

Ethics and Healing and Caring Ministries

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A Message from the UMA Ethics Committee

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- a. if this monograph has been useful**
- b. if something is unclear or missing**

**Sincerely,
UMA Ethics Committee**

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Note: References throughout this document to those we serve will refer to patients, clients, and residents; these terms should be considered interchangeable to fit the reader's framework.



Introduction

Sue Waverly, a resident of Wesley Assisted Living, is experiencing rapidly declining health. Recently her Chronic Obstructive Pulmonary Disease worsened limiting her ability to care for herself. Sue is now on home oxygen and has moved from her facility's independent living apartments to an assisted living unit. Her two adult children live 700 miles away. No other family member is available to her locally.

Having known for sometime that her pulmonary disease could not be cured and would in fact become progressively worse, Sue has thought about her declining health and life needs for several years. She has concluded that she never wishes to be placed on a ventilator should her breathing fail even though she would likely die from her respiratory failure. Sue has spoken with the social worker and chaplain about her wishes. She has been encouraged to complete a Durable Power of Attorney for Healthcare in which she would document her wishes. She is reluctant to execute these documents because of conflicts with her two daughters about end of life care.

When Sue's husband died quickly 12 years ago after refusing for several days to seek medical attention, their daughters vowed that they would never allow their mother to die in a similar way. They wanted her to receive maximal medical and technological care. On the occasions Sue has voiced her opinions to her daughters regarding her desire to avoid long-term intensive care and to simply be made comfortable when her pulmonary disease worsens, the daughters have repeatedly interrupted her. The daughters have made it clear that they want no part of a process which would lead to their mother's death.

Complicating Sue's dilemma is a requirement of Wesley Assisted Living that residents who lack a Living Will or Durable Power of Attorney for Healthcare must acknowledge in writing that should they experience cardiopulmonary arrest the organization will attempt to resuscitate them and call for emergency medical services. Sue has written the Wesley Administrator requesting an exception to this policy. She says she is willing to affirm her wishes in writing to the staff, but she is not willing to execute the formal legal documents required. She does not feel she has the emotional strength to "stand up" to her daughters. At the same time Sue is adamant that she wants only comfort care when her disease worsens.

Her long history of clinical depression that is being treated with medication complicates matters. Her daughters have implied that if Sue attempts to prepare advance directives they will seek to declare her incapable of making her own decisions. The Administrator has offered to speak with the daughters and arrange a teleconference with them including the social worker, chaplain, and attending physician. Sue, thus far, has refused this offer saying she prefers her children not be involved. The Administrator has now referred the matter to the agency's Ethics Committee for guidance.

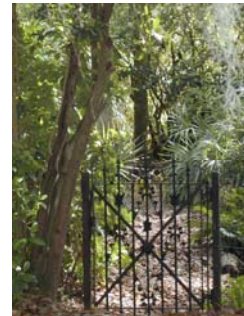
The staff and residents of Wesley Assisted Living discovered that people and organizations face complicated and diverse circumstances and needs where ethical reflection, resources, and guidance can be important resources. How faith-based health and human service organizations deal with these realities affects the spiritual, mental, relational, and physical health needs of their residents. Just as important, staff members of these organizations also face ethical questions and dilemmas in their daily work both with agency clients and with the organization itself. Fairness, integrity, and quality care are not only agency priorities, but they are also values that are important to staff and residents as well. Ethics, whether recognized as such or not, is a daily part of personal and organizational life.



What is Ethics

Definitions of ethics abound. Central to most definitions is a focus on values, character, principles, right actions and decisions, and desired outcomes.

Ethical perspectives focus on making conscious choices, distinguishing between good and bad, right and wrong, using norms which seek to indicate why a given behavior is good or bad or an action is right or wrong, and reasoning processes for ascertaining fitting actions and decisions.



Approaches to Ethics

In daily experience ethical concerns most often arise when persons face conflict about the best choice of actions or behavior in the midst of competing claims. When choices seem clear and certain, ethics is rarely in the foreground of awareness. In contrast when one finds it difficult to decide about the most life-giving values, ethical dilemmas and questions take center stage.

For example, two single residents of an older adult ministries community decide to marry with each one's family blessing. No ethical dilemma is apparent in such circumstances. The scene shifts if the same persons decide to cohabitate in the facility in violation of the policies of the faith-based independent living facility.

Ethics relates closely to morality, character, and values. Different approaches to ethics emphasize different aspects of decision making and behavior. For example, one approach to ethics sees obeying **rules** (such as “Always tell the truth.”)ⁱ as a means of ethical behavior and decision making. Such rule-based ethics are clear until the rules themselves conflict. Imagine a circumstance in which a person who seeks to “always tell the truth” does so at the peril of breaking another rule, “do not betray a friend”.ⁱⁱ

A second approach to ethics sees maximizing a positive **outcome** (utility, for example) as the goal of any behavior or decision. The end result of actions and the degree to which such actions achieve the greatest good for the largest number of persons determines decision-making. Such an approach might be seen in a hospital’s decision to limit its care of persons seeking emergency department care with non-emergency needs who cannot pay for their care. This action achieves the greater outcome of keeping the organization financially solvent in order to serve persons with more life-threatening emergencies.ⁱⁱⁱ

A third approach to ethics emphasizes **character** as the optimal guide. The focus is less on the decisions or actions a person takes and more on the virtues the person affirms and by which s/he lives. The “good” person takes center stage rather than the “right action”.

Truer to the complexities of daily life, humans often combine these approaches and seek to integrate and balance the competing claims of rule-based ethics, outcome-based ethics, and character-based ethics. Ethical actions are best seen in persons of positive character who live by core principles and seek to make decisions that maximize the needs of a wide variety of parties or persons involved in decision-making.

A fourth dimension to ethics relates to faith orientation. In places where Western secular cultural norms prevail, ethical principles are often based on values that are not directly religious in nature. Thus, the value of **autonomy** (understood as self-rule) is often a key ingredient in bioethical dilemmas. While the value of autonomy may be important in faith-based ethical perspectives, the value itself operates independently of religious perspectives in a secular culture.

Faith-based ethical perspectives are important streams of ethical life. Many persons see a vital connection between one's religious beliefs and one's values and principles in making decisions. The culture may be secular but many persons within the culture function out of specific faith orientations. Church-related, faith-based organizations are especially concerned with this linkage of ethical actions, principles, and values within the life of the organization to the imperatives of faith itself. Faith-based health and human service organizations were originally founded from the impulse to care for the neighbor rooted in Judeo-Christian traditions.



Reasons/Occasions for Using Ethical Resources

The circumstances that evoke ethical discussion and prompt a search for ethical resources most often occur when the ordinary standards, practices, and procedures of personal guidance and organizational life do not satisfy the issue or problem at hand. Competing values, purposes, and goals lead to dilemmas where it is not automatically clear what the best course of action will be.

Advances in medical technology have raised new issues about the beginning and end of life with which previous generations have not had to deal. Technological capability (e.g. the ability to sustain a person in a persistent vegetative state indefinitely through tube feedings and/or ventilators for respiratory insufficiency) has run beyond our ethical wisdom in deciding when to begin and end the use of such resources.

Children, Youth, and Family Service Organizations balance competing claims of clients who have beliefs and values quite different from the organization and the individual's parents/guardian. There are also possible competing claims between the governmental requirements of secular state funding programs and the faith values of the organization. These competing claims may create perplexing dilemmas about what the organization can legitimately require of its clients. For example a 17-year-old client becomes pregnant and demands an abortion. In this scenario some

of the issues which arise include the following: the legal and ethical rights of a 17 year old with clear decision-making abilities, the rights of parents/guardians who may disagree with the client's preferences and/or the agency's values and policies, and the potentially different values and policies of state funded care programs and the organization.

Ethical resources for these and other dilemmas take a variety of shapes. The most obvious resource in an organization may be a Clinical Ethics Committee that serves in an advisory capacity for clients as well as staff members of the organization. Such Committees are usually multi-disciplinary and may include representatives from the larger community. They serve as a sounding board for parties facing conflict and uncertainty and offer both a "3rd person" perspective and potential ethical knowledge and experience beyond day-to-day experience.

Another ethical resource is an Organizational Ethics Committee. This type of Committee does not focus on the individual dilemmas of clients or staff. Rather the emphasis is on the ethics of the organization itself. Such a Committee serves as a resource when major issues about the agency's own ethical practices and standards emerge. Such Committees are useful not only for staff members but also for boards of directors as well. They assist the organization in "walking the talk" through open discussion and evaluation of system practices and policies leading to greater institutional integrity.

Whether persons or an agency use a formal Ethics Committee or not, an ethical assessment or work-up of a dilemma or policy proposal includes the following steps:

1. What is/are the issue(s)?
2. What are the facts of the matter, both known and unknown? (This would include medical and psychosocial facts if it is a clinical issue.)
3. What is your initial "gut"/ emotional response to the issue(s)? What does your initial response indicate about your values and perspective?

4. What possible choices seem fitting for the matter at hand? What do you think you or another should do in these circumstances?
5. What is the organization's perspective? What present policies, professional standards, and legal expectations apply? Are there case precedents that may offer insight?
6. What and whose values and needs should be considered?
7. With whom might you consult for further input?
8. What actions do you recommend and why?
(By: Christine L. McHenry, MD, MATS)

ⁱ Such rule-based ethics are often called deontological or duty-based approaches which focus on the act rather than the consequences.

ⁱⁱ Some of the key principles involved in rule based ethics include autonomy (self-determination), beneficence (what is best for the person), non-maleficence (do no harm), justice, truthfulness, and fidelity (faithfulness).

ⁱⁱⁱ Outcome-based ethics are often described as teleological ethics where the emphasis is on the greatest good for the greatest number of persons involved, or where the end justifies the means.



Faith-Based Ethics

Once we answer the question, “What is ethics?” the next question particularly in a faith-based organization is, “What is the connection between faith and ethics?” Broadly defined, faith is the governing principles of belief by which a person lives. Faith-based organizations are defined by the beliefs that form the foundation for all manner of business. Everything from the ordinary tasks of life in community to long-range planning is held up against the beliefs that provide the cornerstone for the faith-based organization. In as much as ethics seeks what is the good, and faith defines

that good, ethics in a faith-based organization is inseparably linked to the foundational beliefs. While ethics can be viewed through secular lenses, the lenses of faith add other dimensions to the way ethics is seen much in the same way that bifocals and magnifying glasses both enhance sight but have different purposes and may come to different conclusions.



A. Ethics and the Christian Tradition

Christians believe there is one God and the one God is the Supreme Authority. God is the one who has the authority of life and death. Our obligation is to care for the living and acknowledge those who have died (Sellers, 2005).

Two bodies of scripture provide the rubric for ethical decision-making within the Christian tradition: the Ten Commandments and the Great Commandment in Mark 12:31 to “love your neighbor as yourself” (Bratcher, 2005). Accountability is thus seen in light of relationship to God. Fair business practices, honesty in relationships, and attention to the individual rather than only to the bottom line should be characteristic of organizations whose core value is faith (Ortberg, 2005).

To love God and love neighbor are central convictions for people of faith. However, advances in medical technology have called into question the living out of these core beliefs in hospitals, nursing homes, retirement communities and other faith-based organizations. For example, is it more loving to continue or discontinue nutrition by tube if the patient is in a permanent vegetative state? Would love tell us to treat with antibiotics or withhold antibiotics in the case of a person with end-stage Alzheimer’s disease who has pneumonia? What is the most loving thing to do for a cancer patient who is actively dying and in a lot of physical pain?



B. Ethics from a Wesleyan Perspective

John Wesley advised his societies, “General rules are easily laid down but it is not possible to apply them accurately in particular cases, without the anointing of the Holy One”. The essential requirement for ethics according to Wesley was divine aid. Therefore Christian perfection, the aligning of one’s will with the will of God, was the key to good ethics (Dunning, 2003).

Wesley said Christian perfection predisposes us for ethical behavior that must be grounded in love. Before we were aware of God we were recipients of God’s grace. Because God so loves us, as people of faith our lives and our decision-making are to be driven by the double commandment to love God and to love neighbor (Stone, 2001). Wesleyan tradition ethics is a reflection of the heart in tune with God (Batcher, 2005).

As people of faith in organizations founded on the basis of faith, we in the Wesleyan tradition are to go beyond a simple conformity to rules in the practice of ethics. Wesley’s ethics demand that as individuals and communities we struggle with living out in positive ways the transforming power of the gospel (Batcher, 2005). For John Wesley the goal of ethical decision-making was to promote human renewal into the image of God. Freedom from sin and love for God are lived out in the community as we reflect this image of God’s love for us in Jesus Christ (Christian, 1999).

The question remains: how are we to do ethics in a way that reflects our faith? Jesus calls us to be the light of the world and the salt of the earth. Ethical issues will continue to surface in the organizations in which we serve Christ. As light and salt we must boldly face those issues with faith. In confronting the issues of his day John Wesley used four tools for decision making which we now call the Wesleyan Quadrilateral: Scripture, Reason, Tradition-including the wisdom of the Church through the ages, and Experience-including God's work in our lives and the inner witness of the

Holy Spirit. These four signposts, with Scripture providing the lens through which we view Reason, Tradition and Experience, are our guides in ethical decision-making in the Wesleyan tradition (Cranston, 2005).



C. Faith-Based Ethics in a Pluralistic World

Another aspect to consider as we explore faith-based organizations and ethics, concerns the particular path of faith followed. What is considered good ethics in a Catholic faith-based community and what constitutes good ethics in a Jewish faith-based community may have many similarities but may also have many differences. The challenge of coming to an ethical consensus is complicated by the fact that faith-based organizations have persons of all faiths both living in and receiving services from those organizations. We live in a world of diversity where the charge nurse is a Presbyterian, the aide is a Buddhist, the resident is Catholic, the social worker is agnostic, and we are all together in this United Methodist related community. People of faith today live with the tension between what it means to believe that “ours” is the right faith and still be tolerant of the sometimes very different beliefs of others (Zikmund, 2003). Faith-based individuals and faith-based organizations are both challenged to confess what is believed and at the same time respect the differing beliefs of others.

As we walk the tightrope between tolerance and religious conviction, keeping our balance requires a solid understanding of what we believe. If we are to keep from falling into the abyss of ethical relativism, we need to be as clear as we can about what it means to represent organizations within the Christian and specifically the Wesleyan tradition.

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Ethics Committees

Advancements in technology, changes in social mores, and the ever-increasing plurality of our communities and society are the major contributors to the increase in and complexity of ethical issues today. No place can ethical issues be seen so clearly as in the health care and human service arenas.

Multiple questions arise in the clinical health care arena that did not exist only 30 years ago. When is it morally acceptable to write a do-not-resuscitate order? Is keeping this patient on a ventilator in his or her best interest? Must food and water always be supplied even by artificial means? Who has the right to decide for an incompetent individual? Should a patient be listed for a 4-organ transplant thus utilizing organs that could benefit 4 individuals?

For those organizations involved in research, especially human subject research, ethical questions abound. How can we adequately protect human subjects in clinical trials? Under what circumstances might children participate in clinical trials? How can we ensure adequate informed consent? How can a researcher avoid undue influence by a sponsoring proprietary company?

Along with these questions directly related to individuals come questions related to organizational life. If our resources are limited how should we distribute them justly? How are such allocation decisions made? What is the proper balance between the best interest of the individual and the best interest of the community? Is the organization portrayed accurately in advertising materials? Should alternative life-style couples or unmarried couples be allowed to live together in a United Methodist-related residential community? To what extent should a United Methodist-related facility accommodate the needs of those from different cultural and faith traditions?

These questions whether related to an individual, to research, or to the organization can be emotionally charged, philosophically and theologically perplexing, and sometimes legally challenging. Over the past 25-30 years acute care medical facilities and social service agencies have responded to these challenges by establishing Clinical Ethics Committees to address clinical questions and Institutional Review Boards to address questions related to human subject research. The Board of Trustees and senior management have usually been entrusted to deal with questions related to organizational life.



A. Scope of Ethics Committees

While both Clinical and Organizational Ethics Committees have varied expectations, accountability structures, and assigned tasks, they have

some common features. Such common features of both types of Committees include the following:

1. Ethics Committees make recommendations. While significant, these recommendations are not decisions. Decision-making authority lies within the doctor-patient/surrogate relationship in medical cases and within administration and the Board of Trustees in organizational cases.
2. In matters involving policy, Ethics Committees can offer helpful feedback, recommendations for improvements, and raise consciousness about ethical matters often overlooked.
3. In educational matters an Ethics Committee may become the organization's source of expertise about ethical issues. Such recognition comes with the Committee's ongoing efforts in self-education and its availability to persons within the organization who have ethical concerns and interests.
4. Ethics Committees strive to be open to all parties involved in ethics concerns. The Committee's sense of integrity is vital for developing trust among staff, patients, and the leadership of the organization. The Committee's freedom to speak candidly is rooted in its availability to all parties at hand and its track record of lifting up the highest ethical standards and offering the best ethical wisdom available to it.



B. Development of an Ethics Committee

The following describes the development of an Ethics Committee within a United Methodist-related health and human services organization. Depending on the nature of the organization, the Committee may function primarily as a Clinical Ethics Committee addressing clinical ethics questions and secondarily addressing organizational questions that impact clinical care. Or, the Committee may function primarily as an Organizational Ethics Committee addressing questions related to organizational life and rarely

address questions related to clinical care. Some organizations have separate Organizational Ethics Committees and Clinical Ethics Committees. Human subject research questions should be handled by a knowledgeable and experienced Institutional Review Board.

As an organization considers developing an Ethics Committee, the following overarching questions should be contemplated:

1. Why are we forming this Committee?
2. Who are we ultimately trying to serve?
3. What are we attempting to accomplish?

Purpose

An Ethics Committee is a multidisciplinary advisory committee empowered by the organization to address clinical and/or management issues within the organization.

Composition

Most Ethics Committees can fulfill their functions with 12-20 members. They are most effective when composed of members from diverse disciplines and backgrounds. Membership might include an administrator, board member, community representative, physician, nurse, social worker, chaplain, non-affiliated legal representative, and a resident of the organization. Care should be taken not only to have a Committee composed of members from diverse disciplines but also a Committee that represents the cultural composition of the residents and staff.

When developing an Ethics Committee it is important to establish the composition of the Committee, the length of the term served, and a staggered membership rotation. Many Committees have a 3 or 4-year term with the option of serving a second term and rotate 1/3 or 1/4 of its members off yearly. This allows for diversity within the Committee. The selection of the chairperson could be made by the Committee or by the governing body of the organization that is responsible for the Committee.

Functions

Traditionally, the primary functions of a Clinical Ethics Committee have been education, consultation, and policy development and review. If your organization has both a Clinical Ethics Committee and an Organizational Ethics Committee you might find that (a.) the Clinical Ethics Committee devotes most of its time to education and consultation around clinical issues, and (b.) the Organizational Ethics Committee devotes most of its time to consultation around the organizational issues and to policy development.

The following will apply to both Clinical Ethics and Organizational Ethics Committees:



1. Education

Education falls into two broad categories: self-education and community education. It is incumbent upon the members of all Ethics Committees to educate themselves, as individuals and as a group, about common ethical theories, approaches to ethical decision-making, and the common ethical issues that affect their organization. The initial educational process usually takes 12-18 months and may be guided by an ethics consultant. It is only after the initial self-education process that the Committee should begin to provide educational programs, consultation services, and policy development and/or review. The Committee, whether Clinical or Organizational, should consider providing educational programs for staff, residents, and their family members.

Committee education is an ongoing process. Retrospective review of an issue within the organization and a literature review are two ways a Committee can continue its own education.



2. Consultation

Ethics consultation may include prospective (current) case review or retrospective case review or both. The goal of prospective ethics consultation is to provide guidance to those who are experiencing conflict over a value-laden issue. The goal of retrospective review is to analyze the case to seek improvements in process and outcome. The Ethics Committee should consider the following questions before offering a consultation service:

- A. How accessible is the committee? 24 hours a day, 7 days a week? 9 A.M.—5 P.M. Monday through Friday?
- B. Who can access the committee for consultation? Staff? Residents? Family members? Administration?
- C. Must permission from the individuals involved in the controversy be obtained?
- D. How will emergency consultations be handled?
- E. What is the ethics consultation mechanism?
- F. How will the process and recommendations be documented?

The most effective system and the one that maintains the integrity of the relationships involved in the case or issue is the system in which the Committee strictly plays an advisory role.



3. Policy Development and Review

The Ethics Committee can play an instrumental role in reviewing existing organizational policies such as those that address equal employment opportunity, resident rights, alternative life-styles, advance directives, and do-not-resuscitate orders. In this role, the Ethics Committee makes sure these policies follow established ethical guidelines. The Ethics Committee can also be a valuable resource when the organization is developing a new policy with broad ethical implications.

Meetings

Regularly scheduled meetings are vital to a well-informed and active Ethics Committee. Ethics Committees often meet on a monthly basis to review consultations, plan educational programs, review policies, and continue Committee education. Depending on the size of the Ethics Committee and the demand for ethics involvement, the specific functions of the Committee may be best fulfilled by subcommittees that meet outside the monthly meetings. The subcommittees then would report to the Committee-at-large at the monthly meetings.

Accountability

For an Ethics Committee to be successful over time it must have the support of the administration of the organization. The appointment of and accountability of the Committee will vary from organization to organization. The Ethics Committee may function as an administrative staff committee, a committee of the governing board, or a committee of the medical staff. The organization's placement of the Committee may, to a certain degree, influence the Committee's composition as well as its functions.

Summary

Life is filled with ethical dilemmas, especially in the world of health and human service ministries. An Ethics Committee can be a valuable resource for an organization, providing education, consultation, and policy development and review. There must be strong support from the administration of the organization for the Committee to be successful. As technology advances and social mores continue to change, there will be an ever-increasing need for individuals, either singly or through a Committee, to provide guidance to other individuals and to organizations as difficult decisions are made.

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Appendix

Core Competencies

The American Society of Bioethics and Humanities (ASBH) in its *Core Competencies for Health Care Ethics Consultation*, 1998, suggests that every Committee member have certain basic knowledge and skills in order to do ethics consultation. Those include:

1. Knowledge
 - a. Moral reasoning and ethical theory
 - b. Bioethical issues and concepts that typically emerge in ethics consultation
 - c. Health care systems
 - d. Clinical context
 - e. Health care institution in which the committee works
 - f. Health care institution's policies relevant to ethics consultation
 - g. Beliefs and perspectives of patient and staff population
 - h. Health law

2. Skills
 - a. Identify the nature of the value uncertainty or conflict that underlies the need for consultation
 - b. Analyze the value uncertainty or conflict
 - c. Facilitate formal and informal meetings
 - d. Build moral consensus
 - e. Listen well and to communicate interest, respect, support, and empathy
 - f. Ability to elicit the moral views of involved parties
 - g. Ability to represent the views of involved parties to others
 - h. Ability to enable the involved parties to communicate effectively and be heard by other parties
 - i. Ability to recognize and attend to various relational barriers to communication

The ASBH also suggests that at least one member have skills and knowledge in the following:

1. The ability to utilize institutional structures and resources to facilitate the implementation of the chosen option;

2. The ability to document consults and elicit feedback regarding the process of consultation so that the process can be evaluated;
3. The ability to educate involved parties regarding the ethical dimensions of the case;
4. Knowledge of relevant codes of ethics, professional conduct and guidelines of accrediting organizations as they relate to ethics consultation.

Additional Resources

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Websites

The Hastings Center for the Study of Bioethics: www.hastingscenter.org

The Kennedy Institute of Bioethics: www.georgetown.edu/research/kie/

Midwest Bioethics Center: www.midbio.org

Human Values in Aging: aarpnews@aarp.org

Glossary of Concepts and Terms

Autonomy (respect for) – An ethical principle which stipulates that a personal decision made by an individual who is capable of rational decision-making should be respected.

Beneficence – An ethical principle that holds that an act is right in so far as it produces good.

The Common Good – The common good conveys the notion that there are good social arrangements for the community as a whole not derived by summing individual goods, but by asking whether one kind of community is “as a whole” better than another.

Ethical dilemma – A situation in which ethical principles, rules, or virtues may clash and do not provide clear guidance as to right action or good behavior

Ethics – A systematic reflection on moral judgments in the realm of human character, actions, and rules. Different approaches to ethics include:

Deontology – The “rightness” or “wrongness” of an action is based on the individual’s duty in the situation, rather than on consequences.

Teleology – The “rightness” or “wrongness” of an action is based on the consequences and what maximizes the “good”. An example of a teleology theory is utilitarianism where the “good” is utility.

Divine Law – God gives the commandments that produce the ethical obligations.

Natural Law – The law within nature is normative.

Natural Rights – All persons possess individual rights and our moral obligations come from those rights.

Character (Virtue) Ethics – A category of ethical theory that tries to answer the question, “What type of person do I want to be in this situation?”

Care (Relationship) Ethics – A category of ethical theory that asks the question, “What must I do to promote this relationship?”

Fidelity – A state of being faithful.

Justice – An ethical principle which promotes fairness and, in the Christian tradition, promotes greater equality.

Morality – A common sense notion of “right” and “wrong” within a given culture.

Nonmaleficence – An ethical principle which holds an act is wrong in so far that it produces harm.

Organizational Ethics – Organizational ethics comprises all organizational relationships, internal and external, to the organization and all the activities and behaviors of the organization resulting from these relationships.

Veracity – An ethical principle which emphasizes truth telling.

Virtue – A trait of character that our ethical system considers praiseworthy. Traditional Christian virtues include faith, hope, and love.

Wesleyan Quadrilateral – Four tools for decision-making used by John Wesley that we now call the Wesleyan Quadrilateral

Scripture
Tradition
Experience
Reason