Three Realms of Ethics: An Integrating Map of Ethics for the Future

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Abstract

The study of bioethics often, especially among health professionals, focuses on the health professional and patient (or other individual) relationship. This limited context serves important ends, but taken alone, distorts the true environment in which health professionals and others live and make moral decisions. A three-tiered partial paradigm of ethics designed to complement existing approaches is described in this chapter.

The first section of the chapter provides background information from many sources and introduces the notion of benevolence and beneficence as used in the paradigm. Benevolence is our inner attitude of "mind and heart relative to human dignity" and aims at affirming all that allows the human spirit to flourish. Beneficence refers to our specific external actions springing from benevolence but takes into account that hard choices must be made because the biddings of benevolence cannot always be realized toward all, due to practical constraints in our everyday lives within society. The foundation upon which benevolence and beneficence is based is the idea of human dignity as the inherent value that every person possesses by virtue of their individual and unique personhood. Some of the reasons we try to avoid hard choices are delineated.

The second and major section of the chapter describes three realms of beneficence or three realms of ethics—individual, organizational, and societal. The several dimensions at each level and the interaction among levels are described.

In the final section, the author provides conclusions and opportunities for further exploration within the three realms paradigm. He explores the potential of a "community of concern" and a shared common vision of community members, including two examples of moving from the individual to the societal realm as the basic orientation by which hard choices are analyzed and acted upon.

Health care ethics lacks a paradigm of ethics that integrates but also differentiates its various realms or dimensions. This is a costly lacuna that, in the judgment of many, leads to confusion and even significant harm to the enterprise of ethics.

Some 40 years ago, Catholic ethicist John Courtney Murray voiced a concern about the failure of Christian morality to recognize the "analogical character of the structures of life (personal, familial, political, social)." Dennis Thompson raises a similar concern about levels of morality in his study of ethics in Congress. He comments, "the task of ethics reform ... should shift its focus from individual corruption to what is here called institutional corruption. ... Instead of simply generating more rules and mounting more investigations to prevent the familiar forms of individual corruption,
we should put more effort into identifying the less familiar institutional forms and devising remedies appropriate to them."\(^2\)

Richard Lamm identifies the same problem in medical ethics and warns that the current map of medical ethics "is leading to increasingly unethical public policy results. ... Medical ethics needs to be revised if it is to provide meaningful guides to future health policy. We need a new ethics map."\(^3\)

In this chapter I address the concerns I share with Murray, Thompson, and Lamm to develop a paradigm that distinguishes and integrates three realms of ethics—individual, organizational, and societal. I want to clarify how and why all of these realms deal with the substance of ethics, but how there is need for significant distinctions between and among these realms. Figure 16.1 illustrates some basic features of this paradigm of layered and nested ethical unity and complexity.

The full picture of ethics includes a fourth realm—global ethics—which I will not discuss further because of the limited concerns of this chapter.\(^4,5\) But I believe that the paradigm I am suggesting—a layered and nested beneficence ethic—calls for and is very compatible with this further dimension.

\section*{ANOTHER MAP OF ETHICS?}

A decade ago I offered this caution about mapping ethics, "Imagine that someone handed you a AAA road map of California and suggested that this represented the state. If you want to drive from Santa Ana to Sacramento, the statement is a valid one. But if you want to drill for oil, plant a vineyard, sell medical supplies, or run for public office, a map of California highways is the wrong map. I am concerned that too often in healthcare ethics we have taken one of many valid maps and treated it as if it were the one, true map of ethics."

Ethics, like friendship, marriage, or death, for example, is too rich a reality to fit into any simple, single conceptualization. As Samuel Johnson reminded us, "We are moralists perpetually, geometers only by accident." So morality is as broad and deep as life itself. It demands a correspondingly wide range of mental models and paradigms.

A strength of recent criticisms of medical ethics is their thrust to expand our understanding of ethics to better approximate the scope of reality. A weakness of some criticisms is that they give the impression that they have arrived with the true map. It seems obvious that the truth lies in no single map but in the complementarity of many essential maps.

This chapter intends to offer another partial and complementary map of ethics. It is only the beginning and more a sketch than a blueprint, but it is, I believe, a map that in its evolution and refinement will become increasingly useful in dealing with the growing challenges of our society and our organizations.

\section*{Human Dignity as Foundation of Ethics and The Moral Law}

Our first step is to establish a common foundation of ethics that will then allow us to identify key differences and relationships within and between the three realms.

I propose that we think of ethics as the disciplined and systematic effort to promote and protect human dignity. As the starting point for ethics, I begin with the human experience that persons and their world are precious—they deserve our reverence, esteem, careful attention, and service. When we look to history we see that its moral heroes are persons who have brought sensitivity and passion to promoting human dignity.\(^6\) Conversely, history's villains are
consistently those who have disregarded and trampled the dignity of their fellow humans. Our experience further confirms that this is a moral law—much like the law of gravity—that we ignore at our own peril: to devalue and abuse the dignity of others leads inexorably to the erosion of our own humanity; to respect and champion human dignity correspondingly deepens our humanity.

By “human dignity” I mean the inherent value that every person possesses by virtue of their individual and unique personhood. This is what Kant points to with his notion that a person is an end and should never be treated as a means. It is what the U.S. Catholic bishops describe in religious terms, “The dignity of the human person, realized in community with others, is the criterion against which all aspects of economic life must be measured. … When we deal with each other, we should do so with the sense of awe that arises in the presence of something holy and sacred.”

There are many perspectives from which we can view and describe this dignity including secular/philosophical and religious/theological; in terms of values and virtues; in terms of law and politics; in terms of ethics and aesthetics. The foundation for building this layered paradigm of ethics is the experienced value of human persons—“human dignity.”

On the one hand, there is a clarity and simplicity about this foundation of ethics—respecting human dignity. On the other hand, we routinely experience how enormously difficult this can be—hence the need for the discipline of ethics. Because it will help develop my line of thought, I want to recall only two of the many reasons why respecting human dignity can be so tortuously difficult; first, human dignity is extremely complex; second, choices for human dignity here are choices against human dignity there.

**Human Dignity is Extremely Rich and Complex**

We are historical beings—placed in the flow of human history and developing individually through the “seven stages” of personhood. We are social and relational in a multilayered and evolving manner, from conception to death. We are unique and individual. There are many schema for teasing apart this social/individual body-mind-spirit complexity. To mention only a few, we have Maslow’s hierarchy of needs; we have the *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV) categories of psychosocial deficits; we have the fields of human studies listed in a university’s catalogue of course offerings. These and multiple other analyses remind us of the expanse and depth of this mystery that we refer to as human dignity.

**Human Dignity and Finitude**

Our hearts and minds create endless dreams but the reach of our serving hands is severely limited. Both philosophical and religious literature make a helpful distinction here between benevolence and beneficence, which can help us understand ethics and its service to human dignity.

*Benevolence* refers to our inner attitude of mind and heart relative to human dignity. It aims at openness and affirmation of all human dignity; a readiness to cherish and reach out to all. Wherever there is human suffering, benevolence weeps; wherever the human spirit rises up in hope, so too does benevolence. *Beneficence* refers to our specific external actions, which spring from our disposition of benevolence. However, beneficence has no alternative but to make hard choices—decisions that serve human dignity here, in this way, at the cost of not serving dignity there, and in other ways.

Bruno Schüller illustrates this with the example of a physician who must cause her patient pain in order to provide needed care. He observes, “In such a situation one stands before two values that compete with one another. To realize one value a person must leave the other unrealized. One must then decide which of the values deserves priority. If we look carefully we see here the characteristic and fundamental human condition: as a finite being, a person has only limited possibilities available for serving the neighbor’s good. A person’s actions cannot effectively benefit everyone, nor respond to any and every legitimate need and deficit. One must make a choice and decide which of those currently available possibilities deserves to be
selected. ... In our daily lives we are not normally conscious of this constant choosing between competing values. In any case, we have become so accustomed to this unrelenting value preference that it hardly ever catches our attention [emphasis added].

The great Western thinker, Augustine of Hippo, provided a succinct statement of the key elements of this approach to ethics which I paraphrase in the following way: We must love everyone equally (benevolence), but since we cannot be of equal service to everyone (beneficence), we should choose those we will serve according to reasoned criteria (i.e., ethical methodology).

I want to emphasize that beneficence as I am using it here is radically different than its usage in bioethical discussions of the last decades. The prevailing bioethical understanding of beneficence interprets it as being virtually synonymous with a paternalistic attitude toward patients. Pellegrino and Thomasma comment, "This is the conception of beneficence still dominant in the minds of many physicians and patients; it still shapes the ethos and ethics of medicine. It is the conception, too, that is the focus of criticisms by proponents of autonomy who equate beneficence almost entirely with medical paternalism."

The way I am using beneficence it does not carry any connotation of superiority or paternalism. Nor is it one of several moral principles; it is not a principle at all. Rather it is the fundamental action and reverential response of a finite moral agent to human dignity. The discipline of normative ethics (which is not the entirety of ethics) is the network of human systems and tools that individuals and communities use to discern where and how dignity should be served in a specific situation.

One might wonder why I would choose beneficence as a central concept when it is so burdened with negative connotations. I have done this because my intended meaning and the role of beneficence have a rich and long tradition measured in millennia. It has this longevity, I believe, because of the power it has to emphasize, integrate, and differentiate foundational realities of human moral existence. I prefer to work for the reestablishment of its profound and original meaning in Western thought, rather than leave it in its current diminished and blemished usage.

**Hard Choices: An Overlooked Essential of Ethics**

The insight that the fundamental situation of normative ethics always involves a hard choice—for some values to the detriment of others for dignity here at the cost of dignity there—has found various expressions across millennia and traditions. Still, in my opinion, its cardinal importance has not been recognized and exploited for health care ethics. This is puzzling, and deserves some exploration before we move on.

Prominent authors—rather than identifying values-in-conflict as an essential dimension of ethical existence—explicitly identify this as an occasional occurrence in ethical experience. For example, we read, "Sometimes we confront two or more prima facie duties or obligations, one of which we cannot fulfill without sacrificing the other(s)." Another author says, "It is clear that an increasing number of theologians insist on understanding moral norms within the conflict model of human reality. Conflicted values mean that occasionally our choices (actions or omissions) are inextricably associated with evil. Thus we cannot always successfully defend professional secrets without deliberately deceiving others..." If, as I am claiming, such value conflicts are omnipresent, how might one explain that this very fabric of value existence and its centrality for ethics are so little noticed?

A partial explanation lies in Schüller's citation of Wittgenstein suggesting that "the aspects of things that are most important to us are concealed under their simplicity and their everyday nature. (One cannot notice the thing because it is always right in front of our eyes.)" We can compare this to our breathing, to the structure of our mother tongue, to the rules of logic—we are inclined to notice these "infrastructures of life" only when they take the forms of aberrations or exaggerations. We only notice our breathing when we are "out of breath"; we spend weeks using our language without attending to its grammatical structure, until someone makes a grammatical mistake.
Then, too, most of the daily value conflicts are so disproportionate that their resolution is obvious and requires no explicit attention. Overlapping this consideration is the fact that macro life decisions—choice of profession, marriage, parenthood, and so forth—imply circles of subordinate micro-decisions that flow spontaneously from the priorities established in the macro-decision. Again, resolving the vast majority of our daily value conflicts takes place spontaneously and below the threshold of our attention. Further, our language usage and mental paradigms habitually direct our attention away from rather than toward this value conflict dimension of life. I think of an experience I had recently, which involved actions that could in certain circumstances qualify as battery, sexual assault, invasion of privacy, infliction of bodily pain, causing anxiety, and inflicting financial loss. How did I refer to this experience in my conversations? As my annual physical exam. That is, I name this actual conflict of values in terms of the preferred value(s) that I intend and that I judge to outweigh the disvalues involved. This is, perhaps, an essential characteristic of human perception and expression; and it points to a central task of ethics, namely to tease out hidden dimensions of life so that we can more consciously and responsibly take them in hand.

In this regard it is important to note how much language goes beyond being a mirror of life and functions as hammer and anvil of our conscious experience. Language shapes consciousness certainly as much as it reflects it. Werner Stark suggests that we recognize the role of language as a mental grid. “We see the broad and deep acres of history through a mental grid. … through a system of values which is established in our minds before we look out onto it—and it is this grid which decides … what will fall into our field of perception.”

So we see that we can be inattentive to our finitude, but we cannot escape the hard choices that this finitude serves up, even in our sleep, or resting in our backyard.

Above we have looked at a basic understanding of ethics that I have characterized as beneficence (not used in its traditional bioethical meaning, but understood as) serving and protecting human dignity within the limited human condition. As Gustafson puts it, “the good is sought under the conditions of finitude.” My claim is not that this is the single best way to understand ethics, but that it is an excellent approach, for many reasons, and especially if we want to differentiate and integrate multiple levels of ethical complexity that are often conflated and seldom well integrated.

**THE THREE REALMS**

In this section we will unpack the understanding of ethics-as-beneficence, and explore how beneficence spells itself out on three levels, individual, organization, and society (Fig. 16.2).

We will examine some key relationships between the three realms and finally make some limited applications.
Individual Beneficence

The simplest realm of ethics/beneficence concerns individuals and their relationships: the relationships that exist within one individual between various values and needs. We can think of these values/needs in various ways—for example, in terms of Maslow's hierarchy of needs; or in terms of physical, emotional, mental, and spiritual. Individual beneficence grapples with differences in degree and intensity within and between these goods. For example, it must weigh the relative importance of intense physical good and moderate spiritual good. It attends to differences of probability and certainty; for example, between near certain emotional harm of a moderate degree and probable intellectual benefit to an extensive degree. It must attend to the whole range of comparable elements, such as long/short term, partial/total, transient/abiding, direct/indirect, central/peripheral.

This realm also deals with weighing and balancing the values/goods/loyalties that stand in tension between two or more individuals. For example, we must weigh my privacy and your need to have information about me, or the need of one person's need for medical treatment and the danger of infection for the professional providing treatment. Again the issues of probability, long/short term trade-offs, degree and extent of harms and benefits all come into play.

Two issues are immediately evident: we are comparing apples and oranges—all the time; and there is no simple, math-like formula for weighing and balancing such “non-comparaibles.” We can only marshal all the human powers of discernment—reasons, intuition, imagination, affect, humor; gifts of individuals, and the synergy of community (its centrality will be further discussed below); discipline and surprise, method and madness—to give ourselves the best chance to make such prudential judgments wisely and with consistency.

The first two decades of bioethics have dealt extensively with this realm of 1a. Most of this era's burning questions fit comfortably in this realm of individual good—patient autonomy, informed consent, privacy, patient rights, truth-telling, living wills, and confidentiality. George Amos, a pioneer and leading researcher in U.S. bioethics captures this focus and spirit when he says, “The core legal and ethical principle that underlies all human interactions in medicine is autonomy.”

But beyond the intra- and inter-individual issues are questions that treat sphere 1b: relationships of individuals to organizations. What responsibilities do patients, nurses, physicians have to their hospital? What trade-offs in income, safety, efficacy of treatment, and confidentiality can individuals be expected to make for the benefit of the institution?

Beyond this realm are issues in the sphere of 1c: relationships of individuals to the common good of society. What personal benefits should I forego or burdens should I bear in order to make community benefits available or harms avoidable? For example, what limits on care, what delays or diminished quality should an individual accept in order that the whole community can be ensured of basic services?

So, in this realm of individual beneficence/ethics there are three aspects: (1) within and between individuals; (2) from individuals toward organizations; and (3) from individuals toward the larger society.

Organizational Beneficence

Normally, the use of the word beneficence has only individuals as its referent. The present analysis understands beneficence in terms of organizations as well. The social realities that I refer to as “organizations”—a family, a union, a business, a hospital, a religious community—have an identity, a purpose, a history, and character. They have vital systems that account for their vigor and health. They have commitments, claims, relationships, and responsibilities.

A primary object of organizational beneficence is the net organizational good—that is, a state of organizational vigor and development that enables the organization to maximize its purpose now and into the future. Those responsible for the organization must seek this net good just as individuals seek net good at an individual level. Obviously the resolution of beneficence choices, in terms of complexity and extent, increases exponentially at this level.

But such pursuit of the organizational good must also consider 2c: the individual good of
those within the organization. For example, let us assume a demonstrated need for the good of a hospital to reduce its size. There are usually many ways to accomplish such a goal. The imperative of beneficence is to find the complex balance of burden/benefit distribution that serves organizational net good, but also attends to the needs of individuals.

An abiding central concern in this regard must be to create a workplace in which human dignity can flourish. In organizations this is accomplished primarily through organizational systems and structures. A simple rule of thumb to guide this effort says, “continuously improve systems and structures so that they make dignity-respecting behavior the easier, rather than the harder, thing to do.”

Organizational beneficence must also attend to 2b: the common good of the society within which the organization exists. For health care institutions not only provide health services, they are also a powerful cultural force and agent. By their presence, their promotional efforts, their budgets, and their services health care institutions have a significant influence on what the general population thinks, hopes, and demands in terms of health care. Hospitals not only respond to but also create demand in the general public about what to expect of a hospital by way of service, convenience, and opulence. Health care institutions are significant forces in shaping public apathy, energy, and indignation. In an over-bedded community, a hospital could even have to face the subordination of its institutional good to the good of the community, resulting in its consolidation with another institution or even its dissolution. Beneficence in the sphere of 2b sustains a consciousness of the organization’s impact on the larger society and insists that as the organization pursues its own net good, it does so constrained by this consideration: how can we best achieve the net good of the organization while also promoting the common good of society? Ethics on this level rejects the adage, “what’s good for General Motors is good for America.”

In daily operations these issues of organizational/institutional ethics are commonly thought of as “operational questions,” “organizational issues,” “financial concerns,” “management issues,” or “marketing programs.” They are that. But in the terms of our discussion they must also be identified as issues that have an impact on human dignity and, therefore, vital issues of ethics.

**Societal Beneficence**

The third realm of an ethic of beneficence is that of society. This realm deals with the common good of society. The *Hastings Center Report* defines the common good as “that which constitutes the well-being of the community—its safety, the integrity of its basic institutions and practices, the preservation of its core values. It also refers to the telos or end toward which the members of the community cooperatively strive—the ‘good life,’ human flourishing, and moral development.”

Garrett Hardin offers a helpful illustration of the common good and how it differs from and can conflict with the good of individuals. He asks us to think of a group of herdsmen who share a common grazing pasture. As long as there is enough pasture to feed the cattle and rejuvenate itself for the future, each individual herder can pursue personal aggrandizement without jeopardizing the common good. But at some point the danger of overgrazing emerges if each individual continues to increase the size of his herd. As long as the horizon of reflection remains individual—“what benefit comes to me from adding one more animal to my herd?”—the problem can neither be identified in a timely way nor resolved. Hardin says, “Therein is the tragedy. Each man is locked into a system that compels him to increase his herd without limits—in a world that is limited. Ruin is the destination toward which all men rush, each pursuing his own best interest in a society that believes in the freedom of the commons. Freedom in a commons brings ruin to all.”

This echoes the comment of Lamm at the beginning of this chapter, that bringing the categories of individual ethics to societal problems “is leading to increasingly unethical public policy results.”

Societal beneficence is another term for the ethics of the commons. It knows that the common good is not achieved by some invisible hand as we each pursue our own individual
good. Societal beneficence brings heart, mind, imagination, and hands to the nurturing of this common good.

Attending to the commons involves balancing the many conflicting needs/goods of the commons—education, housing, defense, health care, art, infrastructure, and so forth. Being unable to meet any one or all of these societal needs fully, we seek a reasonable balance among them. The major task of societal beneficence is continually to attend to this balance by correcting historical aberrations, adjusting to new forces and circumstances, and creating new opportunities so that society can be the environment of dignity’s flourishing.

A further dimension of societal ethics concerns the balance within the essential institutions of societal common good—education, health, housing, and so forth. For example, achieving the “health care good” of society involves finding the appropriate balance among competing health care needs, such as prevention and cure, acute and chronic care, research and education, administration and direct service.

The primary goal of societal ethics is not to attend to the unique and specific goals of each individual but to so structure society and allocate resources that the fabric of society in which individuals and institutions exist can be an environment of human flourishing in the present moment and into the future. But in seeking this primary goal of the common good of society, the good of individuals and the good of organizations must also be attended to. As in the other two realms of beneficence the concern must look in three directions: 3a, primarily to the common good, to the net good of society as a whole; secondarily to 3b, the good of organizations; and 3c, the good of individuals.

**DETERMINING THE PRIMARY LEVEL OF ETHICAL CONCERN**

Most issues have ethical significance on all three levels and need to be addressed on each level appropriately. For example, informed consent has ethical concerns on the levels of individual, institution, and society. This issue deserves ethical inquiry. On the individual level, what should this physician disclose to this patient/family in this set of circumstances? On the institutional level, what policies, procedures, educational programs, patient brochures, quality assurance mechanisms, ethics committee activities should a hospital have to promote informed consent in the institution? On the societal level, what professional standards, federal regulations, state laws should be in place to promote a general practice of informed consent?

But hardly ever are these levels of equal importance. Some questions are primarily “institutional questions,” with the individual/societal levels being secondary and/or tertiary considerations. Other issues are primarily issues of individual ethics, and still others are essentially issues of societal ethics.

For example, the decision to downsize an institution is primarily a question of institutional ethics. This means that the decision results from a careful examination and weighing of the good of the institution: for the good of the institution, is this drastic step necessary? What other alternatives must be tried? For how long? How should it be done? What follow-up is required for those terminated and the survivors? So, even though many individuals will suffer harm from such a decision, it can be the institution’s ethical responsibility to move forward with a reduction in force. An important benefit of the beneficence understanding of ethics is that it demands that we explicitly note and attend to the values that are determined to be of lower priority in this instance.

But the question of participation in an experimental treatment is primarily a question on the individual level. This question should be resolved in terms of the individual patient’s best interest, as defined by the patient. One cannot justify forcing patient participation because the hospital’s experimental program will greatly benefit, or because future generations will benefit. Those are considerations that an individual could include in their calculus on the individual level but could not justify an institution’s coercive action.

The question of national health policy is an ethical issue on the societal level. For the sake of
the common good of the United States many institutions—e.g., insurance companies, hospitals, universities—and many individuals—e.g., patients and clinicians—will have to accept serious burdens and limits set to their expectations and practices in order for society to create a reasonable and just health care system.

One of the fundamental starting points for ethical discussion will be to determine which level, if any, is the preeminent level of ethical importance. This presents us with a set of ethical questions that we seldom ask explicitly and clearly in current discussions. For example, in the extensive discussion of California’s Proposition 161 (the proposition that would have authorized active euthanasia and physician-assisted suicide), most discussions went forward as if this were primarily an issue of individual ethics with some secondary questions on the societal level—primarily formulated in terms of prevention of abuse. There would have been a different series of discussions had we all presumed that Proposition 161 was essentially a question of societal ethics—or even if we had begun by asking which level deserved to be primary.

How does one establish the preeminent level? Although the fullness of this consideration can only emerge from the community addressing these difficult questions over time, the following suggestions are an invitation to take up this challenge. I will phrase these in terms of ethical presumptions (I cast these in terms of societal ethics, but with appropriate changes, similar presumptions could be formulated concerning individual and institutional ethics).

A question is presumed to be one of societal ethics if:

✦ it has serious consequences for future generations;
✦ it involves interdependence of major societal institutions—political, economic, educational, legal, etc.;
✦ it demands sacrifices from significant numbers on behalf of others;
✦ it has disproportionate impact on identifiable groups of persons;
✦ it requires extensive studies of multiple disciplines to reasonably represent its complexity;
✦ it has an impact on significant institutions—schools, businesses, groups of professionals, etc.;
✦ it requires organization and integration of such complexity that individuals and institutions cannot accomplish it adequately;
✦ it endangers the already marginalized;
✦ it involves long-standing cultural assumptions;
✦ its center concerns pivotal mysteries of life—sexuality, partnering, aging, dying, etc.
✦ its success requires broad, coercive measures.

These modest suggestions invite critique and modification; they point to the kind of ethical collaborative work that should rank high on the list of priorities for the future.

UNITY AND DIVERSITY OF BENEFICENCE ACROSS THE THREE REALMS

It is important to emphasize the fundamental unity of beneficence/ethics across these spheres, but also to recognize its diversity.

Unity

The emphasis on unity and the interdependence of these spheres on one another is a major strength of the Three Realms model. Too often our language masks this unity instead of emphasizing it. Authors often distinguish “morality” from “public policy,” the “abstract order of ethics” from the “concrete order of jurisprudence,” the “moral order” from “public policy.” This inconsistent language confuses and fragments our ethical efforts. We need to develop a conceptual world and language that first emphasizes the unity of morality as we move across these spheres. Absent this foundation, we reinforce the common error that the “authentic world of ethics” resides in the realm of individual good and that beyond such real
ethics lies only the ethical “outback” of politics, common sense, and law. Especially in U.S. culture, we further make the mistake of approaching all ethical questions with the conceptual tools, moral imagination, and methodology adequate only for the simplest level of ethical reflection. Such misperception blunts our awareness of the most demanding areas of ethics, and tends to fragment our moral intellect and imagination. A major strength of the three-realm paradigm resides in its emphasis on the unity of ethical reality.

Diversity

But beneficence/ethics across these realms is analogous, not univocal, and this involves significant differences between these spheres with relationships of interdependence that are not always parallel or reciprocal in every way. A suggestive sketch of some differences would include the following:

1. All things being equal, as we move from realm 1 to 3, the ethical reality becomes exponentially both more significant and more complex.

2. Methods, concepts, and principles are presumed not to have the same importance, relevance, and adequacy on one level as they do on another (for example: The principle of autonomy has an importance on level 1a that it does not sustain on level 2a, and is relativized still more on level 3a), nor does this mean that individuals must be honest, but organizations or societies need not be honest. It does mean that telling the truth, the whole truth, and nothing but the truth is not simply the same for individuals, organizations, and society.

3. Conclusions reached on one level do not lead to necessary conclusions on another level. (For example, to demonstrate that active euthanasia could be an ethically reasonable option in an individual case does not lead with any logical necessity to substantive conclusions on the organizational level and even less so on the societal level.)

4. Substantial deficits on a higher level cannot be adequately compensated for by interventions on a lower level. (For example, it is not possible to correct a substantially unjust health care system merely by multiplying the activity of individual hospitals or health professionals.)

5. The ethical character of the higher spheres tends to powerfully define the limits on ethical behavior in the sphere(s) below. (For example, the injustices of a societal system, such as Medicaid, will tend to inhibit just behavior of institutions and professionals by punishing those who attempt to behave beyond the boundaries drawn by the system.)

6. Professional education in different fields tends to develop awareness/unawareness to different levels of beneficence. (For example, in the United States professional training for social work tends to open awareness to the full range of beneficence more than does professional training for law.)

7. Different cultures can predispose their members to emphasize one level of beneficence over the others. For example, according to a statement by Fox and Swazey that for the Chinese “the bedrock and point of departure of medical morality lie in the quality of these human relationships: in how correct, respectful, harmonious, complementary, and reciprocal they are.”21 We would expect this culture to emphasize social beneficence more than individual beneficence. By contrast, the proclivity in U.S. culture is to make the perspective of the individual realm dominant, if not exclusive. This cultural predisposition finds expression in statements that rely on autonomy.

8. Most issues of health care ethics have significance on all three levels, but more often than not an issue has a primary level of ethical significance that constitutes the ethical center of the issue. The other spheres should be resolved relative to this ethical center. For example, refus-
ing treatment is primarily a question of individual ethics, but institutions and society need to make structural protection and facilitation of this refusal a real possibility. On the other hand, developing a reasonable national health policy is essentially an issue of societal ethics, where individuals and institutions must subordinate their specific interests to the greater good of society.

This is a beginning list of some obvious differences that exist between these realms of ethical reality. Here again we meet an area where significant work remains to be done in understanding such differences across these spheres.

✧ FURTHER EXPLORATIONS

At the heart of beneficence is community. The very term beneficence emphasizes that we are essentially social beings—persons-in-relationships. It implies that the natural state of persons is reciprocal, responsive, and engaged. It understands self-giving as essential and self-realizing; it sees the love imperative primarily as an invitation to become, not as a constraint on being. The three-tiered model of beneficence symbolizes how thoroughly individuals are embedded in layers of social reality—individuals exist within networks of mediating organizations and these in turn are woven into a matrix of society. Community is the ocean in which we swim.

Exploring the “Community of Concern” Presumption

In a beneficence ethic there is a presumption that the privileged agent of ethical discernment is the “community of concern.”

Certainly, individual ethics makes sense and existential ethical decisions are always made by individuals. But as the three-layered paradigm makes clear at a glance, most ethical terrain involves community. Beyond this, making normative ethical judgments involves the weighing of complex and subtle values and this emerges primarily from experience of these values—from a pool of experience wide and deep enough to do justice to the issue at hand. Here we are on the wrong track if professionals’ views of patient experience are taken for patient experience; if men represent the experience of women; if doctors mediate nurses’ views; if administrators speak for the general public. To weigh complex values, we need complex, firsthand experience, as well as adequate analysis of that experience.

Gathering the key elements of this firsthand experience is what the “community of concern” is all about. This is a formal concept to be materially specified by the issue at hand. The community of concern is constituted by whatever group is necessary to be in experiential touch with all the essential facets of a beneficence question. Lacking the full community of concern, we are in ethical trouble from the start. No individual or partial group, regardless of ethical fiber or training, can substitute for the full community of concern.

A historical example illustrates this. As late as 1866 the Holy Office of the Roman Catholic Church declared, “Slavery itself … is not at all contrary to the natural and divine law. … For the sort of ownership which a slave owner has over a slave is understood as nothing other than the perpetual right of disposing of the work of a slave for one’s own benefit.” It was not until 1891 that the Vatican formally condemned the institution of slavery as a moral evil. We can imagine how differently the reality of slavery would have been understood, and how much more quickly it would have been condemned, if slaves had been empowered partners in that discernment process.

This historical example illustrates the importance of having all persons relevant to an issue, present and empowered in the discernment process about that issue. There is a tendency that haunts us humans when we face complex value issues; we tend to accept the de facto empowered group as adequate for the discernment at hand. Why is this?

I think a central cause is what I call unconscious, constricted, and stratified consciousness. Our consciousness is unavoidably constricted—we don’t know important things, but we don’t know that we don’t know. Further,
this constricted consciousness is stratified—the systems and structures of life tend to cluster us with others who share our ignorance and the ignorance of our ignorance. Being such a community of compassionate but unaware constricted consciousness, we experience little reservation about the depth or breadth of our vision and little urgency to expand the community of discernment.

If we aim to improve the ethical culture of our organization we will go a long way by first recognizing the fact of our constricted consciousness and our strong tendency to be untroubled by this; second, by building a culture in which decision makers at all levels live by this credo: In this organization, decisions start with defining and gathering the community of concern.

From this perspective, hospitals represent a moral minefield. Hospitals are highly structured along lines that stratify, fragment, and compartmentalize. Such a structure is ethically inhibiting, viewed from the perspective of the community of concern because it keeps like-minded groups reflecting within their limited field of experience. Perhaps the ethics committee movement’s greatest contribution can be to introduce a new paradigm of reflection and empowerment into the highly compartmentalized health care structure.

One of the first questions asked by an ethic of beneficence will be, do we have the right community for this issue? If not, what persons do we need to give us the necessary fullness of perspective?

Exploring a Shared Common Vision of Community Members

A key difference between a gathering of special interest advocates and a community of concern is that the latter share a deeper vision that binds them and their differing perspectives into a coherent whole. There may be strong differences on various perspectives of the issue, but stronger still are their grounding meanings and priorities. Selecting the community of concern involves finding persons who share this deeper vision or are capable of being called to it. This deeper vision demands attention and resources. It is not simply a given. Elsewhere I have explored how a superficial agreement about justice can hide a deeper level of strong disagreements.23 A community of concern needs to nurture its shared vision, to test its consensus, to sharpen its definitions, to deepen it, to revise it. Neglect of this deeper vision erodes the community’s ability to ethically discern.

Tools of Community Enablement

The community of concern needs to be enabled to harness the complexity of values and disvalues, deeper vision and complementary perspectives. For this we need cognitional tools and process tools.

Cognitional Tools

Philosophical and theological ethics can help us understand the importance and role of definitions, distinctions, concepts, principles, and paradigms. These disciplines can provide formal understanding of these elements and material content for application. These disciplines can also suggest methodologies for harnessing this complexity of elements and moving it progressively to closure.

But evaluative knowledge involved in beneficence is more than abstract concepts and cold analysis. Such knowledge is mystic, affective knowledge of the heart and imagination. Here our resources are not extensively developed, and considerable work needs to be done. Fortunately, there is a growing recognition of the direct importance of the arts and literature as tools of enablement for the discerning community. It is in this area that case studies and parables can give human breadth and depth to more discursive principles and definitions.

Group Process Tools

To handle the complex group it has gathered, beneficence needs adequate group process. Adequate process will facilitate a fullness of reflection that (1) is focused but not rigidly constricting; (2) is coextensive with the length and breadth of the problem, not ignoring...
essential areas, not coming to premature closure; (3) attends to persons as well as issues; (4) ensures input from all and monopoly of none; (5) allows for self-examination and interpersonal communication; (6) promotes open challenge and confrontation; and (7) includes intellection, intuition, affect, and imagination. Front-end planning of meetings cannot guarantee these characteristics but it can go far in enabling them.

Moving from Individual to Societal Realm: Two Examples

Now I want to consider two examples that illustrate the U.S. tendency to assume and resolve issues as if they were issues of individual ethics and how differently the issues are discussed and resolved when we locate them on the institutional level.

Example One: Case Consultation—An Issue of Institutional, Not Individual, Ethics

First let us look at the question of case consultation as a function of ethics committees. In an article, “A Paradigm Shift for Case Consultation,” a colleague and I have argued in substance—though not in these terms—that the common practice of ethics committees is to treat case consultations as a series of difficult individual cases. In effect, we are treating the problem as one with its center of gravity on the level of individual ethics. Our suggestion is that we should move our gaze to the institutional level of ethical reality and define the problem as one of institutional ethics.

If we see the cases that come to the Institutional Ethics Committee as symptoms of institutional ethical dysfunction, we will diagnose the institution’s problem and change the organizational systems and structures, rather than focusing on a case-by-case resolution. Our argument is developed in two theses.

Thesis One: Case consultation by an ethics committee should be recognized as an institutional embarrassment to be eliminated as soon as possible and replaced by institutional change—consistent, effective patterns of case conferencing by staff as a routine part of patient care. The chronic problem is an organizational deficit—the absence of adequate discussion of patient care by the community of key stakeholders in the case. Because the worst effects of this chronic deficit have finally come to our attention, the “ethics case consultation,” a stopgap intervention, has been invented. Using Howard Brody’s metaphor of ethics-as-conversation, we would argue that because appropriate conversations were not being held by the right people, at the right times, and in the right places, the ethics case consultation was invented to ensure that at least some conversations, with some of the right persons, were being held somewhere. Given this persistent institutional deficit, the “ethics case consultation” does provide some symptomatic relief, but leaves the fundamental ethical problem—on the institutional level—unresolved. So we find ourselves in the ironic but not uncommon situation in which amelioration in terms of individual ethics becomes a disservice in terms of institutional ethics.

We propose an approach that promises more widespread and abiding results because it addresses the problem on the level of institutional ethics. Most simply put, it involves changing institutional systems and structures, as well as staff understandings and behaviors, so that the primary care community (patient, loved ones, and the clinical professionals involved in giving care) discuss the ethical dimensions of cases effectively, consistently, and adequately in the setting of care. This means institutionalizing the consistent and effective use of case conferences at the unit level.

To achieve this, a number of elements will be needed: (1) an institution will need to develop a consensus across key groups of professionals, from trustees to technicians, that case conferencing is an essential element of excellence in patient care; (2) an institution will need to identify the elements of a case conference and when such a conference would be needed; (3) an institution will need systems and structures to support this practice, including policies, procedures, integration into the quality assurance process, orientation, credentialing, and so on; (4) an institution will need to provide education so that key publics share a common fund of knowledge, including familiarity with (a) the cases that have shaped the current
ethical and legal understanding of our culture, (b) the boundaries set by legislative and administrative bodies, and positions taken by major religions, cultural groups, institutions, and professional societies, and (c) basic concepts, definitions, and principles of the current discussion (e.g., autonomy, informed consent, competence, etc.); (5) an institution will also be helped by a methodology or protocol for conferencing. This overall methodology will attend to three phases of the case conference including preparation, conduct of the conference, and follow-up.

Example Two: Reducing Medical Errors

Lucian Leape has been a national leader in addressing the grave ethical issue of reducing medical errors. He asked, “Why has healthcare been so lax at error reduction?” Leape’s answer, translated into three-realm ethics language is this: We have made the mistake of treating error reduction as if it were an issue of individual ethics, when, in fact, it is an issue of organizational ethics. He says, “[W]e have been locked into an ineffective paradigm. That paradigm, which is rarely questioned, is that mistakes can be avoided if everyone is trained not to make them. But this is a misconception. The truth is, mistakes are inevitable. The key is to learn from them and prevent them from happening in the future.”

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**Figure 16.3** The graphic captures some of the major elements discussed in this chapter.
to make them and punished when they do. Some have referred to this as the ‘train and blame’ approach.”

Organizational ethics looks first and foremost to systems and structures, while individual ethics concentrates on individual intention, attention, and performance. He sees health care’s concern for errors focused on persons, not processes. “Mortality and morbidity conferences, incident reports, risk management activities, and quality assurance committees abound. But … these activities focus on incidents and individuals.” Leape urges significant changes on the organizational level. We need to move from a culture of blame to one of learning and continuous improvement. This involves systems of rhetoric, self-identity, reporting, planning, incentives, evaluation, and analysis.

But Leape also recognizes the societal realm and its importance for organizational improvement, “Finally, healthcare has to deal with the culture of blame outside its walls. It is not only health professionals who are judgmental—it is a characteristic of our society. … But the larger ‘message,’ that errors are systems problems not people problems needs to be spread throughout the land—to regulators, to the media, and to the public.”

In terms of the three-realm model, Leape urges us to move from treating errors as if they were primarily issues of individual ethics to seeing them primarily as issues of organizational ethics. This requires seeing the elements of societal ethics that require attention for our organizational efforts to thoroughly succeed.

**SUMMARY**

I have proposed the beginnings of a partial and complementary paradigm of ethics. This paradigm begins with the experience of the law of human dignity and its demand for respect—alogous to the demand of gravity for respect. But even our fullest-hearted response is always realized in the condition of finitude. The foundational issue of ethics is therefore, where and how am I called to honor and serve human dignity because I cannot serve it all? It is important to see such hard choices/beneficence as falling into three realms—beneficence of individuals, of organizations, and of society. These two key building blocks—the nature of beneficence and its three-tiered realization—provide the foundation for building an approach to ethics more appropriate for emerging problems.

**References**


