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# Phase II of Bioethics: The Turn to the Social Nature of Individuals

by John W. Glaser

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*Ethics encompasses different spheres of human activity: individual, institutional, and social ethics. The doing of ethics on these different levels points to a need to balance values differently, address new kinds of conflicts, and see consequences which vary widely. The societal impact of physician-assisted suicide serves as an example for analysis.*

When I think of the future and evolution of health care ethics, my attention turns, not to a specific issue such as genetics or managed care, but to a question that cuts across all such specific issues and shapes how we might think about them.

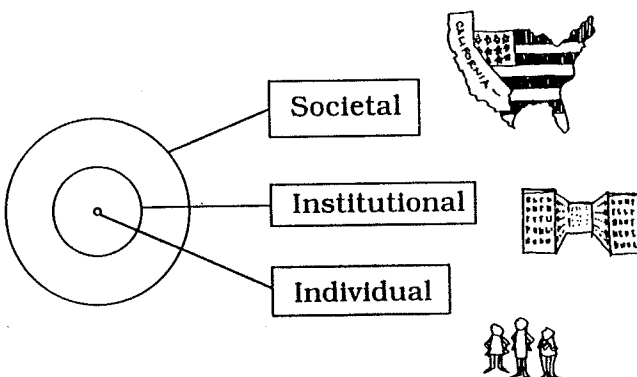
In bioethics we have been living in the small village of autonomy for the past several decades. The motto is captured in the words of George Annas: "The core legal and ethical principle that underlies all human interactions in medicine is autonomy" (Annas 1990). In this village we start discussions with the individual and his/her rights. Our analysis of individual ethics forms the center of our activities. If we move to social implications we often see this as addressing the "slippery slope" or preventing abuse. We are emerging from Phase I of bioethics—the individualistic paradigm—to Phase II, an expanded

paradigm that includes social dimensions of institution and society. The complexity of Phase II can be illustrated by three concentric realms: individual ethics, institutional (or organizational) ethics, and societal ethics (Glaser 1993, 1994). The figure on this page is a schematic representation of this model.

This paper explores these three realms of ethical reality. It then applies this paradigm to the question of physician-assisted death, examining how differently we would address the ethics of physician-assisted death as an issue of societal ethics rather than an issue of individual ethics.

## Three Realms of Ethics: Individual, Institutional, Societal

The simplest realm is that of *individual* ethics. Here the concern is primarily with the good of individuals. This concern includes relationships: the relationships that exist within one individual between various values and needs—physical, emotional, mental, and spiritual. Important in this realm are differences in degree and intensity within and between these goods; for example, it weighs the



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relative importance of intense physical good and moderate spiritual good. The differences of probability and certainty, between near certain emotional harm of a moderate degree and probable intellectual benefit to an extensive degree are important facets of this realm. It examines 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 individuals, for example, an individual's privacy against another's need to have information about that individual. The issues of probability, long/short term trade-offs, degree and extent of harms and benefits are all significant.

Beyond the intra- and inter-individual issues are issues that treat the relationships of individuals to organizations, for example, defining the responsibilities of patients, nurses, physicians to their hospital, and the trade-offs in income, efficacy of treatment, and confidentiality individuals might be expected to make for the benefit of the institution. Finally, individual ethics considers the relationships of individuals to the common good of society, for example, the limits on care, the delays or diminished quality an individual accepts in order that the whole community can be assured of basic services.

#### *Institutional Ethics*

The social realities referred to here as "institutions"—a family, a business, a hospital—have an identity, a purpose, a history. They have vital systems accounting for their vigor and health, as well as commitments, claims, relationships, and responsibilities.

A primary object of institutional ethics is the net institutional good, that is, a state of vigor and development that enables the institution to maximize its purpose. Each institution has its seat of responsibility—parents in a family, officials in a religious community, governance and management in a hospital. They seek the net good of the institution just as individuals do at an individual

level. Obviously the resolution of ethical choices, in terms of complexity and extent, increases exponentially at this level.

Pursuit of the institutional good also includes the good of those within the institution. For example, assuming an urgent need for the good of a hospital to reduce its cost, there are many ways to accomplish this goal. The imperative is to find the complex balance of burden/benefit distribution that serves institutional net good but also attends to the needs of individuals. Institutional ethics must also attend to the common good of the society within which the institution exists.

In daily operations these issues are commonly thought of as "operational questions," "organizational issues," "financial concerns," "management issues," or "marketing programs." In the terms of this discussion they are also identified as central issues of institutional ethics.

#### *Societal Ethics*

The final realm is that of societal ethics, which examines 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" (Jennings et al. 1987). Garrett Hardin offers a helpful illustration of the common good and how disastrous it is to overlook this reality. 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. 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 trag-

edy. 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 to—

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*The primary goal of societal ethics is to structure society and allocate resources so that the society in which individuals and institutions exist can be an environment of human flourishing.*

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ward which all men rush, each pursuing his own interest in a society that believes in the freedom of the commons. Freedom in a commons brings ruin to all" (Hardin 1968).

Attending to the commons involves balancing the conflicting needs/goods of the commons: education, housing, defense, health care, infrastructure, and so forth. Being unable to meet any one or all of these needs fully, we seek a reasonable balance among them. The major task of societal ethics is to achieve this balance by correcting historical aberrations, adjusting to new forces and circumstances, and creating new opportunities so that society can be humane and nurture growth.

The primary goal of societal ethics is to structure society and allocate resources so that the society in which individuals and institutions exist can be an environment of human flourishing.

#### **Ethics—Analogous Across the Three Realms**

Ethics across these realms is analogous, not univocal, and involves significant differences between the spheres with relationships of interdependence that are not always parallel or reciprocal. Some differences include the following:

1. As we move from the realm of individual to that of societal ethics, 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 the individual level, that it does not sustain on the institutional level and it is relativized still more on the societal level);

3. Conclusions reached on one level do not lead to necessary conclusions on another level. (For example: To demonstrate that active physician-assisted death could be an ethically reasonable option in one case does not lead with logical necessity to substantive conclusions on the institutional 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 an unjust health care system merely by multiplying the activity of individual hospitals or health professionals; the injustice must be remedied at the societal level);

5. The ethical character of higher spheres tends to define limits on behavior in the lower ones;

6. Professional education in different fields tends to develop awareness/unawareness to different levels of ethics. (For example: In the United States professional training for social work may increase awareness to the full range of ethics more than does professional training for law);

7. Different cultures can predispose their members to emphasize one level of ethics over the others. For example: According to the statement of Fox/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" (1988), we would expect Chinese culture to emphasize social beneficence more than individual beneficence. By contrast, the proclivity in United States culture is to make the perspective of the individual dominant. This predisposition finds expression in statements such as that by George Annas: "The core legal and ethical principle that underlies all human interactions in medicine is autonomy" (Annas 1990).

8. Most issues of health care ethics have signifi-

cance 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.

### *Meaning in Each Sphere with Preeminence of One Sphere*

Let us consider number eight in more detail. Specific issues have ethical significance on all three levels and need to be addressed on each level. For example, informed consent has ethical significance on the levels of individual, institution, and society. On the *individual level* one would be concerned about questions such as: What should this physician disclose to the patient/family in this set of circumstances? When is silence the equivalent of deception? At what point, if any, may physician judgment trump patient judgment concerning the appropriateness and need of information? On the *institutional level* one would consider questions such as: What policies, procedures, educational programs, patient brochures, quality assurance mechanisms, ethics committee activities should a hospital have to protect patient autonomy and promote informed consent? What protections for professional autonomy deserve attention? On the *societal level* one would consider issues such as: What systems and structures of public policy do we need? Is this an arena for legal intervention? Are professional standards more appropriate than laws? To the extent that laws are appropriate should they be at the federal and/or state level?

Number eight states further that while all issues have significance on all levels, one is preeminent and demands ethical priority. This dominant realm indicates the starting point and the scope of the enquiry; it determines tools and methods needed; it serves as the horizon on which the other dimensions are understood and evaluated. While such preeminence does not ignore the significance of other realms, it relativizes their importance and provides the larger context of their meaning. This means that some questions are primarily individual questions, others are institutional questions, and still others are mainly soci-

etal questions.

For example, 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. It would not be right to force patient participation on the grounds that the hospital's experimental program will greatly benefit, or because future generations will benefit. Those are considerations that an individual could include in his or her calculus on the individual level but could never justify an institution's or society's coercive action. Participation in experimentation is fundamentally a question of individual ethics.

The issue of downsizing an institution is mainly a question of institutional ethics. This means that the overall good of the institution is the first and most important perspective from which to view and analyze this question. Protecting the best interest of the individuals impacted by this action is a secondary consideration. In such cases the best interest of the institution will conflict with the interests of some individuals and when this happens the institution's best interest deserves to prevail. Indeed, the individual good needs to be taken seriously as a limit-setting factor in cases of institutional ethics but here the role of individual good is secondary and constraining, rather than primary and shaping.

The question of national health policy is a good example of an issue that is essentially societal in its ethical importance. This means that to really tackle the ethics of health policy we must start with and focus on the common good, not the best interest of individuals. For the sake of the common good of the United States many institutions—for example, insurance companies, hospitals, universities—and many individuals—for example, patients and clinicians—will have to accept substantial burdens and limits set to their expectations and practices in order for society to create a reasonable and just health care system. Daniel Callahan reflects this judgment about the societal preeminence of health policy when he says: "A society that thinks of illness as simply

an individual phenomenon, with an occasional public face, is already on the wrong track. . . . We have no lasting hope of devising a decent understanding of health—and thus of fashioning a viable health care system—unless we learn better how to attend to the social dimension of health, indeed unless we learn how to shift our priorities sharply in a societal direction.”<sup>1</sup>

Phase II of bioethics will recognize the importance of determining which level is the preeminent level of importance. This will present us with a set of ethical questions that we seldom ask explicitly in current discussions. For example, in the extensive discussion of California’s Proposition 161 that would have authorized active physician-assisted death 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 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.

We’ve begun delineating principles for determining when an issue qualifies as preeminently societal in nature (Glaser 1994). The real work of developing criteria, paradigm cases, methodology, and so on, for determining the preeminent realm of specific questions will emerge as a central issue and challenge in the following decades of Phase II of bioethics.

### **Physician-Assisted Death: Primarily a Question of Individual or Societal Ethics?**

To explore further the three-realms paradigm of ethical reality we will examine the ethics of physician-assisted death: 1) as if it were primarily a question of individual ethics; and 2) as if it were primarily a question of societal ethics.

#### *Physician-Assisted Death as Preeminently a Question of Individual Ethics*

On this level we deal primarily with individual best interest, with the rights and responsibilities that individuals have to themselves and to other

individuals. We ask various questions: May I deliberately and actively end my own life? If yes, what justifying grounds do I need? Does my autonomous wish suffice? Do I need to be suffering unremitting pain? Must I have a terminal condition? Does only God/the State have ultimate dominion over dying or does God/the State share this dominion with me? Is there an ethically significant difference between my refusing life-sustaining treatment and my taking a lethal dose of medication? Is there an ethically significant difference between assisted suicide and physician-assisted death? Beyond having a right to end my life, do I have a duty to end my life under some circumstances? What would they be? Do you have a duty to prevent me from taking my life? Always? If not always, under what circumstances? Do you have a duty to help me take my life if I am unable to do it without your help?

We should establish the definitions and distinctions needed for this level. We might distinguish between assisted suicide and active euthanasia. The deliberate act of ending life might be distinguished from decisions to limit treatment—either by withholding or withdrawing—and thereby hastening death. One would decide whether it is helpful to use terms such as active and passive physician-assisted death or to distinguish between killing and allowing to die. Here we face the fact that all descriptions have language of moral connotation—for example, is this physician-assisted dying? physician killing? tolerated murder? assisted suicide? my final act of self-determination?

Beyond these definitional issues one also elaborates the complexity of principles, value priorities, paradigms, decisional authority, and methodology. To the extent that we are able to clarify such questions we will have reached conclusions about if and when one may deliberately end his/her own life and/or the life of another person. If we believe that persons have a right to physician-assisted death, we will then proceed to draw individual, institutional and societal conclusions that flow from such rights.

The majority of writing on physician-assisted

death seems to move on this level of ethical reflection. The considerations focus on the individual, and the conceptual and affective center of gravity remains on this level. Often a case is presented in which a person is in the final and punishing stages of disease. The patient experiences this condition as degrading and requests that his/her life be ended. The case is then made that the principle of autonomy justifies the request and that others should be helpful to the person in this desperate situation. Conclusions are drawn about conditions, dangers, safeguards, and desired legal changes.<sup>1</sup> Oregon's Measure 16, for example, approaches this question in substantially the same way.

### Physician-Assisted Death as an Issue of Societal Ethics

How would the ethical treatment of physician-assisted death be different if we approached it primarily as an issue of societal ethics? The graphic model of the three realms introduced earlier indicates that the sphere of societal ethics is exponentially larger and more complex than the sphere of individual ethics. *Consequently, the following sketch cannot begin to embrace the fullness of physician-assisted death as a societal issue.* Rather, it examines a fraction of this vast area and gives a sense of how questions might be posed, burdens of proof distributed, and resolution pursued.

#### *Presumptions*

We begin by noting some presumptions that are essential on the societal level and that vary significantly from presumptions on the individual level.

1. The dominant ethical principle is that of the *common good*. We seek the best interest of society seen as a whole, not a remedy for a set of hard cases.

2. A law of the common good is that some individuals and institutions will be required to make sacrifices that others will not in order to achieve this larger common good. No major policy choices are without uncomfortable or even painful consequences. No resolution, then, is disqualified simply because some individuals can be

shown to be endangered or disadvantaged by this arrangement. Societal ethics does not aim at the elimination of all dangers and burdens but at the minimization and fair distribution of dangers/burdens compatible with the common good.

3. Specifically, the *autonomy* of some individuals will always be curtailed in policy decisions. In the societal realm, autonomy is one facet of a larger picture.

4. When we change expectations, understand-

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*How would the ethical treatment of physician-assisted death be different if we approached it primarily as an issue of societal ethics?*

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ings, attitudes, behaviors, systems and structures about central mysteries of human existence—freedom, birth, sexuality, death, and so on—we set in motion a powerful evolutionary process, not merely a discrete and definable change in the immediate future.

5. In giving shape and direction to this evolutionary process, the presumption is that social forces will prevail over the intentions of authors and architects of change. For example, in a society that is stamped by gender bias, major interventions can be expected to evolve incorporating this deeper culture bias regardless of the intentions of the authors of change.

6. Social systems tend to sink deep roots and endure. They develop constituencies, beneficiaries and a social momentum that sometimes perpetuate themselves even when they prove manifestly dysfunctional. Prevention and cautious preparation should be in proportion to the gravity and complexity of the social issue in question.

These are a few of the kinds of assumptions that will ground the societal analysis. Developing a

full range of assumptions and a consensus about them is another task for Phase II of bioethics.

### *Societal Definitions*

Societal ethics requires societal definitions of the reality in question. The following are possible definitions of physician-assisted death in terms of its societal reality.

Physician-assisted death as a social reality involves

- privatization of some homicides, shifting a class of killings from the realm of public scrutiny to the guarded privacy of physician-patient relationships
- establishment of a new level of empowerment for physicians over the dying of their patients
- altering the understanding of death as a medical event
- deepening the understanding of death as a reality to be more managed, planned, and under our control
- introduction of elements that can evolve into a perception of a duty to end our life
- provision of a legal, safe harbor for those who assist others to end their lives

Such attempts at societal definitions suggest some conclusions. First, many definitions are needed on the societal level; no single definition can capture the richness of the societal reality. Next, it is more difficult to develop fair and objective societal definitions than it is to define on the individual level. On the societal level there is greater opportunity for smuggling one's ethical conclusions into the early stages of defining the question. Also, no single discipline has a privileged vantage point from which to define the societal reality because the social fabric is so complex. Each discipline brings its sharper vision for some aspects of the issue, but this acuity is accompanied by a distance and alienation from other dimensions of the reality. Further, there is the question of which of these societal dimensions are so essential that they must be included in an

adequate definition and which are marginal enough to be excluded. Who decides these and similar central questions?

### **Society-As-Is Demands Scrutiny**

Societal ethics is reality-based. It asks: Into what social matrix of forces are we inserting this intervention/change? For example, it is not interested in the kind of physician-patient relationship a physician *should* have to justify participation in a physician-assisted death. Societal ethics is more fundamentally concerned about how, *in fact*, physicians as a group relate to their patients and what the implications of these relationships are for physician-assisted death. Societal ethics does not map the virtues of the "good physician"; it tracks the footprints of the "real, practicing physicians." If legalizing physician-assisted death will introduce a new "mechanism of mortality" into society, then societal ethics will be interested in examining whether or not and to what degree this society has built-in mechanisms of disadvantage related to gender, race, class, and so on.

To advance this discussion we should focus on one dimension of the social forces—namely, physicians—that require examination. The following items represent a partial listing of issues that require careful, extensive review if we would do justice to physician-assisted death as an issue of societal ethics.

*Palliative Care:* What degree of interest and competence do physicians manifest concerning palliative care? Pain management is one aspect of this issue. How important is pain management to physicians? How skilled are they in this area? How concerned are they about deficiencies? To what extent do credentialing and other incentive systems support excellence of pain management? How well do physicians understand hospice philosophy and to what extent do they see hospice care as an integral part of their network of practice?

*Facing Death:* How well do physicians face the ambiguous and painful fact of death—their own and that of their patients—in a direct, open, and constructive way? To what extent do they recog-

nize that dealing directly with death is an essential issue of quality patient care? To what extent does their training include skills in this area? To what extent do physicians pursue ever greater skill in this regard?

*Communication:* To what extent do physicians identify communication as a high priority and recognize it as a skill that demands attention and training? To what extent do they manifest a high level of skill in this regard and invest time in improving this skill? To what extent do they recognize the special difficulties that arise from the lack of parity in the physician-patient relationship and take effective steps to correct for this imbalance? To what extent do they recognize "time for talking" as an essential of quality patient care?

*Depression:* To what extent do physicians understand the role of depression in sickness? To what extent are they skilled in recognizing depression and treating it appropriately, either directly or through appropriate referral?

*Death as personal/social/spiritual event:* To what extent do physicians recognize that death is not primarily a medical reality? To what extent do they see death as a medical failure? To what extent do they see a good death as a medical goal and medical success? To what extent do they see a diminished role for scientific medicine in a dying person's life? To what extent do they have an understanding of the positive tasks and modes of caring for dying persons?

*Exploring the meanings of patients' requests for death:* A patient's wish to die can have a number of meanings: he can be tired of acute medical treatment, clinically depressed; have under or untreated pain; feel that she is a burden, or that others wish that she would die; feel abandoned or hopeless. The meaning can shift over time for the same person. To what extent are physicians aware of the ambiguity of requests for death? To what extent do they have the desire and skills to explore them adequately?

*Nonphysician Issues of Society-As-Is:*

Beyond the kinds of physician issues sketched

above, there are dimensions of society-as-is that are essential to physician-assisted death as a societal issue. We shall consider two to give further ideas of the kinds of investigation that we need to undertake.

*Racial/Gender Bias:* To what extent does our society have built-in mechanisms of bias based on race and/or gender? These mechanisms include language, patterns of professional practice, legislation, judicial practice, funding of programs, patterns of housing, structures of employment, financing of education, availability of insurance, dynamics of the media. To what extent and by what direct and indirect mechanisms can we anticipate these systems synergizing with the above physician behaviors in the evolution of physician-assisted death and lacing this practice with unintended bias?

*Evolution to Capitation:* While we are trying to understand current physician behaviors and their potential impact on physician-assisted death, larger forces are pressing current patterns into unexamined new ones. Steven Miles reminds us: "Meanwhile, the United States is restructuring the clinician-patient relationship into new clinician-plan-member-patient configurations within powerful institutions in which clinicians are accountable for the health of both individuals and of populations on a finite budget. . . . The tide is running too fast to recalibrate this gyrocompass, even with care" (Miles 1995). Societal ethics will give special consideration to such historical changes as vital factors in calculating the common good.

### **Societal Options: Beyond Yes/No**

Societal ethics must generate an adequate range of options and should rarely accept simple either-or scenarios. Even on the individual level, a simple "Shall we permit A, or prohibit A?" is often a failing against moral imagination. But on the societal level a hasty narrowing of options can be catastrophic. Let us consider a range of options that address the problems for which physician-assisted death is seen as the solution.

A society could decide that there are steps to



be taken *before* the legalization of physician-assisted death can be considered. The following issues fall at various points on the continuum of social coercion—from civic sermon to legislative mandate:

- developing standards of practice that reduce patient overtreatment;
- requiring that health professionals demonstrate high levels of competency in managing pain and build this into professional education, licensure, board certification, and so on;
- establishing required levels of competency in discussing death and dying with patients and in providing care appropriate for dying persons;
- educating and empowering the public as to the proper management of pain and care of the dying so that inappropriate care is not tolerated;
- developing an understanding of good and bad death and standards of care that promote good death.

If a society does decide that it should change its legal prohibition of physician-assisted death, there is a larger range of options than a simple yes/no. Some of these options include the following:

- defining death as a personal/social/spiritual reality and authorizing family, clergy, and counselors, rather than physicians, as legal assistants-in-death;
- imitating the Netherlands, where physician-assisted death remains a crime but is not prosecuted so long as specific guidelines are followed;
- maintaining physician-assisted death's status as a crime but accepting the legal defense of mercy;
- allowing only those physicians to practice physician-assisted death who have earned certification requiring demonstrated skills in communication and care of the dying;
- allowing the practice of physician-assisted death only by physicians who are part of a li-

censed "terminal care team" which includes psychological, spiritual, and social professional competencies;

- allowing only assisted suicide, but not physician-administered death;
- treating the legalization of physician-assisted death as a social experiment with stringent design, data gathering, practice and evaluation requirements to be assessed in three-to-five years;
- instituting physician-assisted death institutional review boards that approve each individual case prospectively or review each case retrospectively;
- requiring an environmental impact study to be submitted before any changes could be made.

It seems clear that many of the above options—by themselves or in combinations—provide a better mix of societal risk and benefit than the proposal of moving physician-assisted death from felony to DRG. An examination of such options would help uncover aspects of legalizing physician-assisted death that remain hidden if the only question is whether or not we should legalize physician-assisted death. Societal ethics requires that one expend energy in generating options that go beyond the simplistic (Miller et al. 1994).

### Relevance of the Netherlands

The experience of the Netherlands with physician-assisted death is relevant to our examination of societal ethics. The facts are debated by those closest to the phenomenon and many distinctions and cautions are in order when comparing the experience and relevance of one country with another. Nevertheless, Holland offers us valuable societal data. For example, one Dutch commentator remarks: "In the 1970s the 'euthanasia movement' in the Netherlands began as a protest against the power of contemporary medicine to alienate individuals from their own dying. Instead of counterbalancing that power and enhancing the individual's autonomy and control over his or her own life, it seems that social acceptance of euthanasia is resulting in physicians acquiring even more power over the life and death of the

patients" (Keown 1992).

Whether or not he is correct on this issue, the commentator is addressing important issues in societal ethics: How does decision making happen? How does the balance of power evolve over time? Because of the extensive data generated during Holland's twenty-five-year experiment with physician-assisted death, societal ethics insists on an extended and in-depth examination of this phenomenon.

### Need for Broader Expertise

Societal ethics requires a broader band of philosophical tradition than has been present up to this time. Fox and Swazey note: "It is primarily American analytic philosophy—with its emphasis on theory, methodology, and technique, and its utilitarian, Kantian, and 'contractarian' outlooks—in which most of the philosophers who have entered bioethics were trained" (Fox and Swazey 1988). The three-realm paradigm suggests that this narrower philosophical tradition is not enough. The latter is most comfortable in the realm of individual ethics and has a tendency to keep us confined to a "minimalist ethics" (Callahan 1981) rather than push us to a recognition and proficiency in the broader realms.

As the next phase of bioethics evolves, we will need the help of such fields as sociology, anthropology, philosophy/theology of society, feminist studies, political science, public health, organizational development, and social psychology. The works of writers such as Fox, Swazey, Payer, and Glendon, which set our own ethical and legal assumptions into a broader social and multicultural context, point to the potential of such work for an expanded horizon of bioethics. At present such efforts sit at the margins rather than give us direction and leadership. In the next decades there will be a direct relationship between the level of vigor, creativity, and fruitfulness of health care ethics and the degree to which these now-foreign disciplines assume roles of prominence and leadership.

### Conclusion

The future suggests a significant, startling shift that deserves to be characterized as Phase II of bioethics. This new mind-set will extend beyond the ethics of individuals and move this narrower ethic into the natural and larger context of social reality—institutions and society.

Mary Ann Glendon's comment reminds us of where we are and why we need to expand our vision. "Our simplistic rights talk regularly promotes the short-run over the long-term, sporadic crisis intervention over systemic preventive measures, and particular interests over the common good. It is just not up to the job of dealing with the types of problems that presently confront liberal, pluralistic, modern societies" (Glendon 1990).

Most of the tools needed for Phase II are strewn like Ezekiel's dry bones across the landscape. Our challenge is to search out these scattered essentials, gather them, join ankle to leg to thigh, and set them to dancing.

### Endnotes

1. See Brody 1992, 1993; Miller, Quill, Brody, Fletcher, et al. 1994; Miller and Brody 1995; Quill 1993; and Quill, Cassel, and Meier 1992.

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