the code*

1.0 Clinical Ethics: Recognize the importance of informed consent in

healthcare* 1.0 Business Ethics: Recognize the fiduciary responsibility of

the Governing Board or Owners to a healthcare facility 1.0 Organizational

Ethics: Recognize the integrative role of organizational ethics in

healthcare facilities* 1.0  Social Ethics: Recognize that justice is important

in families, groups and society.*

Sub-Levels

1.1     Awareness; 1.1 Decision Ethics: Reflect on the short, medium and

        long term ethical decision making processes within a healthcare

        setting 1.1 Professional Ethics: Reflect on three ethical codes and

        what that means to the student 1.1 Clinical Ethics: Reflect on

        beneficence, non-maleficence and justice and what those mean to

        the student 1.1 Business Ethics: Reflect on the fiduciary

        responsibility of the CFO to the "bottom line" and what means to

        the student 1.1 Organizational Ethics: Reflect on the positivist

        ethical theory within a healthcare facility and what that means to

        the student  1.1  Social Ethics; Reflect on the communitarian

        theory and how that effects national healthcare delivery policies

        and what that means to the student.

1.2     Willingness to Receive; 1.2 Decision Ethics: Create and lead a

        discussion on a topic of the student's choosing that requires two

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ethical decision processes  1.2 Professional Ethics: Create and lead a debate on the positive and negative aspects of unifying professional codes of ethics 1.2 Clinical Ethics: Create and lead a discussion on a topic of the student's choosing that relates to two clinical ethics issues 1.2 Business Ethics: Create and lead a discussion on a topic of the student's choosing that relates to responsible financial management in long term debt of healthcare facilities 1.2 Organizational Ethics: Create and lead a debate on the issues of organizational ethics versus the moral position of an individual provider 1.2  Social Ethics: Create and lead a discussion on animal rights and the use of vivisection in medical research.

1.3     Controlled or Selected Attention; 1.3 Decision Ethics: Indicate what ethical decision making topics are most interesting to the student 1.3 Professional Ethics: Create a poster on a professional ethics topic that is most personal to the student 1.3 Clinical Ethics: From the three issues of beneficence, non-maleficence and justice, each student must choose one that is most closely aligned with their personal values and indicate why 1.3 Business Ethics: Create a poster on a business ethic topic that is the student's most personal issue 1.3 Organizational Ethics: Provide a case study that indicates what organizational ethical issue is most important to the student and indicate why 1.3  Social Ethics: Provide a case study that

indicates what social ethical issue is most important to the student and why.

First Level

2.0 Responding; 2.0 Decision Ethics: Enjoy engaging classmates in the discussion of the conflicts in and resolution of an ethical dilemma* 2.0 Professional Ethics: Actively participate in discussions or read additional material regarding ethics codes* 2.0 Clinical Ethics: Actively participate in a case study discussion involving informed consent* 2.0 Business Ethics: Create a poster on a topic of the student's choosing that indicates the use of an individual's moral position upon a healthcare facility mission  2.0 Organizational Ethics: Seek material on organizational ethics in other industries and apply it for healthcare facilities* 2.0  Social Ethics: Actively participate in class discussions on justice issues and bring issues raised in the media to those discussions.*

Sub-Levels

2.1 Acquiescence to Respond; 2.1 Decision Ethics:  Indicate the variation of emotions that a student feels about the most important ethical decision making issue to that student 2.1 Professional Ethics: Provide one professional ethic topic that is most important to the student and indicate why  2.1 Clinical Ethics: Indicate the variation of emotions that a student feels about the genome project and its potential positive and negative clinical outcomes 2.1 Business Ethics: Provide one business ethics issue that is not

important to the student and indicate why 2.1 Organizational

Ethics: Provide one organizational ethics issue that is not important

to the student and indicate why  2.1  Social Ethics: Indicate the

variation of emotions that a student feels about the most important

social ethic issue to that student.

2.2    Satisfaction in Response;  2.2 Decision Ethics: Indicate how the

different ethics decision making processes have changed the

student's moral positions 2.2 Professional Ethics: Indicate the

student's personal position on their agreement or disagreement with

a provider's code of ethics 2.2 Clinical Ethics: Provide how the

student would change their moral position if they were in charge of

an experimental intervention rather than the patient of an

experimental intervention 2.2 Business Ethics: Indicate how the

different business ethics issues has changed the student's moral

position 2.2 Organizational Ethics: Provide how the student would

create a patient or resident centered healthcare facility based on the

student's moral positions  2.2  Social Ethics: Indicate how the

different social ethics issues have changed the student's moral

positions.

First Level

3.0 Valuing; 3.0 Decision Ethics: Deliberately examine a variety of viewpoints

and their underlying principles, values and ideals, with a view toward

forming a personal position* 3.0 Professional Ethics: Exhibit strong

adherence to or initiate improvements in respective professional codes*

3.0 Clinical Ethics: Test a variety of viewpoints and new situations to test

the necessity and/or desirability of informed consent*  3.0 Business

Ethics: Initiate improvements in a healthcare facility mission statement

that reflects the student's values  3.0 Organizational Ethics:

Compare/contrast ethics in other industries and use the best to improve

values in healthcare organizational ethics* 3.0  Social Ethics: Exhibit a

strong inclination to find solutions through rational means in problems

concerning distribution.*

Sub-Levels

3.1  Acceptance of a Value;   3.1 Decision Ethics: Indicate an ethics

decision making process that conflicts with a student's moral

position, but is acceptable in at least two situations to the student

3.1 Professional Ethics: Provide a situation where a student may

not agree with the professional outcome, but where the student

agreed with the process to arrive at the outcome 3.1 Clinical

Ethics: Indicate the student's moral position on abortion, and how

the student could accept the current Roe V. Wade outcome for

clinical reasons  3.1 Business Ethics:  Choose a healthcare facility

mission that is different than the student's own moral position and

indicate if the student could work in the organization 3.1

Organizational Ethics: Indicate one organizational vision that has

an ethical statement, and indicate why the student agrees or does

not agree with that statement  3.1  Social Ethics: Indicate the

student's moral position on abortion, and how the student could

accept the current Roe v. Wade outcome for social reasons.

3.2  Preference for a Value;   3.2 Decision Ethics: Indicate two

religious golden rules, and why the student agrees with one

versus the other 3.2 Professional Ethics: Indicate two conflicting

codes of ethics and why the student agrees with one versus the

other  3.2 Clinical Ethics: Rank order the following three clinical

ethical issues in terms of what a student would consider first,

second and third, and why the student ranked them in that order:

Beneficence, Non-Maleficence, Justice 3.2 Business Ethics: Rank

order the following three business ethical issues in terms of what a

student would consider first, second and third, and why the student

ranked them in that order: Fiduciary responsibility, positive cash

flow, high clinical quality outcomes 3.2 Organizational Ethics:

Provide a means to improve the mission and vision of a healthcare

facility based on the student's most valued organizational ethics

issue 3.2  Social Ethics: Rank order three ethical theories in terms

of what a student would consider first, second and third, and

indicate why the student ranked them in that order.

3.3  Commitment;  3.3 Decision Ethics: Indicate one ethical decision

making process that a student would rely upon first for almost all

circumstances, and why the student chose that process  3.3

Professional Ethics: Provide the first professional ethics code a

student would use for justifying a decision and why the student

chose that code 3.3 Clinical Ethics: Indicate a student's position on

an IRB outcome, as found in the literature or from a personal

source, and indicate if the student agrees with the outcome and

why  3.3 Business Ethics: find two leadership decision outcomes

and indicate why the student agrees with one and not the other  3.3

Organizational Ethics: Indicate a student's position in terms of a

non-profit or for-profit structure and indicate why the student

believes more strongly than the other in terms of an ethical theory

3.3  Social Ethics: Indicate a student's position on a right or

privilege framework towards healthcare and why the student feels

that way.

First Level

4.0 Organization; 4.0 Decision Ethics: Bring together a complexity of values and

develop an advanced relationship among the values when solving ethical

dilemmas* 4.0 Professional Ethics: Organize personal and professional

values based on a professional code and handle conflict using the code as

a reference*  4.0 Clinical Ethics:  Bring together a complex set of  values,

ideals and rules and develop relationships among them to determine the

need for informed consent* 4.0 Business Ethics: Bring together the factors

that create a fiduciary responsibility to a health facility, indicate the relationship of the factors and describe which relationships are most important to the student 4.0 Organizational Ethics: Bring organizational ethics issues from other industries and include them in clinical, professional, and social ethics values within a student project* 4.0 Social Ethics: Habitually demonstrate a though process as determined by discussion and actions that includes the principles of justice.*

Sub-Levels

4.1     Conceptualization of Value; 4.1 Decision Ethics: Bring three ethical decision making processes together and create a conceptual framework that is aligned with the student's own values  4.1 Professional Ethics: Compare and contrast three professional codes of ethics and create one code of ethics that is aligned with the student's own values 4.1 Clinical Ethics: Create a concept from three clinical ethical issues that represents a student's ideal orientation towards healthcare interventions  4.1 Business Ethics: Provide a unifying concept from three or more business ethics issues that represent a student's position on financial management in a healthcare facility 4.1 Organizational Ethics: Identify three organizational ethics issues that clarify how a student would structure their healthcare organization 4.1  Social Ethics: Use three ethical theories that ideally represent a student's moral position for creating a social policy on access to healthcare.

4.2     Organization of a Value System; Students are starting to

conceptually organize their values around the objectives presented,

4.2 Decision Ethics: Identify three student's morals in relationship

to ethical decision making and rank those morals to create a value

system   4.2 Professional Ethics: Identify a student's understanding

of three professional codes and rank those codes in parallel with

the student's morals to create a value system 4.2 Clinical Ethics:

Identify three student's morals and rank them in parallel with

beneficence, non-maleficence, and justice  4.2 Business Ethics:

Create a case study where the student identifies three morals that

are ranked in order of use when dealing with a business ethics

issue  4.2 Organizational Ethics: Identify three morals that a

student would use to act as a consultant for recommendations on

improving the ethical decision making in a health organization, and

rank three morals in order of use 4.2  Social Ethics: Compare and

contrast three national frameworks towards healthcare, and create a

parallel framework with the student's moral positions.  Rank the

frameworks and moral positions together to create a value system

for social ethics.

First Level

5.0     Characterization  by a Value or Value Complex; 5.0 Decision Ethics: Act

consistently with the values internalized and develop a philosophy of life

regardless of the ethical dilemma* 5.0 Professional Ethics: Act

consistently with values and principles internalized from the respective professional code* 5.0 Clinical Ethics: Act consistently when implementing or not implementing informed consent within a philosophy of life* 5.0 Business Ethics: Act consistently in class and residencies/internships when interacting with providers of care, in accordance with the values presented by the student in class 5.0 Organizational Ethics: Continuously improve characterization towards others, affective positions on organizational ethics, and point out discrepancies to others when noticed* 5.0 Social Ethics: Act consistently in class and in life in accordance with principles of justice as well as its complementary principles.*

Sub-Levels

5.1     Generalized Set; 5.1 Decision Ethics: Identify the ethics decision making concept that best represents the student 5.1 Professional Ethics: Identify the professional ethics concept that best represents the student 5.1 Clinical Ethics: Identify the clinical ethics concept that best represents the student 5.1 Business Ethics: Identify the business ethics concept that best represents the student 5.1 Organizational Ethics: Identify the organizational ethics concept that best represents the student 5.1 Social Ethics: Identify the social ethics concept that best represents the student.

5.2     Characterization; The student has reached the self-actualization level, with the following objectives 5.2 Decision Ethics:

Demonstrate in class and residencies/internships what character set of decision making processes best represents the student 5.2 Professional Ethics: Demonstrate in class and residencies/internships what character set of professional ethics codes best represents the student 5.2 Clinical Ethics: Demonstrate in class and residencies/internships what character set of clinical ethics issues best represents the student 5.2 Business Ethics: Demonstrate in class and residencies/internships what character set of organizational ethics issues best represents the student 5.2 Organizational Ethics: Demonstrate in class and residencies/internships what character set of organizational ethics issues best represents the student  5.2  Social Ethics: Demonstrate in class and residencies/internships what character set of social ethics issues best represents the student.

CHAPTER V

DISCUSSION AND CONCLUSION: ETHICS EDUCATION AND HEALTHCARE

How to use the typology presented here is as important as the typology itself on improving healthcare. The author discusses the research questions and how they were answered as well as how to use the typology.

Research Questions Revisited

As indicated above, there was support for the typology from at least 55 individuals. In addition to the lack of a respective typology from the literature, those 55 individuals recognized that the typology presented here is a clear indication of how we can better educate future healthcare providers and administrators in the field, as well as those who are currently in the field through the use of continuing education. While it may not be the most robust typology since only one objective is provided for each of the 270 cognitive and affective levels and sub-levels as presented by Bloom, it is a baseline that future researchers can improve upon with additional objectives for each of those 270 objective levels. In addition, an empirical analysis of the typology that could lead to a taxonomy is another future research study as discussed in the conclusion.

However, for the current period, the dissemination of the typology is important so that the 270 objectives can be used in healthcare education. The author discusses below how the dissemination of the objectives may be carried out.

Dissemination of an Ethics Education Typology in Healthcare: Recommendations to

Improve Healthcare Outcomes

The steps involved from the production of the typology presented here to actually improving healthcare outcomes are many.  A first step is to present the typology through several forms of media including: 1. Presentation of the objectives at the AUPHA meeting in 2004 (as scheduled), 2. Create and submit a manuscript that provides all of the material presented here, preferably in a book format, for wide distribution in several educational programs (e.g., medicine, nursing, health services administration), and 3. Create and submit journal articles that provide specific information from this manuscript (e.g., the objectives presented here) to respective audiences who will use the information.

After the creation of additional literature from this manuscript, the author encourages the objectives presented here be used in the classroom, especially in the professions of medicine, nursing and health services administration.  Other allied health programs should also be encouraged to use the typology so that all healthcare providers will be instructed upon the use of ethics education to improve healthcare outcomes.

A third step is to use the objectives in a continuing education format to refresh those who were previously taught the objectives as well as disseminate them to those who are already in the field and may not have had ethics education in their didactic training, or may have only a cursory instruction of the topics (e.g., first levels of the cognitive domain).

Not only is it important to teach future and current healthcare providers, but it is also important to teach the future instructors of those providers.  Therefore, the author strongly recommends that the objectives be incorporated in doctoral level instruction for

future professors in the professions of medicine, nursing and health services administration. In addition, future allied health professors should also be taught the objectives.

Both future and current professors of healthcare education could be instructed on the objectives through continuing education frameworks. This last step may be most difficult since continuing education is not required for professors, unlike their past students in the field who do have continuing education requirements to keep abreast of their field as well as to maintain their license to practice (e.g., medicine). A professional "unwritten" code is well known in academia to continue the pursuit of life-long learning and produce scholarship (Boyer, 1990), but unfortunately, not all professors follow that code, thus the difficulty in obtaining this last step in a unified manner.

Once the previous steps are conducted, those who practice in the field will have a better understanding and improved skills on handling ethical dilemmas and the ethical issues involved in healthcare. If those skills are indeed improved, the author believes that the instances provided in the beginning of this manuscript will be decreased, thus leading to better outcomes in healthcare (e.g., fewer instances of unnecessary interventions). The author also recognizes that not all of the negative outcomes in healthcare will be alleviated by the use of this typology, but that any improvement for even one patient or resident will have been worth the effort put forth on creating this typology.

## Assimilation of Ethics Education in the Classroom

How to assimilate the ethics education presented here in the classroom involves several steps. The first step is to assess how many of the objectives presented here will be incorporated in an already "crowded" curriculum of healthcare. Both undergraduate

and graduate programs in healthcare tend to have few elective courses. It is this author's belief that the objectives here should not be presented in elective courses, but rather that they be threaded throughout core courses as well as a specific required course. However, it is recognized that the first step on changing a curriculum is to first attempt new material in electives and determine secondly if they can be moved into core courses.

Once the objectives are incorporated into the curriculum, the second step is to involve all of the faculty in a program on the use of the objectives. It is not only the professors who teach the material directly who should be involved in the dissemination of the ethics objectives, but all of the faculty including those in healthcare finance, health administration, health informatics, health economics, healthcare marketing, and those who teach in the clinical sciences.

The third and very important step is to incorporate the objectives, and especially the affective ones, into the residencies or internships that healthcare students are involved in. Without the didactic instruction, it is impossible to work in the field. However, without the residencies and internships in healthcare, the mistakes in the field would be far more significant, and therefore the affective objectives here are a crucial factor that may be missing in current healthcare education.

If an empirical assessment of this typology leads to a taxonomy, it may be found that the affective objectives are the crucial elements to improving the "satisfaction" in healthcare that is pervasively problematic in current operations. Not only may the cognitive objectives be important on what to provide in healthcare, but the "how" to provide is just as important, and the affective ethics objectives here may improve that

component in healthcare outcomes.  Both the cognitive and affective objectives are important in the field and thus are important in the educational process.

While the Porter and Schick (2003) article was a start on providing the first level of the cognitive domain objectives for ethics education in healthcare, the sub-levels and sub-sub-level objectives provided here are significantly more precise than that article. The precision here may also be improved with the use of more objectives per level and sub-level, and that will ultimately improve the healthcare education and outcomes in the field.  While it may take a significant amount of time before the objectives are incorporated in the field, it is this author's strategy to incorporate the objectives here into his ethics education courses and related courses in health services administration programs.  The difficulty is in how to incorporate all of the levels and sub-levels into the curriculum.

This author's strategy is only one means of incorporating the different levels and sub-levels into a healthcare curriculum, but it may be adopted as a strategy for many different healthcare education programs (e.g., nursing).  The first strategy is to use all of the cognitive and affective objectives in a single course.  Since there are a significant number of objectives, only a few will be provided in depth, while the remaining are provided in a cursory means.  Those that are given a cursory means will be incorporated in other courses in the curriculum.  Examples of objectives that will be provided more in-depth in another course are those in the business domain; those objectives will be provided in the health administration and health care financial management courses.

Other healthcare programs can incorporate the objectives in the same means by having one specific course that provides the objectives here in a cursory fashion and with

more in-depth discussion in other courses.  The most important addition to the literature from this study may be the specificity of the affective objectives and how those are provided in the curriculum.

While the affective objectives will be provided in the didactic part of healthcare education, the most significant provision will be in the field where professors can determine if the student is ready for care without supervision.  Residencies and internships have long established a period where students can practice their trade or profession and have any mistakes corrected by their instructors.  The same situation holds true with affective ethics education, whereby healthcare students will make mistakes in their ethics decision making prior to starting their profession, but hopefully they will learn from their mistakes prior to that start.

Although all clinically related healthcare professions still have some form of residency or internship, or even field placements for short periods of time, there is a growing number of health services administration programs that are no longer using the residency or internship (Loebs, 2002).  As a cautionary note, it is this author's position that those programs who do not have a residency or internship are increasing the potential for poor affective ethical decision making since the students did not have the chance to practice prior to being in the field.  Although not directly studied here, the author presents a recommendation that all healthcare related educational programs continue with some form of residency or internship so at the least the affective ethical objectives can be better taught and help improve healthcare outcomes.

Continuing Education Suggestions for Healthcare Providers

In addition to ethics education objectives provided to entry level practitioners in healthcare, those who are already in the field must have those objectives in their continuing education. Regulations for continuing education already include ethics education for clinical providers (e.g., medicine, nursing, physical and occupational therapists), but the amount and specificity of that education is usually lacking. Another suggestion, then, is to make all individuals working in healthcare have at least the first level objectives provided to them over a course of two years. That suggestion can be accomplished with the use of the regulation promulgation process in states. Those who want to be change agents in healthcare can go through a program that includes all of the 270 objectives provided here, or help develop more objectives as well.

One means of providing those 270 objectives to individuals in the field is by using a consortium of programs that can bring together several professors teaching in the healthcare ethics education discipline. That model has already been created by this author and it is entitled Executive Certificate in Ethics Leadership (EXCEL), whereby individuals receive a graduate certificate in ethics leadership by completing a 100 hour program in healthcare ethics education.

Conclusion

The ethics education typology in healthcare presented here is the culmination of three years of literature review, presentations in the field with input from both academic and healthcare practitioners, and accreditation standards review. From those reviews and input, a typology was created that will hopefully provide a basis for a living taxonomy in the future. The literature review is revisited directly below along with future research

presented so that research on a typology of ethics education in healthcare can continue and be refined.

*Literature Review Revisited*

The author attempted to review a significant variation of literature sources to ensure a robust framework for creating the objectives provided here. Going back to the late 1890s also ensured that theories not commonly used today may be "re-represented" to help ensure better healthcare outcomes (e.g., nominalism ethics theory). While the author did find a significant number and type of literature sources, there are several future sources that require more in-depth analysis for healthcare ethics objective material.

A more robust presentation of the topics presented could occur from an increased literature of ethics education that is still lacking. For example, it has been proposed by this author and a minor reviewer of this study (D. Barry Lumsden, Ed.D.) that a new journal be created to request articles that assess topics presented here and within the ethics typology framework. That journal is currently under review and is entitled Ethics in Healthcare Research and Administration (EHRA). While the EHRA may overlap with a few journals in the field (Kennedy Journal on Ethics), there is not one journal that brings all of the ethical domains presented here in a focused and hierarchical framework.

As presented, there is a clear need for one single depository for ethics education in healthcare, but it may not be in one volume. Since the typology will be a "living" document, it may be that a series of volumes will occur from this initial study presented here. Like the biology taxonomy discussed earlier, this typology will continue to grow and it may be that a taxonomy will also result after future research.

*Future Research: A Taxonomy of Ethics Education in Healthcare*

This initial research on creating a typology can be further assessed to create a taxonomy. The first step on creating the taxonomy is to determine those professors who teach ethics education in healthcare through a random sample of healthcare programs, including medicine, nursing, health services administration programs and other allied health programs. In addition, practitioners in the field will be identified who represent the professions to be assessed in education. Both the professors and the practitioners will be questioned on their beliefs of how the 270 objectives from the typology presented here should be used for ethics education in healthcare. From those questionnaires, empirical analyses will be conducted, such as structural relations with multiple exogenous and endogenous concepts.

Beyond the ethics domains empirically studied, there will be a re-visitation of Bloom's cognitive and affective domains to determine if that taxonomy is stable within the typology presented here. It may be that the cognitive and affective domains by Bloom are not entirely separate and that further research on those two domains will be required as well. Another future research study is to assess the psychomotor domain in ethics education (Bloom, 1956) for those clinically related healthcare programs, to determine if that domain is appropriate for the six ethical domains presented here.

Recommendations that warrant immediate attention are emphasized here to help create better healthcare outcomes in the near future:

- Disseminate the typology presented here: The assimilation of the typology presented here will generate increased discussion on the required specificity of ethics education in healthcare.

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- Create a taxonomy of ethics education in healthcare: The creation of the taxonomy will itself generate discussion on the specificity of the objectives discussed here and lead to improved ethics education as well as in the field.

- Create the EXCEL program as presented: Bringing together leaders in the field of ethics education in healthcare, among the various healthcare professions, has never been conducted, at least in the last decade.  This author has first hand knowledge on the fact that the healthcare professions have not come together to discuss ethics education because he has shared the responsibility of the Ethics Faculty Forum for the national organization representing health services administrators (i.e., AUPHA) for the past five years, and the previous chair for the past five years earlier indicate the same situation (Personal communique,  Ida Schick, Ph.D., FACHE, June, 2003).  When the healthcare professions finally do come together, the taxonomy may have been created by that time and further research can be conducted to refine the taxonomy.

  The EXCEL program can also be created initially for health services administrators in the field as well as those who are entering the field and have completed their master's or doctoral level education.  The EXCEL program will probably consist of at least two health services administration programs and their respective faculty members who teach ethics education.  The number of programs may be more than two  and the framework can be expanded to other healthcare professions (e.g., nursing).

- Continue residency or internship requirements for all healthcare educational programs: Without the residency or internship experience, there is a significant decrease in the amount of affective education taught to future healthcare providers.  This situation may

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be most apparent in health services administration programs where a significant

number of programs have eliminated the residency or internship requirement.

The ultimate wish of this author is to have healthcare outcomes improve when

the ethics education of healthcare is at the same level of the science of healthcare.  It

appears that the literature, those who helped provide input for this typology, and the

accreditation standards reviewed, support the need and specificity of an ethics

education typology in healthcare.

APPENDIX:

APPROVAL TO USE PORTER AND SCHICK (2003) OBJECTIVES FOR THE

ETHICS EDUCATION TYPOLOGY

From: Will Welton [Via Email]

Sent: Tuesday, February 10, 2004  1:42 PM

To: Porter, Russell

cc: Lori Jacobs

Subject: Re: Permission to use part of article

Russell ---

You have permission to use the material you need.  This is all that is required.

Lori --- Please place this email in the author's article file.

Will Welton

Journal of Health Administration Education Editor


From: "Porter, Russell" [Via Email]

To: Will Welton, Journal of Health Administration Education Editor and Lydia Reed,

Managing Editor

Sent: Monday, February 09, 2004 8:29AM

Subject: Permission to use part of article


Dear Dr. Welton and Lydia Reed: This is to request permission to use part of an article

from the Journal of Health Administration Education.  The specific article is Porter and

Schick (2003) Revisiting Bloom's Taxonomy for Ethics and Other Educational Domains.

JHAE, 20:03, 167-188.  The specific request is to use the objectives created in Table 5

for my second dissertation that covers, in part, all 270 objectives within the two

educational cognitive and affective domains, and six ethics domains of decision making, professional ethics, clinical ethics, business ethics, organizational ethics, and social ethics.  If you require a specific form for permission to use copyrighted material, please let me know.  Thank you for your time on this issue.


Sincerely,


Russell Porter, Ph.D.

Chair: Health and Public Administration

Midwestern State University

Accrediting Commission on Education in Health Services Administration. (2003).

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