A SYSTEMS APPROACH IN CLINICAL, ORGANIZATIONAL AND PROFESSIONAL ETHICS IN HEALTHCARE

Dina Siniora

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A SYSTEMS APPROACH IN CLINICAL, ORGANIZATIONAL AND PROFESSIONAL ETHICS IN HEALTHCARE

A Dissertation
Submitted to the McAnulty College and Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By
Dina Nasri Siniora

May 2022
A SYSTEMS APPROACH IN CLINICAL, ORGANIZATIONAL AND PROFESSIONAL ETHICS IN HEALTHCARE

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Approved December 15, 2021

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Sincerely,

Dina Nasri Siniora
ABSTRACT

A SYSTEMS APPROACH IN CLINICAL, ORGANIZATIONAL AND PROFESSIONAL ETHICS IN HEALTHCARE

Dina Nasri Siniora

May 2022

Dissertation supervised by Gerard Magill, Ph.D.

This dissertation aims to apply a systems approach to clinical, organizational, and professional ethics in healthcare. A systems approach can offer a valuable understanding of bioethical issues and should be more extensively utilized to advance the bioethical analysis. This research is proposed to inspire systemic thinking as an approach to tackle the issues in clinical, organizational, and professional ethics, given that healthcare ethics can be considered as a kind of systems thinking because it takes into consideration the connections among several systems and comprehends their consequences on one another. Systems thinking has appeared as a means of hypothesizing and tackling complex public health problems, thus stimulating more ordinary comprehending of problems and corresponding solutions. Systems thinking tries to tackle the
complexity of problems through qualitative and quantitative modeling. To date, nevertheless, there has been little engagement between systems scientists and those working in bioethics. The purpose of this dissertation is to try to combine the prominent characteristics of the systems approach with bioethics to help solve bioethical challenges. Thinking and working across disciplines is not a novel notion in bioethics, nor is the idea that it is significant to involve and urge the contribution and involvement of different stakeholders. Generally, bioethics recognize that tackling healthcare problems imply taking into consideration the interconnected character of people and their associations with their environments, and this suggests that bioethics is open to incorporating systems thinking as part of the bioethical examination. This dissertation tries to construct a systems approach to be utilized in different areas of clinical, organizational, and professional ethics.
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Chapter 1: Introduction: A Systems Approach in Clinical & Organizational Ethics in Healthcare

This proposal aims to apply a systems approach to clinical, organizational, and professional ethics in healthcare. A systems approach can offer a valuable understanding of bioethical issues and should be more extensively utilized to advance the bioethical analysis. This research is proposed to inspire systemic thinking as an approach to tackle the issues in clinical, organizational, and professional ethics, given that healthcare ethics can be considered as a kind of systems thinking because it takes into consideration the connections among several systems and comprehends their consequences on one another.

Systems thinking has appeared as a means of hypothesizing and tackling complex public health problems, thus stimulating more ordinary comprehending of problems and corresponding solutions. Systems thinking tries to tackle the complexity of problems through qualitative and quantitative modeling. To date, nevertheless, there has been little engagement between systems scientists and those working in bioethics. The purpose of this dissertation is to try to combine the prominent characteristics of the systems approach with bioethics to help solve bioethical challenges, including public health challenges. Thinking and working across disciplines is not a novel notion in bioethics, nor is the idea that it is significant to involve and urge the contribution and involvement of different stakeholders.

There is little recognition of a connection between systems thinking and Clinical, Organizational, and Professional Ethics in Healthcare academic literature. The proposal aims to answer how the essential characteristics of systems thinking can assist in conceptualizing details of specific healthcare ethics challenges. The crucial characteristics of systemic organizations are the collaboration and interaction among participants to reshape the nature of bioethical issues to
offer new possible solutions. A Systems Approach stimulates continual learning. It is suggested
that these characteristics encourage and lead to ethical behavior.

Generally, bioethics recognize that tackling healthcare problems imply taking into
consideration the interconnected character of people and their associations with their
environments, and this suggests that bioethics is open to incorporating systems thinking as part
of the bioethical examination. This dissertation tries to construct a systems approach to be
utilized in different areas of clinical, organizational, and professional ethics.

The thesis of the dissertation is to present a Systems Approach in Clinical,
Organizational, and Professional Ethics in Healthcare. The State of the Question indicates there
is a gap in the literature related to the different approaches that are used in these related fields.
The dissertation engages this gap by presenting a more consistent approach.

The core characteristics of the Systems Approach that shapes the dissertation can be
described in this manner. First, there is collaboration across disciplines, sectors, and
organizations that engage holistically and coherently the complexities and inter-
connected relationships in healthcare. This characteristic nurtures the inter-related identity of
professionals in healthcare. Second, there is continuous learning for practical problem-solving to
address existing and emerging real-world challenges in healthcare. This characteristic nurtures
the accountability of professionals in healthcare. Third, there is leadership that inspires ethical
behavior among all stakeholders, being attuned to the contextual, operational reality of
healthcare. These characteristics nurture ethical conduct among professionals in healthcare.

These characteristics of a Systems Approach guide the analysis of the chapters. Chapter 1
presents an introduction and overview of the dissertation. Chapter 2 explains the meaning of a
Systems Approach that is applied in the subsequent chapters. Chapter 3 discusses ethical
decision-making to highlight the significance of vulnerability and consent in the Systems Approach that is adopted. Chapter 4 discusses a Systems Approach in clinical ethics, focusing on patient safety and epigenetics as pivotal challenges. Chapter 5 discusses a Systems Approach in organizational ethics, focusing on corporate social responsibility as governance ethics as crucial strategic concerns. Chapter 6 discusses a Systems Approach in professional ethics, focusing on virtue ethics and professional virtues as indispensable traits for healthcare. Chapter 7 presents a brief conclusion to the analysis.

**Chapter 1. Introduction.** This chapter provides an overview of the analysis of all the chapters.

**Chapter 2. Adopting a Systems Approach in Healthcare**

Chapter one presents a general introduction to the dissertation, summarizing the chapters as presented below.


2. I. Systems Theory & Systems Dynamics

2. I.A. Systems Theory

Systems Theory engages a Systems Approach. The emphasis upon systems emerged as a response to the failure of reductionist approaches to complexity in biological and social fields. This response sought better organization regarding complexity, focusing on understanding the ‘structures’ that lie beneath complexity to identify crucial relationships within. This approach, originally referred to as Systems Thinking, developed as a trans-discipline in the 1940s and 1950s across many disciplinary fields, engaging real-world challenges and problems coherently.
Systems theory emerged as an interdisciplinary endeavor to understand and explain complex events and relationships in a comprehensive way. This holistic perspective can be described as embracing the relationship and interaction among individual elements in a combined manner. Examples of this approach include the General System Theory of the biologist Ludwig von Bertalanffy and the Open System Model that management scholars incorporated in institutions.

In Systems Theory there can be hard and soft models. Hard systems thinking, a general name assigned by Checkland, is intended to resolve practical problems developed during and directly following the Second World War. The innovators of hard systems thinking adopt a scientific approach to problems for decision-makers. Soft systems thinking emerged in the 1970s and 1980s by Vickers's development of appreciative systems theory, focusing on applying theory to practice extensively. The approach by Vickers on soft systems methodology focuses on organizations and management, seeking to provide real-world, diverse, and comprehensive perspectives.

2. I.B. System Dynamics.

At the Massachusetts Institute of Technology, Forrester and his team established system dynamics as a rigorous applied systems approach. Peter Senge popularized this framework in his book The Fifth Discipline (1990), endorsing system dynamics as the fundamental approach to construct learning organizations. In this approach, ‘learning’ is a critical component in system dynamics, enabling managers to understand the complexity of systems. A fundamental characteristic of his approach was the formation of computer-based simulation models that could be tested for validity against the performance of real-world situations. The focus here is on facts and evidence to explain causes and effects in the complexity of a system. The approach emphasizes how relationships can be understood through causal loops. The connections between
causal loops comprise the general structure of the system and control the system’s behavior.\textsuperscript{16} Here, the focus is upon crucial factors that considerably influence the system.\textsuperscript{17} The goal of system dynamics, focusing on its inherent inter-connections, is to offer a comprehensive structure of complex systems. This approach enables intervention promptly that aligns behavior with the system’s objectives.\textsuperscript{18}

2. II. Systems Thinking & Systems Stakeholders.

2.II.A. Systems Thinking.

The interaction between Systems Theory and Systems Dynamics is crucial for Systems Thinking. Here, Systems Thinking refers to a set of theoretical and methodical techniques to formulate consistent interpretations about events by structurally interpreting interconnections.\textsuperscript{19} This interpretation includes both the broad and the specific items.\textsuperscript{20} The approach makes use of computer-simulation tools,\textsuperscript{21} to create a new way of thinking to give significance to events.\textsuperscript{22} System Dynamics provides a procedural approach to thinking and learning.\textsuperscript{23} This approach enables Systems Thinking to formulate consistent interpretations in relation to an underlying structure,\textsuperscript{24} thereby giving significance to specific events,\textsuperscript{25} and leading to concrete actions.\textsuperscript{26}

Systems Thinking tools have an extensive assortment of applications and functions to foster shared understanding about a subject for timely analysis and action.\textsuperscript{27} This approach focuses on interrelated, intersecting, and contextually sensitive issues,\textsuperscript{28} gathering new information as needed to explore emerging hypotheses.\textsuperscript{29} The significance of System Dynamics in this approach facilitates attention to small issues or fluctuations that can create big effects,\textsuperscript{30} highlighting the importance of learning, as crucial in Senge’s writings.\textsuperscript{31}

2.II.B. System Stakeholders.

For Systems Thinking to understand the significance of relationships, such as in reducing the potential of undesirable effects,\textsuperscript{32} it relies on System Stakeholders and their networks as actors
influencing the relevant system and its components.\textsuperscript{33} The importance of networks and network theory is to focus on a participatory, supportive approach among stakeholders, entailing a renewed method of management, leadership, and connections among institutions.\textsuperscript{34} The focus is on social collaboration, connections, partnership, collective action, trust, and teamwork. A network can be described as a group of three or more persons, clusters, or bodies linked in ways that enable the attainment of a mutual objective. The relations between network partners are primarily nonhierarchical, interconnected by many kinds of links, such as information, materials, financial resources, services, and social support. Network interaction among organizations occurs principally between persons representing organizations.\textsuperscript{35}

2.III.A. Systems in the Healthcare Sector.

Referring to the definition of the World Health Organization, a health system is comprised of all institutions, individuals, and engagements whose chief intent is to encourage, reestablish or preserve health. Its objectives are enhancing health and health justice in economically fair ways, using the most effective use of existing resources.\textsuperscript{36} The WHO “Framework for Action” identifies six building blocks that together establish a Health System: service delivery, health workforce, health information, medical technologies, health financing, and leadership and governance.\textsuperscript{37}

2.III.B. Systems Thinking and Healthcare.

Several characteristics of Systems Thinking emerge are crucial in healthcare. First, there is collaboration across disciplines, sectors, and organizations. Here Systems Thinking requires actors to extend beyond their specialty zone of knowledge to cooperate with partners with different practices, experiences, and objectives. Second, Systems Thinking entails ongoing, iterative learning whereby systems-level change requires an acknowledgment that the setting is
constantly fluctuating. Here, actors must continuously adapt, understand, and apply new knowledge to existing challenges. Third, Systems Thinking involves transformational leadership that challenges fundamental views about health and a shared vision of fairness and efficiency, inspiring ethical values among all stakeholders.

Systems Thinking is especially appropriate in healthcare to address the complexities that surround health today, not least from the perspective of public health were issues discussed later. Here, Systems Thinking is well equipped to address concerns of interdependency, complexity, information management, and relationships within and between institutions. That is, Systems Thinking provides a paradigm change from narrowly focused, reductionist methods to broadly engaged, holistic methods. This broader approach engages the complicated and interrelated interactions among health system complements. This approach also addresses the benefits and influence of its stakeholders. As a result, Systems Thinking can establish pathways to finding and solving health system challenges, address dynamically both clinical and organizational problems, recognize instability, and react adaptably to emerging opportunities. Furthermore, Systems Thinking fosters awareness of the connections and associations in healthcare, while enhancing a variety of competencies to improve communications. These competencies include efforts to support interdisciplinary relationships and maintain trust, to form and direct effective teams, to embrace continuous education especially conflict management, to emphasize procedures and processes, to advance morale, and to support problem-solving.

Systems Thinking is particularly relevant from the perspective of Public Health that transcends individual healthcare to focus on the healthcare of populations, nationally and globally. In this context, Systems Thinking can foster crucial connections and collaborations across healthcare systems, involving multiple stakeholders from policymakers to international
funderson.49 An example of Systems Thinking in this context of Public Health is a Pilot Initiative on the Study and Implementation of Systems (ISIS), funded by the National Cancer Institute (NCI). This Initiative adopts Systems Thinking approaches to engage several inter-related endeavors: to understand causes of multiple diseases related to tobacco use; to enlighten strategic decision-making about plans to decrease tobacco use rate and incidence of tobacco-related disease and to serve as a paradigm for tackling other public health challenges.50 During the first year of ISIS, an expert in Systems Thinking, George Richardson, led a process of focus groups and meetings to investigate a tobacco control system. There were two crucial conclusions. First, there was a recognition of the contribution of complex systems that help to highlight relevant connections.51 Second, when there is insufficient or dysfunctional information exchange, systems that could be operational are compromised and even prevented from accomplishing positive effects.52

In sum, this chapter discusses the contribution of a Systems Approach in healthcare. Understanding the connection between Systems Theory & Systems Dynamics in relation to Systems Thinking & System Stakeholders clarifies the distinctive relevance of a Systems Approach in healthcare.


The core characteristics of the Systems Approach that shapes the dissertation can be described in this manner. First, there is collaboration across disciplines, sectors, and organizations that engage holistically and coherently the complexities and inter-connected relationships in healthcare. This characteristic nurtures the inter-related identity of professionals in healthcare. Second, there is continuous learning for practical problem-solving to address existing and emerging real-world challenges in healthcare. This characteristic nurtures the
accountability of professionals in healthcare. Third, there is leadership that inspires ethical behavior among all stakeholders, being attuned to the contextual, operational reality of healthcare. This characteristic nurtures ethical conduct among professionals in healthcare. 53

These characteristics of a Systems Approach guide the analysis of the chapters, beginning with ethical decision-making (chapter 3), and then discussing pivotal issues in clinical ethics (chapter 4), organizational ethics (chapter 5), and professional ethics (chapter 6).

**Chapter 3: Systems Approach in Ethical Decision-Making**

Chapter 3 discusses the Systems Approach in ethical decision-making, highlighting the significance of vulnerability and consent. In the discussion, the core characteristics of the Systems Approach emerge: collaboration that nurtures the inter-related identity of professionals; continuous learning and problem-solving that nurtures the accountability of professionals; and leadership that nurtures ethical conduct among professionals.

This chapter presents informed consent as the base of bioethics, the tangible indication of respect for people and for autonomous decision-making. Research conducted in international backgrounds, apprehensions about cultural differences, the vulnerability of research subjects, and conditions that limit voluntary consent have created several requirements in ethics guidance papers. These requirements aim to achieve respect for individuals and autonomous choice. Nevertheless, confirming consent is truly voluntary and entirely informed is challenging. 53

Despite the creation of IRB processes and increased government oversight, challenges remain. 54

The ethical dilemmas in the standards of informed consent applied by research institutions and pharmaceutical companies in developing countries will be discussed.

3. 1. Vulnerability in Research and Health Care
3. I.A. Vulnerability in Research and Health

Vulnerability and Vulnerable Populations

“Vulnerability” term is a fairly new one in the discourse of bioethics; it was used in the Belmont Report in 1979 for the first time. The meaning of the concept has gradually evolved. At first, the vulnerability was reflected as a special deliberation in the application of the bioethical principles of respect for persons, beneficence, and justice, mostly applicable in the framework of research with human beings. In the 1993 CIOMS guidelines, the notion of “vulnerability” developed and was described vulnerability for the first time as significant incapability to protect one’s own welfare. This implies that the decision-making may be compromised, hindered, impaired, or lacking by particular internal and external circumstances.55

In order to better protect vulnerable populations in research sponsored by the developed world and conducted in the developing world, it is suggested that exceptional examination and review should be performed by the institutional review boards (IRBs) or Institutional Review Board (IRB) in each country. The documentation of research ethics committee authorization is the final phase in certifying the utmost scientific and ethical standards, and an obligatory stage in safeguarding research subjects and sustaining public trust.56 Such committees follow guiding principles that are based on universal ethical principles: Autonomy, nonmaleficence, beneficence, and justice. These principles are grounded in the 1975 Declaration of Helsinki and the 1947 Nuremberg Codes. They generally seek to confirm that the research subjects fully comprehend the research satisfactorily to make a rational decision, that the participant tolerates no harm, and that the research ends play a role in improving the general wellbeing and public health, and that recruitment admires the notion of justice.57 The ethical principle of respect for personal autonomy endorses the person's freedom and capacity for intended action, upon which the concept of informed consent can be grounded.58
Vulnerability Types

In clinical research ethics, specific groups of people are assumed to have more tendency than others to be abused and taken advantage of as research subjects. These are labeled as “vulnerable”, and this status creates responsibilities and obligations for researchers and ethics review committees to offer special safeguards for them.\(^{59}\) Inherent sources of vulnerability comprise human interdependence and emotional and social natures, which are an inevitable component of the human condition. There are situational sources of vulnerability which are circumstance specific and include ‘the individual, social, political, economic circumstances of an individual or social group’.\(^{60}\)

3.I. B. Respect for Human Vulnerability and Personal Integrity

Article 8: Principle of Respect for Human Vulnerability and Personal Integrity

UNESCO’s International Bioethics Committee (IBC) released the Report of IBC on the Principle of Respect for Human Vulnerability and Personal Integrity. Article 8 of the Declaration involves both a ‘negative’ duty to abstain from doing something and a ‘positive’ duty to endorse solidarity and to share the advantages of scientific advance.\(^{61}\) This declaration is promoted as one of the most fundamental principles of global bioethics.\(^{62}\) It fosters respect for human dignity and protection of human rights, adds value to the normative aspect of bioethical issues, and offers a universal structure of major principles and procedures to guide nations in the preparation of their policies.\(^{63}\)

It is essential to shedding the light on the vulnerability of research subjects because it helps to clarify the problematic nature of the issue and suggest a solution. The research subjects in developing countries are vulnerable because they come from socially underprivileged groups. The human dimensions of vulnerability and integrity deserve uttermost respect and the
participants’ bodies should be treated as a subject, and not an object, that is inseparable from the person it compromises.64

The Ethical Significance of Human Vulnerability

Vulnerability is a fundamental notion in protecting human subjects in research.65 Health-care professionals may be accustomed to recognizing vulnerabilities associated with the physical and mental condition of their patients or research subjects, it may require more conscious effort to identify and explore how social, political, and environmental factors not only result in or aggravate vulnerabilities, but how this later set of elements affects the former.66

Informed consent is the basis of bioethics, the tangible indication of respect for people, particularly for vulnerable populations. Research conducted in international backgrounds, apprehensions about cultural differences, the vulnerability of research subjects, and conditions that limit voluntary consent have created several requirements in ethics guidance papers. These requirements aim to achieve respect and protection for vulnerable individuals and autonomous choice. As demonstrated in this essay, in many developing countries, the lack of access to health services can undermine the process of informed consent as a protective measure of vulnerable populations.67

3. II Informed Consent

3.II.A. Informed consent Applied by Research Institutions as a Protective Mean to Protect the Vulnerable

Informed Consent and Exploitation of the Vulnerable

The informed consent form has a philosophical basis, religious basis, and legal basis. “Respect for persons” is the ethical principle found in the U.S National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research reflects the solid reason to seeking informed consent. This principle confirms that the research subjects will be treated as
ends, not merely as means to another’s ends based on the Kantian principle.\textsuperscript{68} To ensure that, informed consent should be dealt with as a process, a discussion, or ongoing conversation.\textsuperscript{69} Nuremberg Code is the first universal normative framework standardizing the norms of research in clinical trials. According to Nuremberg Code, the research participant must meet the four conditions to consent to participate in a given research trial, and any compromise in any of these conditions risks the ethical adequacy of the consent.\textsuperscript{70} It has subsequently been duplicated in all major ethical codes including the International Covenant on Civil and Political Rights, the Declaration of Helsinki, and (CIOMS) guidelines.\textsuperscript{71}

The appearance of the human immunodeficiency virus (HIV) pandemic and its related negative social effects has employed new requirements on ethical standards concerning informed consent for medical investigations.\textsuperscript{72} Informed consent is a vital ethical principle that was first systemized in the Nuremberg Code in the wake of the Nazi experiments. It has subsequently been duplicated in all major ethical codes including the International Covenant on Civil and Political Rights, the Declaration of Helsinki, and (CIOMS) guidelines.\textsuperscript{73} To put an end to the exploitation of the economically disadvantaged, in 1979, voluntary informed consent was made with the drafting of the Belmont Report.\textsuperscript{74} In 1986, the Belmont Report was accepted by sixteen federal organizations and departments and codified the Common Rule, which commands researchers to draft consent forms and have all research subjects sign them. Organizations getting federal funding to conduct research trials must affirm that they will comply with the Common Rule requirements including informed consent. The Office for Human Research Protections (OHRP) is accountable for guaranteeing that institutions conform to their assurances and the Common Rule through conducting site visits.\textsuperscript{75}

Inadequacy of Informed Consent with Vulnerable Populations
Informed consent is one of the cornerstones of research ethics. It may be impossible for potential subjects who are ill and lack health care services to refuse research involvement, informed consent is strongly compromised in such cases. Informed consent fails to fully protect vulnerable research subjects. Due to gaps in knowledge and authority between researchers and their subjects, informed consents are not sufficient by itself as means of protection. In informed consent, the rationality of the subject is deemed sufficient to confirm his or her autonomy. However, this kind of justification disregards the significant link between autonomy and freedom.

3.II.B. Informed consent in Developing Countries Applied by Research Institutions and Pharmaceutical companies

Informed Consent related to Conducting Research in Developing Countries

Based on the American Medical Association, informed consent is a fundamental policy in both ethics and law that health care professionals must respect. It is a method of communication between the researcher and the research participant that eventually ends in the approval or negation of a specific intervention or research study. Cultural, socioeconomic, and educational elements might also influence the process of informed consent. In developing countries, there is a lack of understanding related to terminology in the presence of low literacy levels. Another challenge to informed consent arises from the complexity and uncertainty of the information created by developed technologies and extended research prospects. Moreover, the therapeutic misconception of research subjects poses a real challenge to the sufficiency of the informed consent process and the ethics of clinical trials.

Major problems with Informed Consent related to Conducting Research in Developing Countries

Major problems have been faced when researching developing countries that have different cultural perspectives than that of developed countries. Guarding the rights of the most
vulnerable while corresponding to the needs of the many. The relevant informed consent should balance an institutional review board’s (IRB’s) rule: addressing the needs of the host country, balancing the principles of ethical research recognized by developed countries, suitable for the culture of the developing country. Beneficence, justice, and respect for the rights of each human being should be conveyed.\(^{85}\)

3.II.C. Moving Towards a Better Informed Consent Process
How to Improve Informed Consent

Ground-breaking strategies and rigorous studies are greatly required to help the development of informed consent, and thus better fulfill one of the central obligations of ethical research.\(^{86}\) Fifty years after Nuremberg, it is evident that the law by itself is inadequate to control unethical medical experimentation and protect vulnerable human research subjects.\(^{87}\) There should be a collective effort to comprehend the motivations, preferences, and needs of people in developing countries who participate in clinical studies.\(^{88}\)

A framework of Improved Consent Process by HIV Prevention Trials Network (HPTN)

Through domestic and global studies conducted by the HIV Prevention Trials Network (HPTN), funded by the National Institutes of Health, a framework of the improved consent process is presented after the researchers in the study faced many scientific and ethical challenges.\(^{89}\) The HPTN is an international collaborative clinical trial network that develops and tests the safety and efficacy of non-vaccine trials intended to stop the spread of HIV.\(^{90}\) HPTN researchers have found it critical not to go beyond the subject’s absorptive capacity. Thus, researchers have to increase their efforts and spend more time with potential research subjects. They should explain the informed consent process and the array of responsibilities the subjects have to abide by during the research period.\(^{91}\)
3. III. Clinical Ethics Consultation

The practice of Health Care Ethics Consultation (HCEC) has become an ordinary way for hospitals to tackle ethical challenges and problems while delivering healthcare services. Consultation services should be formally integrated into organizational policy because many elements play a significant role in creating quality consultation services. They should have leadership support, accountability, staff time, organizational learning, access, and proficiency.92

3.III.A. Clinical Ethics Consultation (CEC): Background Information

Historical Development of CEC

In response to the requests of the patients and their families and practitioners for support in tackling the ethical dilemmas they face in attaining and delivering health care, the practice of Clinical Ethics Consultation (CEC) has appeared over the past 30 years. Concerns in clinical ethics are usually of great significance in the lives of the involved parties, and they are often complicated and challenging as they involve complex notions and foreseeable uncertainty. CEC help in finding, investigating, and assessing potential solutions, a range of suitable moral choices from which those with a decision-making expert may select.93 In 1991, the Joint Commission on Accreditation of Healthcare Organizations approved new patients’ rights standards that necessitated hospitals looking for accreditation to create means to tackle ethical questions in patient care.94

The Current State of Clinical Ethics Consultation (CEC)

Bioethics is different from clinical ethics consultation in many aspects. At the end of the 1960s, the multidisciplinary field of bioethics appeared principally out of the curiosities of university-based academics, researchers, and clinicians. Academic journals rapidly emerged and concerned researchers started to gather learned societies. In 1969, The Society for Health and
Human Values (SHHV) appeared, followed by the American Society of Bioethics (ASB) in 1994. The discipline of bioethics had appeared, combined by associated academicians in medical humanities.95

3.III.B. Clinical Ethics Consultation (CEC): In-Depth

Overview of Clinical Ethics Infrastructure Development in Different Countries

In the US, CECs have been set up succeeding the compulsion of the Joint Commission on Accreditation of Health Care Organizations (JCAHO) to create organizational mechanisms and solve any ethical problems that may arise in the institution.96 By 2007, nearly 81% of the hospitals in the United States had an ethics consultation service of some nature, and 100% of hospitals with 400 beds or more, hospitals that are members of the Council of Teaching Hospitals, and federal hospitals were found to Ethics Consultation Services (ECS).97

Typical Problems that Necessitate the Use of HCEC

People conducting HCEC come from diverse professional and personal backgrounds such as nurses, physicians, social workers, chaplains, administrators, philosophers, and theologians.98 Clinical ethics committees have usually been involved in various activities such as case consultations; drafting ethics-related strategies and policies; and training of healthcare staff in clinical ethics.

The characteristic “problems” that necessitate the use of clinical ethics consultation can occur at three main levels: uncomplicated cases, cases that involve a dispute between two or more parties, cases that involve a frequent difficulty.99

3.III.C. Ethics Consultation Forms and Goals

Forms and Models of HCEC
While ethics consultation can take numerous forms, ethics committees are the principal approach to tackling ethical problems in hospitals in the US. Ethics consultation comes in many forms: there are three Models of HCEC: Independent Consultant, a Standing Interdisciplinary Committee, or a Team Model. Irrespective of the shape ethics consultation takes, it appears extremely important that its role goes past the provision of knowledge and the facilitation of debate for challenging and demanding cases. Ethics consulting should be a fundamental element in persuading and supporting the ethical existence of a healthcare organization.

The Goals of HEC
Healthcare ethics consultation (HEC) is a service offered by an individual or a team to assist patients, families, surrogates, healthcare givers, or other interested parties tackle doubt or conflict concerning value-laden topics that arise in healthcare. The goals of HCEC should be first outlined before articulating the skills of ethics consultants. The functions of HEC are categorized under four general categories: to self-educate, to assist in the development of guidelines and strategies for approval by the hospital’s management and trustees; to examine and evaluate distinct patient cases actively and retrospectively; ethically and legally, and to consult with healthcare providers, patients, and their families by assigning representative or two from the HEC to represent it when not in the full conference.

3.III.D. HCEC: Process and Approaches
Process of Ethics Consultation
HCEC usually starts with an intake process following a consultation request. In this stage, the consultant should evaluate whether the case is suitable for ethics consultation, determine realistic expectations for the whole process, and decide the next steps. Then, he
should assess and examine the collected data. To lead to an ethically acceptable solution, the consultant should be able to summarize narratives and points of view, listen actively, reinterpret different perspectives. To excel in these, the consultant should undergo direct practice and attend to critical and sincere feedback.\textsuperscript{108} Due to the nature of the ethics consultation, which is a strictly facilitative and counseling role, the primary duty for executing any agreed-upon plan of action stemming from it lies with the care team members and others immediately affected in the case, the primary decision-makers. In addition, documentation and a summary of the results of the consultative process are very essential. Moreover, ethics consultation should have a structured procedure for follow-up in cases where they require follow-up consultation when circumstances change.\textsuperscript{109}

Approaches of Clinical Ethics Consultation

There are two main approaches. First, The Cases Approach which is a step-by-step method to offering reliable and successful ethics case consultation at VHA facilities. The steps guide ethics consultants through multifarious serious thinking which is essential for ethics consultation.\textsuperscript{110} The Bioethics Mediation: The Montefiore Medical Center Model is the second approach which is a "facilitation" approach where the consultation staff is encouraged to think specifically about the dynamic of the discussion and the organization of the decision without instructing the medical staff about what must be done in the clinical setting.

3.III.E. Ethics Consultants: Essential Character Traits and Required Competencies

Character Traits for Ethics Consultants:

The healthcare ethics consultant should have intelligence, knowledge, and prudence to argue and think through the many phases of debate and decision-making safe toward ethically justifiable decisions, recommendations, and activities.\textsuperscript{111} Moreover, he should have the courage
to face ethical challenges, be compassionate and caring, capable of understanding the desires and needs of others and displaying authentic concern for those who are in misery.\textsuperscript{112}

Hospital Ethics Consultants: Competencies and Skills

Hospital ethics consultants are those who offer guidance about how to deliberate and discuss debatable decisions concerning medicine and the biomedical disciplines, within the limitations of the philosophy and attitude that is recognized at law and in public policy.

Healthcare ethics consultants must have a respectable knowledge of relevant law and public policy in their specific area and should recognize how to successfully negotiate the grey zones of public policy and law, and to advance the goals of those who engage their services.\textsuperscript{113} Braddock and Tonelli have argued that clinical ethics consultants should have adequate clinical knowledge and proficiency to comprehend the clinical context and clinical consequences of their actions.\textsuperscript{114}

This chapter discusses the Systems Approach in ethical decision-making, highlighting the significance of vulnerability and of consent. In the discussion, the core characteristics of the Systems Approach emerge collaboration that nurtures the inter-related identity of professionals; continuous learning and problem-solving that nurtures the accountability of professionals; and leadership that nurtures ethical conduct among professionals. The core characteristics are aligned with the pivotal topics of vulnerability and of consent.

\textbf{Chapter 4. Systems Approach in Clinical Ethics}

Chapter 4 discusses the Systems Approach in ethical decision-making, highlighting the significance of patient safety and of epigenetics. In the discussion, the core characteristics of the Systems Approach emerge collaboration that nurtures the inter-related identity of professionals; continuous learning and problem-solving that nurtures the accountability of professionals; and leadership that nurtures ethical conduct among professionals.
4. I. Patient Safety

Improving patient safety is one of the most extremely broadcasted and significant topics facing the healthcare industry today. Patient safety, as defined by the National Patient Safety Foundation, is the prevention and improvement of adverse events originating from the process of healthcare. This chapter attempts to reflect on the way leadership in healthcare organizations can impact and encourage patient safety culture and create a patient-centered organizational culture.

4. I.A. Towards a Safer Health System

Medical Errors

The influential Institute of Medicine (IOM) report, To Err, Is Human: Building a Safer Health System, found medical errors annually kill between 44,000 and 98,000 people in U.S. hospitals. Preceding the first IOM report (2000), most endeavors to decrease rates of medical errors and advance patient safety concentrated more on persons rather than processes and systems. The first IOM report used the general popular expression of Alexander Pope – to err is human – to highlight the point that condemning persons for being human is not a successful approach to advance patient safety. Current research now indicates that the bulk of errors are caused by system and process failures and not by human failures. The Institute of Medicine committee recommended that healthcare organizations must work to build a setting in which a culture of safety is a well-defined organizational objective that should be driven by leadership.

Measuring Medical Errors

The most common process for measuring errors and safety is incident reports, self-report of errors by healthcare providers. They are regarded as the “gold standard” because they include rich detailed clinical information. However, many doctors do not report errors through incident reporting systems, while some nurses are usually inclined to do so. Another method of measuring
safety is through a sequence of patient safety indicators collected from large organizational
datasets. The Agency for Healthcare Research and Quality’s Patient Safety Indicators is the most
extensively used one. Nevertheless, these indicators do not relate very well to actual safety.119
Furthermore, the use of trigger tools, developed by the Institute for Healthcare Improvement, has
appeared as a preferred method to measure the frequency of unfavorable events in numerous
healthcare settings. These tools shifted the emphasis from errors to unfavorable events as targets
for measurement and interventions120. Nonetheless, these tools are neither perfectly specific nor
sensitive. They are also labor-intensive unless they become fully automated. 121

4. I.B. Creating a Patient-Centered Culture

Patient Safety Culture

A blame culture has been unsuccessful to develop patient safety results. On the other
hand, safety culture stresses a more comprehensive systems tactic to dealing with medical errors.
The modern patient safety movement is more of a system thinking oriented.122 This standard
acknowledges the human condition; it recognizes the fact that most errors are made by
proficient, careful, and considerate providers. It concludes that the establishment of systems that
predict errors in advance and prevent them determines safety. This paradigm focuses on all the
fundamental circumstances that made an error probable.123 The system thinking approach
underlines the assumptions that humans are imperfect and they are expected to make some
errors, and thus the systems and circumstances under which healthcare professionals work can be
improved. This focus encourages communication of mistakes and positively influences
organizational learning within an environment that is supportive of open discussion to enable
safe practices. Most importantly, this approach inspires and encourages leaders to promote a
culture of safety.124 Safety culture is the approach by which safety is accomplished and managed
in the healthcare system, and it divulges the behaviors, perspectives, moral values, and principles of employees concerning safety issues.\textsuperscript{125}

**Characteristics of a Culture of Safety**

There are seven main characteristics for a culture of safety: Leadership (Many scholars acknowledged administrative leadership as one of the most noteworthy enablers for creating and endorsing a culture of safety, \textsuperscript{126} Teamwork (The increasingly multifarious disease procedures and complicated treatments and technologies, this fact necessitate greater efforts toward applications of teamwork practices among caregivers to achieve a system-wide culture of patient safety), \textsuperscript{127} Evidence-based (including standardized processes, protocols, checklists, and guidelines, are thought to show a culture of safety), \textsuperscript{128} Communication (cultivating communication skills, forgoing a more unified environment, motivating caregivers to speak up when the have apprehensions, applying tools, and tackling errors in broad-minded fashion), \textsuperscript{129} Learning: The hospital learns from its mistakes and pursues innovative opportunities for performance development and integrates this with the care delivery process. Learning should be appreciated among all staff, including the medical staff.\textsuperscript{130} Learning (Learning cultures make use of root-cause studies to examine medical errors), \textsuperscript{131} Just Culture, and a patient-centered culture that embraces the patient and family as the exclusive motivation for the hospital’s being.\textsuperscript{132}

4. I.C. Moral Responsibility of Leadership

**Patient Safety and Morally Imperative Responsibility of Leadership**

From an ethical perspective, the objective of a healthcare system in terms of patient safety can be deliberated in two main ways. First, patient safety has a practical significance: where the benefits, results, efficiency, and economic factors of care provided are taken into consideration. Second, the objective of patient safety is seen as a moral worth, the patient has intrinsic human dignity. Thus, the tangible and moral reasons for patient safety are linked and
form the main crucial point for patient safety movement.\textsuperscript{133} Despite this significance, the ethical features of patient safety have not been described. As a concept, patient safety has an intrinsic essentially ethical nature. Henceforward, ethical patient safety can be seen as associated with nursing management in terms of protecting human dignity and authorizing and managing the application of ethical protocols.\textsuperscript{134} Ethical issues are considered as the intrinsic theoretical groundwork for patient safety and also as a value-bound basis of healthcare delivery and safety culture. The underlying standards of patient safety are found in its operational culture and incorporated into organizational culture, which results from the essential assumptions of the primary purpose of a healthcare organization.\textsuperscript{135} From an ethical viewpoint, the duty of patient safety is shared by all healthcare specialists and organizations, but also incorporates patients and families to some degree. The provision of safe care involves cooperation between healthcare practitioners.\textsuperscript{136}

Common objectives between Ethics Committees and Patient Safety Team

A close collaboration between the patient safety team and the ethics team would improve patient safety practices, especially those directly ethical conflicts, and progress the quality of patient care.\textsuperscript{137} By collaborating, professionals from patient safety and ethics departments can tackle the issues in a systematized and proactive system-oriented approach. Such kind of collaboration would improve the organization’s general setting by assisting staff to recognize the right thing to do in different ethical encounters.\textsuperscript{138} Patient safety directors and ethics boards can develop procedures that incorporate a well-defined system for determining the proper management of common ethical conflicts, a system that integrates ethical principles and patient safety goals.\textsuperscript{139} A systematic procedure that incorporates ethical practice procedures can be a significant tool to foster that final objective of quality health care.\textsuperscript{140}

4. I.D. The Organization and the Process of Patient Safety
Challenges Facing Health Managers in Promoting Patient Safety

There are many challenges for healthcare leaders in the promotion and advancing patient safety: Monitoring and Measurement: Because there is no readily decided metric for evaluating the safety, it is challenging for leaders to assess the care their organizations offer.\textsuperscript{141} Expanding and Maintaining Change: Expanding improvements are among the toughest challenges for healthcare leaders. Leaders find it extremely demanding and challenging to expand prosperous patient safety.\textsuperscript{142} Multidimensional and Complex Patient Safety: Mostly, healthcare is a high-risk activity, and therefore unsafe practices will always happen, and it is not possible to eliminate practice errors from healthcare systems entirely.\textsuperscript{143}

Numerous research papers discussing patient safety issues have highlighted the significance of visible leadership in improving patient safety and reducing adverse events.\textsuperscript{144} The attitudes and actions of healthcare professionals toward safety can change; nevertheless, for this transformation to be sustainable, it needs strong organizational commitment to safety. In small hospitals, formal leadership is critical; leaders in larger hospitals should find more means to efficiently communicate and validate their safety obligation and support to managers to better involve them in patient learning activities.\textsuperscript{145}

The Role for Leaders of Health Care Organizations in Patient Safety

Safety culture encompasses far more than what happens in the operating rooms and on the wards. It is influenced and determined by the organizational culture, leadership, context, incentives, and other related aspects. For this reason, there has been a growing emphasis on the engagement of healthcare boards and other leaders.\textsuperscript{146} Managers in healthcare have a legal and ethical duty to confirm great excellence of patient care and to attempt to advance care practices. These managers are in a crucial spot to command policy, systems, practices, and organizational climates. Endorsing a patient safety culture can best be comprehended as an array of
involvements rooted in values of leadership, behavior change, and teamwork. Promoting a culture of safety does not include a single team or a single process. In general, healthcare leaders should work on four main areas: Building better communication, Building better delivery Systems, Building Better Teams, and Building Better Accountability.

4. I.E. A Greater Leadership Role
How Hospital Leaders Promote Patient Safety Through Building of Trust

Another dynamic and fundamental element of patient safety culture is trust in hospital management. To shape and sustain trust, indispensable management features are required such as integrity, kindness, and proficiency. Trust is crucial in creating and maintaining a positive safety culture and patient safety as the foundation of the leader-member relationship. To gain and cultivate trust, hospital leaders must take a sincere and ongoing attentiveness in building a patient safety culture. This might include systematic safety meetings, where hospital leaders and frontline staff can cooperate on patient safety concerns.

The Ethical Responsibility of Nurse Managers

Clinical leaders offer motivating visions and promote behavioral change. The implementation of safe and high-quality practices depends on outstanding leadership. Clinical leaders should have a high degree of leadership competence to provide quality clinical care and managerial duties. Formal and informal organizational leaders play critical roles in running safety improvement endeavors. The role of a senior nurse or healthcare professional staff members is essential to developing employees’ performance levels to advance the performance of the group, systems, and the whole organization.

From the standpoint of the nurse manager, the responsibility of the organization is to construct the fundamental infrastructure for ethical patient safety and guarantee continuous excellence in patient safety practices.
4. II. Corporate Social Responsibility & Epigenetics

This section discusses epigenetics, defined as the structural change of chromosol areas to register, signal, or disseminate transformed activity conditions, and its relation to the social responsibility of health. It suggests that bioethicists need to widen the extent of bioethics reflection about justice, a scope that is more articulate with the extremely complex and interconnected character of human health.

4.II.A. Bioethics and Social Responsibility

Bioethics: Emphasis on Individualism

The emphasis on individualism bioethics is reflected in the clinically-oriented focus of many bioethics graduate programs and the demonstration of the Principles of Biomedical Ethics by Beauchamp and Childress as the main reference textbook. This method should be interrogated since such a reductionist concept of bioethics is essentially challenging. A rich literature in public health has proved that health is strongly affected by and associated with several environmental influences that can differ based on social, economic, geographic, cultural, or physical settings. Moreover, the disease-centered medical model of health permits individualistic research in bioethics and nurtures a prominence on individual focus over health in politics. Additionally, this medical model makes it harder to see the association between health problems on one hand and the social and economic inequalities on the other hand. Autonomy centered bioethics and the medical model of health lead to neglecting the environmental and social dimensions of health and the nonpathological bases of poor health.

Bioethics: Attempts Aiming to Embrace the Notions of Social Responsibility

Even if social responsibility is not at the center of bioethics, there have been several efforts to develop theoretical models that would embrace the notions of social responsibility for health. The deliberations on access to healthcare in the 1980s introduced social and political
philosophy into bioethics. Moreover, social responsibility for health is the specific crucial aim of the UNESCO International Bioethics Committee’s report (2010). The report states that, following UNESCO’s Universal Declaration on Bioethics and Human Rights (2005), which dedicates a whole article to social responsibility and health, there is an essential need for novel viewpoints that go outside mere medical ethics and bioethics, and expands toward a wider concept of social responsibility.

4.II.B. Epigenetics

Epigenetic Studies

Currently, epigenetic regulation has been proven to be predominant in the genome, and information known might only be the tip of the iceberg. From cancer to environmental toxicity to maternal behavioral effects to in vitro fertilization risks, epigenetic effects play a vital, formerly under-appreciated role in the interaction of nature and nurture. The epigenome is extremely sensitive and receptive to environmental stimuli, such as toxic exposures, dietary influences, and behavioral influences. While the nature of at least some epigenetic variations is well-established, many of the inferences and processes of epigenetics remain unclear. The word "epigenetics" was first presented in 1942 by Conrad Waddington to illustrate the connections of genes with their environment. Today, epigenetics denotes alterations of the genome that do not include a change of DNA sequence; they alter the timing and quantity of the production of certain genes in tissues at crucial points. Such changes in defining which genes are expressed and their level of expression can have dramatic outcomes on the development of an organism.

Human Epigenome Characteristics
At least three biological characteristics of the human epigenome contribute to making its characterization a very overwhelming task when compared with Human Genome Project represented 20 years ago. First, in contrast to genomic information which is exceptional and ever-present in all the cells of an organism, each cell line—therefore every tissue and biological system—has its epigenome. Second, the many epigenomes of an individual are comparatively plastic and subject to numerous alterations that depend on several factors (e.g., prenatal environment, lifestyle, age).\textsuperscript{164} Contrasted with genetic modifications, epigenetic modifications are very dynamic biochemical reactions, this is often called the plasticity of the epigenome.\textsuperscript{165} Consequently, epigenetic programming can be seen as an active biological mechanism that intends to develop an individual’s ‘fit’ to its environment. On the other hand, this programming can convert to a maladaptive one when the environment changes and thus become damaging to health.\textsuperscript{166}

4.II.C. Epigenetics and the Environment

Features of Epigenetic Changes

Unlike the genome sequence, which remains fundamentally constant throughout life, the epigenome may be transformed by environmental exposures. Additionally, a change initially triggered by environmental exposure (such as diet, ionizing radiation, tobacco smoke, air pollution) may be transmitted to offspring for an unspecified number of generations.\textsuperscript{167} Epigenetic changes are formed through numerous biological processes, including methylation, acetylation of histone proteins, transposable elements, RNA interference, and imprinting. These processes impact the timing and number of gene products. Epigenetics disturbs the expression of certain genes.\textsuperscript{168} For instance, methylation suppresses gene expression; more methylation means less gene expression. This might cause harm or benefits, and this depends on the type of gene affected. Methylation changes are heritable both from an ancestor cell to its progeny cells
through mitosis (cell division) as well as from a progenitor organism to its progeny organisms through meiosis (sexual reproduction). Consequently, epigenetic effects caused by methylation may be transgenerational, which results in the heritability of acquired characteristics.\textsuperscript{169}

Molecular Epigenetics: Linking the Environment to Gene Expression

Over the previous decade, epigenetic studies have been offering more indication of the molecular interaction between gene expression and its health results on one end, and the social and physical environments in which people are conceived, born, and live on the other end. As a consequence of a better understanding of the associations between gene expression, lifestyle, living conditions, and health, anticipations of medicine and public health have been raised. As a result, this relatively new field of epigenetics has recently urged some researchers to question the likely inferences of this new scientific information regarding moral duty related to health.\textsuperscript{170}

4.II.D. Epigenetics: Some Implications to Bioethics

Epigenetics: New Insights Toward the Social Responsibility for Bioethics

Epigenetics serves to emphasize the effects of inequality in living and working conditions, as well as a range of disparities in access to health care and other societal outlooks. Moreover, epigenetics raises difficult questions about the responsibilities of society to preserve the wholeness of the human genome and epigenome for the sake of future generations.\textsuperscript{171}

Molecular epigenetics highlights the importance of considering the external factors affecting a system (the human body system in this case) in the resolution of a systemic dilemma, a health disease in this case. The close biochemical interaction between genes and environment, explained by recent scientific research in epigenetics, illustrates the ecosystemic connection that human beings are part of.\textsuperscript{172} Thus, bioethicists should seek to find the link between the individualistic approach of bioethics and the social dimensions of health.\textsuperscript{173}
Epigenetics and Health Justice

There are some public health inferences of epigenetics when presenting epigenetic mechanisms within the wider context of the social factors of health inequalities. The accumulation of several factors contributes to the establishment of social health inequalities such as material (e.g. poverty), behavioral (e.g. diet), biological (e.g. blood pressure), and psychosocial (e.g. stress). Several features of epigenetics raise thought-provoking and significant ethical concerns, including the following: 1) Environmental justice. Epigenetic effects have been associated with exposure to several toxic chemicals, airborne pollutants, pesticides, and other harmful substances. 2) Equitable Access to Health Care: Greater understanding of the link between environmental exposures and epigenetic effects will broaden the significance of unprotected people receiving health services for prevention, supervising, and treatment. A just society must not permit future generations to experience the devastating health effects triggered by existing environmental exposures especially when the health outcomes are known and the environmental settings are avoidable or remediable.

This chapter discusses the Systems Approach in ethical decision-making, highlighting the significance of patient safety and of epigenetics. In the discussion, the core characteristics of the Systems Approach emerge: collaboration that nurtures the inter-related identity of professionals; continuous learning and problem-solving that nurtures the accountability of professionals; and leadership that nurtures ethical conduct among professionals. The core characteristics are aligned with the pivotal topics of patient safety and of epigenetics.

**Chapter 5: Systems Approach in Organizational Ethics**

Chapter 5 discusses the Systems Approach in ethical decision-making, highlighting the significance of corporate social responsibility and of governance ethics. In the discussion, the
core characteristics of the Systems Approach emerge collaboration that nurtures the inter-related identify of professionals; continuous learning and problem-solving that nurtures the accountability of professionals; and leadership that nurtures ethical conduct among professionals.

5. I. Social Responsibility (CSR) in the Healthcare Sector.

This chapter discusses the significance of corporate social responsibility (CSR) in the healthcare sector. The healthcare sector is rigorously anticipated to behave ethically and deliver treatments for all individuals. As such, it is under very tight pressures from policymakers and organizational ethics are essential to regain vanished confidence of the local and international communities and win back the admiration of skeptical patients and doubting communities. Therefore, HCOs have to have a renewed commitment to ethics/CSR in health care applied to hospitals and pharmaceutical companies should promote shared values and common ethical principles in new patterns of hospital governance.\(^{176}\)

5. I.A. Organizational Ethics

The Moral Status of Organizations

Organizational decisions are taken by the employees, with various particular roles, on behalf of the organization to represent its mission and purpose. Health care organizations (HCO) are granted the same official rights as individuals and are treated as legal persons under the law. This implies that these institutions have legal obligations and moral obligations as well.\(^{177}\)

Therefore, institutions are exposed to several ethical expectations by society.

Stakeholder Theory

This theory takes into account the interests and rights of the comprehensive range of individuals and organizations who cooperate with and are affected by business decision-making. It emphasizes the role of various stakeholders in the long term and the success of the
organization. This theory argues that the goal of any organization or company is to prosper the firm and all its stakeholders.

5. I.B. Corporate Social Responsibility: Past and Present

Background History of CSR

While CSR was broadly examined in the last forty years of the twentieth century, the notion that business has social responsibilities was apparent at least as early as the nineteenth century. Early examples of CSR referred to obligations above and beyond economic and legal responsibilities and CSR was mostly identical to philanthropy. The following period mainly highlighted the role of management, the need to estimate, plan, and shape CSR as well as evaluate social performance. During the 1980s, a sequence of ethical disgraces affected the public view, and the CSR topic was carried to the public and communities. In the 1990s, the CSR notion was highly accepted and companies with good reputations were known to have good CSR practices. Nowadays, CSR is known as a rising business strategy that companies are integrating into their core activities, plans, and operations.

CSR: Present Day

Many factors including economic and social globalization, scientific and technological development, and better access to information emphasized the fact that ethical behavior and social responsibility are vital to an organization’s practices. Social responsibility should tackle and meet other stakeholders’ interests while simultaneously increasing shareholders’ profits. Re-interpreting the view of social responsibility means that an organization should not only accomplish its economic and legal requirements but also dynamically contribute to the social good. Legal regulation and norms (such as Social Accountability SA 8000 and ISO 26000 are
international norms) is an essential condition for respectable corporate social performance but an inadequate one.\textsuperscript{186}

5. I.C. Corporate Social Responsibility
CSR Concept

For this section, CSR is defined as a business approach that generates long-term shareholder value by taking up opportunities and managing risks originating from socially responsible decisions.\textsuperscript{187} Early subjects in CSR conceptualization highlighted the fact that business volunteerism was important to accomplish social responsibilities duties.\textsuperscript{188}

CSR and Health Care Organizations

For HCOs, the new consideration for CSR should take into consideration the global vast poverty-related health challenges. Nowadays, society expects more from corporations and organizations due to hard social and economic realities. They expect businesses to have a responsibility to stakeholders, society, and future generations. The important responsibility of any health care organization or pharmaceutical company is to enlighten itself about its effect on society's numerous needs and objectives and to be thoughtful and responsive to the demands of stakeholders. Through this tactic, the business enterprise or organization will have a practical and defined social responsibility that is based on corporate values, resources, technical know-how, and enlightened leadership.\textsuperscript{189}

5. I.D. Central Ethical Values and Obligations of Health Care Organizations
Ethical Values of Health Care Organizations

Ethically admirable organizations must hold a deep set of values applicable to the promotion of health and care of the sick and must be skilled at dealing with conflicting values that arise in health care. Organizational ethics refers to an organization’s attempts in defining its
core values and mission, seek the best possible resolution of struggles, and run its functions to confirm that it acts according to the defined set of values. The scarcity of resources in the health care sector drives organizations to set significance in a way that is both ethically justifiable and clinically sound. It is important to note that the health care sector cannot solve the underlying causes of poverty, however, the social circumstances for human health are more accountable to global economic organizations ranging from the World Bank and IMF to international governments who work within this international economic structure. Thus, a partnership of the pharmaceutical companies and hospitals with governments, international institutions, NGOs might achieve social and health equity.

UNESCO Article 14: Social Responsibility and Health

The Report of the International Bioethics Committee of UNESCO on Social Responsibility and Health has addressed this idea of social responsibility in the framework of health care delivery proposing a new standard in hospital governance. The scope of this responsible behavior necessitates hospitals and other healthcare organizations to accomplish their social and market goals, based on law and general ethical standards. The report proposes that social responsibility should be considered a moral obligation to create organizational value. The originality and the significance of this article are that it openly broadens the concept of social responsibility, applying it not only to the private sector but also to the public sector and governments to fulfill the full recognition and deliverance of health care as a right to everyone based on universal ethical principles.

5. I.E. Ethical Principles

Principle of Justice
Justice explains how social burdens and benefits should be distributed. The egalitarian theories state that people should receive an equal distribution of health care. Based on John Rawl’s principle of Justice, fair opportunity is vital to justice in the health care field. This implies that each person, regardless of his/her social status, should have equal access to a sufficient level of health care. There should be a right to a decent minimum of health care: basic health care and other health-related resources. Hence, pharmaceutical companies and healthcare organizations have a moral responsibility to provide access to medicine for those who cannot afford them while achieving sustainable business ends.

Principle of Beneficence

In addition to the justice principle, pharmaceutical companies and HCOs must follow the principle of beneficence. In their Principles of Biomedical Ethics, Beauchamp and Childress describe beneficence as not simply kindness or charity, but a real obligation to support others and further their genuine benefits. Beneficence states that one should prevent harm, remove harm, and promote wellness. It is important to note that there is an embedded beneficence assumption in all health care professions; health education and vaccination programs. HCOs have a moral responsibility to research medicines that can help those in disadvantaged regions, not just profit-driving medicine for Western conditions or lifestyle medications. Active social responsibility requires hospitals and other healthcare organizations to do something beneficial (out of beneficence duties) and not only abiding by the law or too broad ethical principles. This implies that the interests and values of all stakeholders are taken into concern.

5. I.F. Common Good

Pharmaceutical Corporations & Health Care Organizations
Pharmaceutical corporations and HCOs contribute to the common good. With their goods and services, they make different types of value-added for society. For instance, current medicines and therapies, aid in reducing death rates and preventing/curing diseases. Therefore, it is argued that successful HCOs increase the quality of life of the sick, minimize costly hospitalization through researching, manufacture, and distribute drugs of high social benefits. HCOs should pursue their ends by contributing to their society. They own the know-how, vast resources, expertise, and management talent to solve social problems that they fully comprehend both in the developing world and in economically deprived communities. Therefore, HCOs with their embedded ethical values combined with their knowledge and resources should focus their CSR activities on solving health-related issues in local and international communities.

CSR and Health Care

In the health care setting, a set of values should be followed such as equity in access to health care, universal coverage, and efficient resource allocation. Therefore, the implementation of socially responsible behavior could be a vital step for a hospital to expand its competitiveness and to protect its external image. Having a vigorous CSR program can help HCOs attract and maintain key talent. Companies and hospitals will have better social perception and community engagement. Surveys indicate that people not only desire to work for socially responsible firms, but may essentially give up a proportion of salary to do so.

5. I.G. Corporate Social Responsibility and Competitive Advantage

Examples of CSR

Nonprofit hospitals have some responsibility for contributing to the general welfare of the community, as required by the Internal Revenue Service (IRS). Many hospitals were established based on a charitable objective to serve the poor and there is a long tradition of healthcare
institutions offering benefits to the surrounding community. The pharmaceutical industry could reinterpret the notion of social responsibility by acknowledging the access of vulnerable populations to lifesaving medicines. Developing and enriching the local communities are as essential as profit maximization. Eli Lilly is one of the largest charitable foundations in the United States. Moreover, corporations should address the health and safety of employees at work from possibly toxic processes and products. For instance, hospitals should offer increased health and safety protection for technicians while working with radioactive substances in particular oncology treatment manufacturing procedures. Other examples include: building LEED standard Green buildings, adopting environmentally friendly practices such as energy-saving processes and packaging reduction, conserving water, protecting the supply of clean potable water to the surrounding communities.

The Link Between Competitive Advantage and Corporate Social Responsibility

Strategic CSR initiatives start with a strong strategic grounding to connect an organization’s values to investments in social issues that can reinforce the organization’s competitiveness. The CSR of HCOs and pharmaceutical companies should create a balance between their responsibilities to add value to society and the growth of the enterprises. Strategic CSR can be a source of opportunity and competitive advantage rather than a cost to the health organization and more than a moral obligation. Achieving both social and economic interest for the organization demands looking beyond community anticipations to opportunities. Strategic CSR should integrate society, business, and ethical values.

5. I.H. Managers of Health Care Corporations

Virtue Ethics of Managers and Leaders at Health Care Organizations
Professional ethics, such as in healthcare, is an application of virtue ethics. This kind of ethics focuses on the moral agent and not on the results of actions taken by the moral agent. Virtue ethics lists good judgment as a fundamental characteristic of the moral agent. High moral standards of employees would provide the organization’s excellence and decent ethical climate. The good character of honesty, compassion, trustworthiness, and devotion of high-level managers is an essential requirement for excellent ethical practice. However, this is not sufficient.

Managers’ Role in Undergoing Corporate Social Responsibility Activities

The healthcare industry is significantly regulated, but the continuing request for it to be socially responsible and ethically oriented is definite. It follows that a new organizational culture is considered crucial to overcoming the market failures that can appear in the health care sector. Public inquiry of business activities has boosted over the last years, causing more deliberation to be placed on social contribution, social responsibility, and the ethical performance of managers and directors. This necessitates health care managers to fully comprehend the conceptions around CSR.

5. II. Governance Ethics

This chapter examines the various ways in which the board of directors works to create good ethical governance in healthcare organizations. The disturbing changes in the healthcare field—the beginning of managed care, the emergence of novel technology, and a competitive business nature have shaped exceptional challenges for governing boards. The convergence of these subjects is causing a loss of public and stakeholder trust in health care institutions. Boards of health care organizations are called upon to achieve numerous responsibilities that span from the short term to the long-term, tactical, and mission-driven. However, all their tasks
stem from a core and ethical duty, which is to gain and preserve the public’s trust in and
devotion to the health care organization.217 Boards have the legal duties of care, loyalty, and
obedience.218 A board applying its duty of care must be concerned about the quality and patient
safety in all of its decisions.219 Moreover, they should have a professional duty to employees to
form an ethical culture such as circulating an organizational code of ethics and reinforcing
behaviors that indicate that ethics is vital to accomplishing the organization's mission.220

5.II.A. Organizational Ethics
Organizational Ethics: Background
Organizational ethics is the study and practice of the ethical conduct of healthcare
organizations. It involves elucidating and assessing the values rooted in organizational policies
and practices, and seeking methods and procedures for founding ethically acceptable values-
based practices. Variations to hospital accreditation standards in the United States in 1994 aided
to commence the noteworthy new consideration to organizational ethics in healthcare.221
Organizational ethics is concerned chiefly with the ethical topics confronted by managers and
board members of healthcare organizations, the ethical implications of organizational decisions
and actions on several stakeholder interests (such as the patients, employees, and community),
and the ethical hurdles of assessing the objective of quality patient care with other significant
objectives such as financial sustainability, staff well-being, and public accountability.222

The Contribution of Organizational Ethics to Bioethics and Business Ethics
Organizational ethics has been portrayed as the subsequent step in the development of
bioethics. Bioethics as a field has inclined to center on ethical subjects in the delivery of direct
patient care, the behavior of healthcare research concerning human subjects, and the
characterization of professional integrity. Lately, attention has twisted toward organizational
ethics as a field of bioethics examination and practice.223 In 1998, the American Society for
Bioethics and Humanities Task Force on Standards for Bioethics Consultation recognized knowledge and proficiency in organizational ethics as a fundamental capability of an ethics consultation service but was only able to present conditional guidance for practice given inadequate knowledge about organizational ethics in health care, the needs of people requesting organizational ethics consultation, and the likely role of clinical ethicists in countering to these needs.224

5.II.B. Corporate Governance
Definition: Corporate Governance

As developed by the Organization for Economic Co-operation and Development (OECD Report) (2001), corporate governance (CG) is outlined as the processes and procedures by which organizations and companies are directed and managed. This operational standpoint which concentrates on the shareholders, the board, and the management has been the foundation for much work in corporate governance.225 Additionally, the OECD report reinforced the operational standpoint by including the association among several participants. It specified that the corporate governance (CG) structure requires the allocation of rights and duties among the various members in the organization such as the board, managers, shareholders, and other several members in the association such as the board, managers, stakeholders, and lays down the directions and procedures for decision-making.226

Corporate Governance Theories

Agency Theory: A theory created by academic economists in the 1970s, it asserts that shareholders are owners of the cooperation and implies that corporate managers must maximize shareholder’s value; as shareholders are owners by virtue of their position, and thus they have decisive control over the business of cooperation.227 The concepts promoting the agency-based model originate in Milton Friedman’s popular New York Times Magazine piece, 1970,
condemning corporate “social responsibility” as a socialist principle. Much of the academic research on agency theory has focused on verifying that managers try to capitalize on shareholder returns—principally aligning their benefits with those of shareholders. This caused the introduction of the view that boards of directors act as an organizational mechanism for controlling shareholder’s costs that arise due to giving power to managers; known as agency costs. Therefore, the main role of the board must be monitoring management and designing managerial compensation to bring into line management’s welfares with those of shareholders.

Stakeholder Theory: This takes into account the interests and rights of the comprehensive range of individuals and organizations who cooperate with and are affected by business decision-making. It emphasizes the role of various stakeholders in the long term and the success of the organization. This theory is important to business ethics because it recognizes many values and moral agency on diverse levels. A stakeholder is any individual or group of people whose role is essential to the survival and well-being of the organization. Stakeholders are mostly affected by the cooperation or organization and its activities and guide it in defining objectives and mission. Management, employees, shareholders, customers, suppliers, society, and the community are examples of stakeholders.

5.II.C. Board of Directors

Board Responsibilities: Aspects of Governance

Elected by shareholders, the board of directors supervises the managerial role and function. In theory, they are present to resolve the agency dilemmas linked with the separation of a company’s ownership from decision controls. The main responsibility of the board of directors is to guarantee that the company’s assets are secured and that the managerial decisions and actions are accomplished in a way of maximizing shareholder wealth while shielding the welfares of other stakeholders. Overall, the board has to direct the company. This activity can be
seen to include four fundamentals: strategy formulation; policymaking; direction of executive management; and responsibility to shareholders and others. In delivering their duties, directors have to think and respect the future of the company as its present location and current results. They also need to look inwards at the organization and its parts, and outwardly at the company in its competitive market position and its wider economic, political, and social setting.

Fiduciary Duties of the Board of Directors:

Fiduciary Duties mean that as shareholder’s protectors, directors must be truthful and honest, acting in the best interest of investors and shareholders, and turn have assurance in the director’s activities. These are the main duties: Duty of Due Care, Duty of Loyalty, Duty to Promote Success, Duty to Exercise Diligence, Independent Judgment, and Skill, and Duty to Avoid Conflict of Interests.

5.II.D. Governance in the Health Care

Key Governance Factors in Achieving High Operating Performance

Several issues impact the operating performance of complex healthcare organizations. These include internal factors (management and clinical staff competencies) and external factors (economic environment). A recent study published by HRET (Governance in High-Performing Organizations: A Comparative Study of Governing Boards in Not-For-Profit Hospitals, 2005) validates that board culture in high-performing hospitals is noticeably more interactive and proactive as parallel to the boards of mid-performers. Two keys issues emerged: Right People, Right Size culture where there is diversity in age, gender, and ethnicity, to mirror the patients and the community served, and secondly a culture that incorporates physicians, nurses, and other healthcare professionals on the board because their clinical capability and perspectives are appreciated by other board members and will assist the board better to recognize and appreciate the concerns of several stakeholders.
Healthcare Boards: Great Responsibility

The challenges confronting healthcare delivery organizations today are considerably vaster than in the past. Boards are accountable for establishing the tone within healthcare organizations and assuring that everything is going in the right direction. Boards across profit and non-profit hospitals consequently face an immense responsibility, in terms of conveying mission and goals, establishing checks and balances, integrating several quantitative and qualitative performance standards and restructuring different arrangements of care delivery, and at the same time endorsing transparency and accountability. Based on the literature, there is an immense need for visionary and strategic thinking as an indispensable characteristic of healthcare boards. This relates to the increasing complexity of healthcare organizations, which necessitates an advanced level of leadership and broader visions. Moreover, it is important for healthcare boards to work together with management and to plan and put into practice organizational policy.

5.II.E. Role of Board of Directors in Creating Good Ethical Governance (Part 1)

Improve the systems and processes that ensure high-quality care and patient safety

The two main types of board authority for quality and safety consist of decision making, which has to do with medical staff credentialing, and an oversight role. However, most boards designated oversight of clinical issues to their medical personnel and managers. Boards characteristically centered their capacities and resources on financial matters due to scandals. Boards have the legal duties of care, loyalty, and obedience. The duty of care denotes the responsibility of corporate directors to act as follows: (1) in good faith, (2) with the care a normally insightful individual would exercise in like conditions, and (3) in a way that they rationally believe to be in the best benefits of the healthcare organization.
A board applying its duty of care must be concerned about the quality and patient safety in all of its decisions. Board oversight activities for hospital quality and patient safety necessitate deliberating, examining, and monitoring performance and allotting satisfactory resources to guarantee high-quality safe care. Regulatory agencies (such as US Centers for Medicare and Medicaid Services) and accreditation agencies (such as the Joint Commission) strengthen board responsibility through standards that specifically direct governance functions linked to the quality and patient safety. 245

Develop and Enforce Corporate Codes of Ethics

Due to the recent corporate scandals, the focus turned to the effective role played by boards of directors on the development and monitoring of corporate codes of ethics, forming internal codes of conduct to sustain the reputation, ethical conduct, and integrity of companies. 246

Moreover, codes prevent wrongdoing and encourage ethical behavior, including the ethical management of conflicts of interest in the personal and professional relationship, improvement in management and corporate culture, better social responsibility, better compliance with related government laws, rules, and regulations. 247

5.II.F. Role of Board of Directors in Creating Good Ethical Governance (Part 2)

Develop an Ethical Organizational Culture: Beyond Legal Compliance

Organizational culture is described as the collective morals, underlying assumptions, and beliefs, or perceptions held by workers within an organization, and it is the social tie keeping an organization joined. 248 The present healthcare business environment offers an outstanding opportunity to create an organizational culture that goes beyond simple legal compliance. 249

The American College of Healthcare Executives supposes that all healthcare executives have a professional duty to employees to form an ethical culture. Therefore, healthcare executives should direct these efforts by Representing and showing the significance of and commitment to
ethics through decisions, practices, and behaviors; Circulating an organizational code of ethics that involve of guidelines for all employees' ethical standards of behavior and practices; revising the principles and ideals expressed in vision, mission and value statements, and other leaflets to ensure that there is a mutual perception of the organization's devotion to ethics; and reinforcing viewpoints and behaviors that indicate that ethics is vital to accomplishing the organization's mission.\textsuperscript{250}

Assess societal and community health needs

In today’s U.S. healthcare setting, well-qualified board members need an exceptional number of skills such as the capability to assess societal and community health needs, to be predominantly supportive of any offer that possibly advances the delivery of quality care, to be capable to exercise sound business reasoning and to be comparatively up-to-date with how the health field commonly functions.\textsuperscript{251}

This chapter discusses the Systems Approach in ethical decision-making, highlighting the significance of corporate social responsibility and of governance ethics. In the discussion, the core characteristics of the Systems Approach emerge collaboration that nurtures the inter-related identify of professionals; continuous learning and problem-solving that nurtures the accountability of professionals; and leadership that nurtures ethical conduct among professionals. The core characteristics are aligned with the pivotal topics of corporate social responsibility and of governance ethics.

**Chapter 6: Systems Approach in Professional Ethics**

Chapter 6 discusses the Systems Approach in ethical decision-making, highlighting the significance of virtue ethics and of virtues and the professions. In the discussion, the core characteristics of the Systems Approach emerge collaboration that nurtures the inter-related
identify of professionals; continuous learning and problem-solving that nurtures the accountability of professionals; and leadership that nurtures ethical conduct among professionals.

Virtue ethics is a framework that mainly highlights the nature of the moral person, rather than the rightness of a particular act. It acknowledges a significant element of human moral involvement, through recognizing the effects of emotional reactions on judgments and decisions. Therefore, virtue ethics studies the way moral agents can learn -via regular habits- how to acquire and foster good characteristics which would, in turn, help them act well.²⁵²

6. I. Virtue Ethics
6. I.A. Background: on Virtues and Virtue Ethics

The Concept of Virtue

The notion of virtue originated in the Western world with the Greek philosophers. The Sophists thought that virtues are important for the exercise of power and that they could be taught to any individual. The Sophists paved the way for the perceptions of Aristotle and Plato.²⁵³ In the Western culture, the most prevalent and persisting notion of virtue, the one most officially and fully advanced, is found in the philosophy of Plato and Aristotle, complemented by the Stoics and Epicureans, and shaped to full realization by Thomas Aquinas. The combination of those streams of thought turned out to be the Classical Medieval synthesis that has formed moral philosophy Classical-Medieval in the West for 2,500 years. This Classical-Medieval origin of virtue has also been the leading one in the ethics of the health professions as professions.²⁵⁴ The elements of the Classical-Medieval synthesis that are most significant for a revival of virtue-based ethics in the health professions— i.e., the idea of virtue (1) as distinction in traits of character, (2) as a characteristic focused on to ends and objectives, (3) as a distinction of a reason, not emotion, (4) as focused on the practical decision, and (5) as learned by practice.²⁵⁵

Virtue Ethics-Origins
Virtue ethics started with the ancient Greek philosophers Socrates, Plato, and Aristotle. They explored the essential components that made a person good through exploring the kind of character he had. They proposed that a good person who acts well must cultivate virtues, which, through constant use, develop part of that individual’s character. Rachels defines virtue as a trait of character, demonstrated in habitual action, that it is suitable for an individual to possess. There is no complete list of virtues. The fundamental virtues developed by ancient Greek philosophers are courage, prudence, temperance, and justice. The theological virtues (faith, hope, and charity) are not extensively studied in secular moral philosophy; while Toon has assessed them in a medical setting and illustrated them to be very beneficial. Beauchamp and Childress have studied and regarded five virtues relevant to the medical doctor: trustworthiness, integrity, discernment, compassion, and conscientiousness.

6. I.B. Virtues in the Medical Field
The link between Principles and Virtues

Virtue Ethics (VE) denies the basic and significant characteristics that are communicated by both utilitarianism and Kantianism: moral reasoning is a subject of utilizing principles, all human beings are obligated by universal duties, and the worth of the virtues originate from the concept of the right or of the good. It is worth noting that the idea of moral obligation is closely associated with religion. The virtuous person is not virtuous because he admires the principle, but because he differentiates the vital and general nature of this principle and views it not merely a duty in the Kantian sense, but as part of his character, into his identity and person. People deem others virtuous because they perceive and act habitually in a way that shows the habitual outlook to perfection— that, as humans, we perceive to be coherent with what it is to be a good individual. Obligation-based moral theories have many well-established flaws. Furthermore, act, rule, and indirect forms of consequentialism fall short in taking sincerely some other morally
significant characteristics. For example, they fail to deliver a rich interpretation of moral character; fail to offer a rigorous interpretation of the uniqueness of people and the importance of relations in human life and fail to recognize the significant role played by feelings in the moral life of people. Because of these (and other) failings and omissions, obligation-based moral theories in overall ethics are inadequate and insufficient.

Advantages of the virtue-based approach in the Medical Practice

There are numerous significant advantages of the virtue-based approach. First, this approach precisely mirrors the language of the virtues and vices, such as ‘care’ that healthcare professionals exercise regularly. Second, this approach places a strong prominence upon the critical role played by feelings and emotions in the moral lives of caregivers and care receivers. Third, this methodology makes fundamental the significance of using reasoning and moral insight to empower professionals in making ethically good choices and decisions with patients in diverse settings. Fourth, this method places strong importance upon moral education, for example, the importance of ethically (and clinically) good role models. Healthcare professionals confront further moral pressures beyond what is usually expected by the general ethical obligations of ordinary life. The very nature of professional ethical agency presents discrete role-related responsibilities and understandings professionals. Furthermore, patients often have high expectations of health professionals to act in ways truly reflect the nature and purpose of the healthcare professional’s specific field.

6. II. Virtues and the Professions
6.II.A. Professional Ethics
Professional Ethics & Virtuous Professional Role

A profession is a well-organized group of individuals who abide by extraordinary ethical standards and uphold themselves to and are acknowledged by, the public as having distinct
education and skills in a broadly established body of learning derived from education and training at a high level, and who are equipped to use their knowledge and skills in the interest of others. Professionalism, based on the Healthcare Leadership Alliance (HLA), is the capability to align personal and organizational behavior with ethical and professional values and standards that comprise accountability and duty to the patient and the community, a service orientation, and a pledge to lifelong learning and development. Professionals possess systematic knowledge which helps them in resolving problems and making decisions.

Medical Virtues

Many medical virtues are discussed in this section. Examples include Fidelity to Trust (Fidelity to trust prevents manipulation, coercion, or dishonesty in acquiring consent), the Virtue of Compassion (co-suffering with the patient), Phronesis (medicine’s indispensable virtue, practical wisdom), Prudence in Medicine and in the Clinical Context (The virtue of prudence allows the physician to evaluate the relative weight of the methods at his disposal, the morals and life conditions of the patient and his preferences, the therapeutic potentials and results and side effects), Justice (One of the most challenging of all virtues; as it does not have any mean), Fortitude (a virtue that encourages confidence that physicians will fight the enticement to lessen the patient’s good through their own uncertainties and fears or through social and bureaucratic pressure, and that they will use their time and education and skills efficiently to achieve good in society), Temperance (the constant disposition of physicians toward accountable use of power for the good of their patients evading both the underuse of technology and other interventions and the overuse of technology and interventions), Integrity (the moral completeness and soundness developed by continuous practice through the interconnection and relationships among people).

6.II.B. Professionalism and Compassion
Meaning of Compassion

Compassion differs from sympathy and empathy. Compassion, as an immediate, still non-processed affect, could be understood as a certain emotional response to the experienced suffering of another person. Compassion incorporates valuable elements besides benevolence: the identification of a bad condition, a more personal emotion of accountability, and a strong inclination to do something helpful for the needy person.

Compassion Within the Framework of the Physician-Patient Relationship

Compassion should involve both identifying with another's involvement in suffering and the outlook to want to lessen the other's suffering. Therefore, compassion can be comprehended as a moral virtue and excellence of personality.

6.II.C. Compassion and Healing

Compassion: A Basic Virtue in Healthcare

Compassion has a significant place in the AMA Principles of Medical Ethics; Item 1, which states that the physician shall be devoted to delivering, experienced medical services with compassion and utmost respect for dignity. Compassion has two main components: A capability and willingness to enter into another's state deeply enough to gain an understanding of the person's experience of suffering, and a virtue characterized by the desire to lessen the individual's suffering.

Healing and Compassionate Care

Compassion also relates to the virtue of intending to diminish the patient's suffering, the patient’s chief interest. Because patients have diverse needs and health care practitioners have so many rapidly evolving standards, the precise duties of physicians differ by context. Compassion is not an additional value some physicians create within the context of physician-patient relationships: it is the responsibility of all physicians. Compassionate care also implies
that the patient who cannot be cured by medical sciences and technology — the chronically ill, the mentally retarded, the psychotic— may still be "healed."  

This chapter discusses the Systems Approach in ethical decision-making, highlighting the significance of virtue ethics and of virtues and the professions. In the discussion, the core characteristics of the Systems Approach emerge: collaboration that nurtures the inter-related identify of professionals, continuous learning and problem-solving that nurtures the accountability of professionals; and leadership that nurtures ethical conduct among professionals. The core characteristics are aligned with the pivotal topics of virtue ethics and of virtues and the professions.

Chapter 7. Conclusion.

This concluding chapter summarized the contribution of the Systems Approach in clinical, organizational, and professional ethics in healthcare. The core characteristics of the Systems Approach are these: collaboration that nurtures the inter-related identify of professionals; continuous learning and problem-solving that nurtures the accountability of professionals; and leadership that nurtures ethical conduct among professionals. The core characteristics are aligned with each chapter.

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Chapter 2: Adopting a Systems Approach in Healthcare

1. Introduction

Systems thinking provides a distinctive lens for developing the understanding of healthcare ethical issues and enlightening healthcare research. It helps in developing more innovative solutions that involve various stakeholders and take into consideration all levels of a system while accounting for the multifarious, multidimensional nature of health care organizations. This dissertation is concerned with fostering creativity in viewing health ethics and in creating shared value innovatively using the approach of systems thinking. Systems thinking allows leaders of healthcare organizations to view ethical issues as interdependent, and thus challenge their resolution in a more integrated and profound way. In this dissertation, systems thinking is presented as a methodology to problem-solving that understands "problems" as part of a broader and vibrant system. Systems thinking encompasses much more than a response to existing effects or incidents. It requests a greater understanding of the associations, connections, connections, and activities among the components that illustrate the complete system. It presents a way in which many organizations can work as systems through enablement, self-organization, involvement, and constant evaluation. This implies that there is a prospective key to resolving more complicated ethical issues, and, in turn, creating added substantive constructive changes in health care.

2. I. Systems Theory & Systems Dynamics

2. I.A. Systems Theory.

As a response to the failure of reductionist approaches of the traditional scientific approaches to manage the difficulty integral in the biological and social fields, systems thinking
was established due to the failure of reductionism to manage problem circumstances displaying added complexity and disorder. Systems thinking is positioned toward attaining forecast and control so that enhanced regulation of the organization can be achieved. It is a discipline for considering and understanding the ‘structures’ that lie beneath multifarious settings and complex events. Thus, it facilitates the observation of richer relationships lying underneath the incidents.

Systems thinking developed as a trans-discipline in the 1940s and 1950s. The development of system thinking has included many scientists from disciplinary fields. It has several origins in many disciplines including physics, management, biology, anthropology, psychology, mathematics, and computer science.

At the beginning of system thinking, it appeared for a while as in opposition to the scientific approach. Nevertheless, lately, the concepts of systems thinking have been appreciated in chemistry and physics as new possibilities of investigation, Quantum theory in physics is an example. The foundation of the complexity theory, a new type of general system theory in science, was a very important milestone. Complexity theory is likewise concerned with disorder and unevenness in systems. However, it emphasizes the astonishing level of pattern found despite the randomness. As systems thinking developed, and systems theories established in the way explained below, the emphasis was shifted towards the possibility of the systems approach in tackling applied real-world challenges and problems.

Systems theory is an interdisciplinary concept about every system in nature, society, science, economic setting, and within information systems; a framework that helps in the examination of events and relationships in a comprehensive way and not as an addition of the distinct elements of the whole system. This holistic perspective refers to the relationship and interaction among individual elements that are logically related to a combined objective.
term is related with a wide-ranging diversity of researchers and scientists, including the biologist Ludwig von Bertalanffy who developed General System Theory; psychiatrist Ross Ashby and anthropologist Gregory Bateson who established the field of cybernetics; Jay Forrester, a computer engineer who launched the field of systems dynamics; scientists at the Santa Fe Institute, such as Noble Laureates Murray Gell-Mann and Kenneth Arrow, who have assisted in defining complex adaptive systems; and an extensive variety of management scholars, including Russell Ackoff, an innovator in operations research, and Peter Senge, who has popularized the learning organization concept.  

Karl Ludwig von Bertalanffy, an Austrian biologist, has become the best-acknowledged biologist who reasoned that organisms should be studied as complex wholes. He published an article in 1950 that discusses the main differences between closed systems, which do not connect with their environment, and open systems, which interact with their environment to sustain themselves in survival. Von Bertalanffy proposed that the way open systems behave in biology could be exhibited by open systems in other fields, and he introduced and termed this concept ‘general system theory’. Management scholars incorporated this concept by transferring the open system model to their institutions.

Von Bertalanffy defines a system as a multifarious setting of interrelating components. Von Bertalanffy promotes systems thinking in all disciplines to establish general norms valid to all systems. “System” is presented as a new systematic paradigm conflicting the logical analytical standard, which describes classical science. General systems theory highlights the importance of relationships and interactions within the components of the system. In open systems, there are exchanges of energy, substance, people, and knowledge with the outer setting. Referring to general systems theory, Open system theory (OST) developed from this theory, and
it perceives the interactions between the organizations and the setting in which they are engaged, and this mirrors the organizations’ capability to adjust to variations in environmental settings.\(^{21}\)

Norbert Wiener, a control engineer, and mathematician is the second found father of system thinking. He published a book in 1938 on cybernetics, the science of interaction and control in the animal and the machine. He debated the significance of cybernetics, to various fields because it dealt with general laws that managed control procedures irrespective of the nature of the system. He also highlighted the importance of negative feedback in comprehending control and brings the performance back towards the objective by neutralizing divergences from a goal.\(^{22}\)

A model is described as an illustration of the physical and actual world. Hard systems thinking, a general name assigned by Checkland to many systems methods, was intended to resolve practical problems developed during and directly following the Second World War.\(^{23}\) The innovators of hard systems thinking were greatly delighted of the fact that they used the scientific approach to problems of actual prominence to decision-makers.\(^{24}\) Hard systems thinking is preserved in the statement that the examination is stimulated by the presence of problems due to gaps between actions and objectives.\(^{25}\)

In the phase after the Second World War, vigorous efforts were completed to use the lessons learned from wartime processes research to industrial enterprises and government organizations. In undertaking such efforts, an influential component of systems thinking, "hard" systems thinking, was used, and involved mostly with engineering a system to accomplish its goals. Systems were broadly defined as objective seeking, and concepts of system control were outlined in cybernetics. Generally, Herbert Simon pursued a discipline of managerial behavior and administrative decision-making.\(^{26}\) Simon due to his great influence on the management field
and due to Vickers’ reliance on Simon’s goal-pursuing approach of human action. Simon’s legacy is his principle of problem-solving, programs and procedures for constructing smart machines, and methodologies to the design of organizational structures for handling multifaceted and complex systems. Simon stated problem-solving happens after goals formation, noticing distinctions between the current condition and future objectives, and examining processes and or tools to diminish these differences. Every problem makes subproblems, till the subproblem is discovered to be solved. Thus, consecutive solutions of such subproblems happen until the goal is accomplished.

This concept originated from the systems theory of the 1950s and dominated the management science that played a role in the post-Second World War industrial development. Nevertheless, the systems thinking of the 1970s and 1980s offers a more profound viewpoint, in specific by Vickers's development of appreciative systems theory and by soft systems methodology- a methodology to involvement in human activities that can be understood as making the applied practice of that theory. Appreciative systems theory defines examining processes, with a perspective to understanding; while the soft systems approach offer the outlook to taking action to progress real-world problem conditions.

The work on the theory of appreciative systems by Vickers and work done on soft systems methodology, provide a more profound view about organizations and management. Soft System Methodology (SSM) had developed in an action research program at Lancaster University by Checkland. It was revealed that its method represented to a notable level the philosophies Vickers had been establishing in his books and articles. Soft modeling denotes to theoretical and contextual methodologies that are more likely to be more realistic, diverse, and comprehensive than ‘hard’ models. The real-world managerial setting is described by
contradictory appreciative settings and standards. Thus, the system-engineering method failed to
tackle the technical problem conditions and its managerial sophistication.\textsuperscript{36}

Hard and soft models are occasionally denoted as ‘quantitative’ and ‘qualitative’,
correspondingly.\textsuperscript{37} Hard systems thinking embarks on precise problems (such as improving the
production of a chemical plant), while the soft approach is more appropriate for imprecise and
disordered problems (such as choosing a health care policy in a resource-scarce condition). The
actual difference between the two approaches lies in the designation of systemically (having the
characteristic of system-like features). Hard systems thinking assumes that the planet is a set of
systems (i.e., is systemic) and that these can be methodically engineered to accomplish goals. In
the soft approach, there is the assumption that the planet is problematical and challenging, but it
is also supposed that the practice of investigation into the challenging settings that make up the
world can be structured as a system. In other expressions, assumed systematicity is transferred:
from taking the planet to be systemic to taking the procedure of examination to be systemic.\textsuperscript{38}

Checkland established soft systems approach in the 1960s. In the standard form of these
approaches, a researcher or an observer facing difficulty makes as few assumptions about the
kind of problem as possible. Afterward, a strong and vivid picture is established by trying to
describe in detail the rationality, connections, value decisions, and nature of the problem
situation. Crucial descriptions of the system are then described and illustrated.\textsuperscript{39} Peter
Checkland’s soft systems methodology contradicts the importance that systems thinking as a
modeling and measurement attempt, considering it instead of an evolving and learning practice.\textsuperscript{40}

Driven by the purposeful actions of its stakeholders, this methodology has become a
segment of the analytical systems thinking methodology adopted by Flood and Rommd, and
Midgley, in which systems thinking is seen as a stakeholder-driven procedure. In his
characteristic book Systems Thinking, Systems Practice, Checkland himself describes systems thinking as a method that highlights the importance of wholeness in the word “system” to direct the individual’s reflections and opinions. “Soft” systems methods focus on processes and people, such as Checkland’s soft systems methodology, Midgley’s participatory stakeholder-driven methodologies, and Senge’s theory of learning organizations. When matched with the traditional system dynamics, these methods study the development of a system as an ecological procedure, weakly or incorrectly represented through mathematical simulation.41

The development of SSM has been characterized by four points in time at which what can now be seen, with hindsight, as crucial ideas moved the project forward.42

- The first was the awareness and understanding that all real-world problem conditions are described by the fact that they disclose human beings looking for or desiring to take purposeful action.43
- Second, the models are applicable to debate about real-world action, but not representations of actual action.44
- Third, the problem-solving method would include a learning phase because the models of human activity systems could be used to creating an effective discussion about change.45
- The awareness that models of human activity systems could be employed to investigate matters regarding what information systems would best be created to support actual everyday activities—action—took SSM into the arena of information systems.46

2. 1.B. System Dynamics.
Forrester, with an education in the computer sciences and control engineering, became a lecturer in the Sloan School of Management at MIT in 1956. He guided the System Dynamics Program there until 1989. He pioneered the approach, which was the main innovation for decision-makers; it was initially named ‘industrial dynamics’ and was publicized to the world in a 1958 article for the Harvard Business Review titled “Industrial dynamics.” Later, Forrester expanded his possibility and retitled the approach ‘system dynamics’.47
W. Forrester developed system dynamics to expand the scope of applied systems thinking to more strategic issues. He assumed Operational Research (OR) starts to fail in addressing the actual anxieties of managers because of its increasing concentration on particular strategic problems, responsive to mathematical modeling where they involve only a small number of variables in linear associations with one another. On the other hand, system dynamics uses the science of feedback to reveal the elements of multifarious non-linear systems. Most importantly, social systems are of this type and can be modeled based on the rules of system dynamics because the effects of the decisions of human actors can be exhibited using identical rules. At the Massachusetts Institute of Technology (MIT), Forrester and his team did all the actual groundwork essential to found system dynamics as a rigorous and valued applied systems approach.

Peter Senge popularized this framework in his book The Fifth Discipline (1990). This volume, endorsing system dynamics is reflected as the fundamental approach to constructing ‘learning organizations’; it stroked the best-seller lists globally. In essence, Forrester always saw inspiration of ‘learning’ as a significant component in system dynamics. If managers could understand the complexity of systems, they could work on them to bring about advancement. Nonetheless, the fundamental characteristic of his approach was the formation of computer-based simulation models that could be tested for validity against the performance of the real-world systems they were assumed to exemplify.

The use of the systems dynamics model offers ways to envisage significant elements and their relationships. A systems dynamics model based on facts, evidence, and principle portray possible causes and effects related to the behavior of the components of the system. This greatly aids in conceptualizing the complexity of the system. By forming a systems dynamics model,
various components present in a complex system are recognized and their relationships are envisionered and understood through causal loops. The connections between causal loops comprise the general structure of the system and control the system’s behavior.\textsuperscript{50} In addition, the border of the system should be determined to incorporate important factors and to disregard all those that do not considerably influence the system.\textsuperscript{51} Once the association between factors is concluded, causal loops can be created.\textsuperscript{52} Loops can be categorized either as \textit{reinforcing} (i.e. factors within a loop \textit{intensify} behaviors within the loop) or \textit{balancing} (i.e. factors within a loop \textit{dampen} behaviors in the loop).\textsuperscript{53} In a systems dynamics model, arrows are used to exemplify how components are linked. Interactions between the elements can be determined and labeled as positive (+) when both related variables change in the same way, or negative (-), variables change in opposite directions.\textsuperscript{54}

The structure of the system is the systemic connections between feedback loops. This structure is the major factor of system behavior. The goal of system dynamics is to offer managers an apprehending of the structure of complicated systems so that they can interfere promptly and confirm the behavior is aligned with their objectives.\textsuperscript{55}

1. The boundary must be marked to incorporate all significant interrelating components and to exclude all those that do not influence the behavior of the system. Thus, there is an underlying assumption that all significant dynamic behavior results from the connections of components inside the system boundary.\textsuperscript{56}
2. Next, identify feedback loops inside that boundary and their nature (positive or negative) and map their interrelationships.\textsuperscript{57}
3. To validate the model, compare the behavior of the model with the real-world activity until an honest agreement has been attained.
4. Work to launch recommendations on how the managers might alternate the position to make it improved.\textsuperscript{58}

Using one of the programming languages customized for system dynamics, it is possible to build a computer model. This simulation will disclose the major feedback loops and forecast any time delays that might arise in the system. Managers can investigate the model to test the effect
of potential interferences. They can intervene in the system to fund the “leverage points,” parts of the system at which they can make orders and attain the greatest return in terms of their goals. This may require, for example, breaking present associations or inserting additional feedback loops.\textsuperscript{59}

Systems approach refers to a set of theoretical and methodical techniques used for systems thinking and modeling. The general practical way towards systems thinking that will be further discussed and analyzed in this dissertation is the system dynamics method. In the late 1950s, Jay Forrester and others at the Massachusetts Institute of Technology established the field of system dynamics, based on improvements following World War II in the following main areas:

- The concept of information feedback systems;
- The knowledge of decision-making processes;
- The use of mathematical models to simulate complex systems; and
- The advancement of high-speed electrical digital computers as ways of simulating mathematical models.\textsuperscript{60}

Coyle (1977, 1996), Randers (1980), Richardson and Pugh (1981), Roberts \textit{et al.} (1983), Senge (1990), Wolstenholme (1990), Richardson (1991), Mohapatra \textit{et al.} (1994), Morecroft and Sterman (1994), Vennix (1996), Richmond and Petersen (1997), Sterman (2000), and many others have all contributed to the development of systems thinking and system dynamics.\textsuperscript{61} Based on Maani & Cavana, the development of systems thinking and modeling intervention encompasses five chief stages:

1. Problem structuring;
2. Causal loop modeling;
3. Dynamic modeling;
4. Scenario planning and modeling;
5. Implementation and organizational learning (learning lab).\textsuperscript{62}

These stages follow a process, each comprising many steps. Nonetheless, it must be highlighted that an ST&M involvement does not necessitate all stages to be carried out. Rather,
these phases and steps are offered as guides, and the type of problems that have caused the examination of the system determines the phases and steps that should be utilized in the ST&M intervention. However, the aggregate use of the stages adds more significance and influence to the examination. These phases are described below.\textsuperscript{63}

Referring to the definition of the system dynamics methodology delivered by Eric Wolstenholme, Wolstenholme’s explanation of the range of system dynamics is explained within a structure that respects and cultivates the principles and values of mindfulness, honesty, and accountability.\textsuperscript{64} A system dynamics is an approach used to solve problems while decreasing the possibility of unintended results through assisting in thinking, envisioning, and communicating the potential development of multifarious institutions. This assistance happens through the creation of simulation models, which express mental models and capture the connections of physical and behavioral methods, institutional boundaries, policies, communication response, and time delays. The functioning maps are employed to analyze the whole effects of alternative strategies.\textsuperscript{65}

System dynamics empower managers to handle complexity and take more fruitful decisions in fulfilling their objectives. It avoids them to become dependent on effortless solutions; look for small fluctuations that can create big effects rather than trying to significantly transform the whole system.\textsuperscript{66} Additionally, system dynamic models assist in identifying crucial decision ideas and alternative strategies and identify the effects of current policies given that the decisions of managers are incorporated in the models. This leads to highlighting the importance of learning, which is predominantly prominent in Senge’s writings.\textsuperscript{67}

Senge emphasizes that system dynamics can offer the essential understanding and encourage individuals to realize more proper responses by seeing the greater structural
arrangements that escalate problems. Senge (1990) considers system dynamics, presented as ‘the fifth discipline’, as the most significant tool that organizations must follow to become ‘learning organizations. Only system dynamics can reveal the systemic structures that govern their behavior. Nevertheless, it is essential to support the study of the fifth discipline with research on the other four disciplines seen as significant in the creation of learning organizations. These are ‘personal mastery’, ‘managing mental models’, ‘building shared vision’, and ‘team learning’. Personal mastery encompasses persons in regularly clarifying and expanding comprehending of their purposes. The discipline of managing mental models necessitates institutions regularly to question the taken-for-granted expectations that reinforce the worldviews leading their existing behavior. Shared vision demands exposing visions of the future that encourage harmony and promise. Team learning allows an institution to get the benefits of cooperation from the knowledge understood by persons.

The System Dynamics Society has something very influential to offer to the progressively distressed and anxious planet. First, it is a way of thinking and learning. Systems Thinking is the art and science of formulating consistent interpretations about events by building a profound interpretation of the fundamental structure of the whole system. Fundamentally, Systems Thinkers understand and appreciate both the broad and the specific. Behaviorally, they realize both the configuration and the event - not just the second dimension.

Systems thinking offers new tools to address applied and multifarious problems. Some researchers perceive system dynamics as a subdivision of systems theory. Others see the opposite; systems theory is a subdivision of system dynamics. Systems thinking is a method for examining and handling multifaceted feedback systems. System dynamics is grounded on systems thinking but makes use of computer-simulation tools. Forrester perceives systems
thinking like a small subgroup of System Dynamics, seen in terms of what the system dynamics has to offer in helping individuals better comprehend the way the world looks. However, in this paper, the view of Barry Richmond is adopted in which systems thinking is seen encompassing system dynamics and much more. Systems investigator, Barry Richmond, argued that system dynamics modeling shapes a big part of the broader field of tools and approaches incorporated by systems thinking. Systems thinking is reflected as a “new way of thinking" where it helps people understand events and give significance to events.

In summary, decision-makers will be conscious of the systemic relationships that their decisions cause, and thus are more likely to act in ways that aggravate current problems. If they are concerned in constructing causal loop models; nonetheless, they become mindful of the fundamental structures at work. They are more enthusiastic to questioning the mental models that cause the strengthening of destructive models. Ultimately, a systems dynamics model can be a vital evaluation tool.

The systems thinking and modeling methodology summarized has many various applications.

1. **Strategy and policy**

Systems thinking is considerably employed for strategy formulation and testing. This happens at both the level of government, industry, and at the institutional level Systems thinking highpoints the succeeding areas of strategy, which are frequently overlooked or neglected by other methods:

- Internal inconsistencies in a strategy;
- Unseen strategic opportunities;
- Unused strategic powers.

2. **Operations and design**

Systems thinking also has extensive applications in operations and design. Some of the particular applications are:
• Novel product and service development;
• supply-chain management;
• Network design and management.

3. **Functional modeling**

The systems thinking and modeling approach can be used to illustrate functional areas such as finance, marketing, and human resource management.\(^{80}\)

### 2. II. Systems Thinking & Systems Stakeholders.

#### 2.II.A. Systems Thinking.

Systems thinking spans 2,600 years to the time of Lao Tzu and the initial formal description of a complex system in the yin and yang of the Tao.\(^{81}\) There are several early adopters of systems thinking, including biology, geology, and earth sciences, engineering, business, management and leadership arenas, and education. All of these fields confront the same challenge: as they try to put an end to their problems by systems thinking, they unintentionally connect to new chaos of problems.\(^{82}\) The theories and approaches in systems thinking are each intended to tackle multifarious problems as they include various interacting elements, where the setting in which they function continues to change in a nonlinear fashion.\(^{83}\) Systems thinking tools have an extensive assortment of applications and functions. It can be a means of enabling groups of people to have a shared understanding of a subject to achieve timely additional analysis and action.\(^{84}\) The table below shows the essential skills of systems thinking and how it differs from traditional thinking.

Skills of systems thinking\(^{85}\)

<table>
<thead>
<tr>
<th>The standard approach of Systems Thinking Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Static thinking</strong></td>
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</table>

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75
<table>
<thead>
<tr>
<th>Concentrating on specific incidents</th>
<th>Enclosing a problem in terms of an arrangement of behavior over time</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Systems-as-effect thinking</strong></td>
<td><strong>System-as-cause thinking</strong></td>
</tr>
<tr>
<td>Seeing behavior produced by a system as caused by external forces</td>
<td>Assigning duty for behavior on internal actors who manage the policies of the system</td>
</tr>
<tr>
<td><strong>Tree-by-tree thinking</strong></td>
<td><strong>Forest thinking</strong></td>
</tr>
<tr>
<td>Considering that knowledge means focusing on the details</td>
<td>Considering that knowledge requires comprehending the framework of relationships and</td>
</tr>
<tr>
<td><strong>Factors thinking</strong></td>
<td><strong>Operational thinking</strong></td>
</tr>
<tr>
<td>Listing factors that impact or associate with some outcome</td>
<td>Focusing on causation and understanding the way behavior is caused</td>
</tr>
<tr>
<td><strong>Straight-line thinking</strong></td>
<td><strong>Loop thinking</strong></td>
</tr>
<tr>
<td>Seeing causality as operating in one direction, disregarding (either deliberately or not) the interdependence and relationship between and among the causes</td>
<td>Seeing causatives as a continuous process with outcome feeding back to impact the causes and the causes influencing each other</td>
</tr>
</tbody>
</table>

*Modified from Richmond, 2000 (28).*

Systems thinking is presented as a developing outlook that can offer noteworthy gains to health systems research and practice. The healthcare field is multifaceted and complex because it involves various causes and consequences that are extremely situation-dependent and not receptive to linear approaches of intervention. The approaches help in tackling the interrelated,
intersecting, and contextually sensitive parts. Systems thinking methods can also offer assistance and support on where to gather more facts or to foster new explorations and hypotheses. For instance, health researchers use systems thinking to clarify epidemics and to enlighten programmatic extension efforts. Through tools of systems thinking, they sometimes explain the failure of interventions that were duplicated at a large scale, after these same interventions were proven effective at a small scale. Systems thinking approaches helps in viewing the functioning of social, health, environmental, and behavioral factors within the setting of applied public health programs. They also offer theoretical frameworks with which to re-envision how programs are executed, examined, assessed, and informed to the larger public health audience. By using these approaches, researchers can comprehend and measure the wider public health context and think about the vibrant interaction of the social and environmental factors, and finally, develop more effective and successful health programs and policies.

In essence, the approaches of systems thinking are of great significance to inspiring a systematic and methodical habit of mind. This habit leads to novel opportunities to comprehend and continuously investigate the interventions intended to advance people’s health. Churchman debates the role of systems designers to challenge the mental models of influential managers, that they are pushed to act based on the drives of customers because the people are assumed to take advantage of the systems they share. Systems thinkers should tackle systems as wholes, and they must listen prudently and wisely to all ‘opponents’ of the systems approach (such as religion and ethics) since these opponents mirror the very failure of the systems approach to be wide-ranging. Churchman claims that when it comes to problems of purposes and proper means, which certainly involve moral deliberations decisions, there can be no experts. AsChruchman argues, resonating Singer, the system thinker should pursue his or her career in the ‘courageous
attitude;’ aggregating human dedication and contribution in systems design is a constant activity.\(^{94}\) Therefore, all involved parties will be included in the decision process; bringing many different perspectives on the problem set. This will present many challenges to the suggested course of action, and present alterative perspectives and actions.\(^{95}\)

Senge summaries 11 laws of the fifth discipline, which he derives from lessons found in various theories like chaos theory, complexity theory, organizational theory, management theory, and system dynamics:

1. Today’s troubles come from yesterday’s resolutions.
2. The harder you push, the harder the system pushes back.
3. Performance develops the better before it develops into the worse.
4. The easy way out frequently leads back in.
5. The treatment can be worse than the illness.
6. Quicker is slower.
7. Cause and effect are not meticulously associated in time and space.
8. Minor changes can generate big results, but the parts of highest leverage regularly are the least noticeable.
9. You can have your cake and eat it too, but not entirely at once.
10. Splitting an elephant in half does not create two small elephants.
11. There is no blame.\(^{96}\)

Similarly, Gelb perceives systems thinking as the main item that connects his seven principles of effective thinking. Gelb suggests that effective thinking nowadays can be outlined by seven main principles; his statements are distinctive of Leonardo da Vinci’s intelligence.\(^{97}\) Gelb thinks that da Vinci’s attitudes will aid individuals to nurture their imagination and vision daily, foster analysis with creativity, maintain unceasing knowledge, adopt and support uncertainty, encourage imagination and novelty, and utilize systems thinking to problem-solving.\(^{98}\) The principles are:

1. An insatiable seek for knowledge and unceasing development;
2. Learning from experience;
3. Refining the senses;
4. Control uncertainty and transformation;
5. Whole-brain thinking;
6. Body-mind fitness;
7. Systems thinking.\textsuperscript{99}

Enlightening individuals to cultivate a capacity for systems thinking is significant for policymakers and experts in all fields. Systems thinking to help them tackle problems differently.\textsuperscript{100} When working on interventions, a systems thinking methodology will aid in anticipating and alleviating unwanted consequences and controlling unpredicted interactions by adjusting the interventions.\textsuperscript{101} Systems thinking emphasizes the importance of appreciating the setting, and looking for relations among the components. Systems thinking helps in foreseeing, rather than responding to, the effects of variations in the system, and detecting points of control. This is similar to the ways employed in the health sector but systems thinking involves a more inclusive, methodical, and thoughtful approach.\textsuperscript{102}

2.II.B. System Stakeholders.

The systems thinking approach models multifarious real-world interrelationships iteratively over time with feedback, more comprehensive and accurate models of the dynamics of facts. This representation acknowledges the investigation of effects, such as unintentional and unplanned consequences.\textsuperscript{103} Systems thinking understand a complicated intervention as a system in itself, interrelating with other components, and helps in reducing the potential of unpredicted and undesirable effect.\textsuperscript{104} The way system stakeholder networks are incorporated, comprised, and controlled, and the way the framework and circumstances structures stakeholder behavior is a very important aspect of systems thinking. Stakeholders are very important because they are actors influencing the system, and they are moderators and recipients. This includes their contribution as entities, civil society societies, and stakeholder networks, and also as crucial players manipulating each of the other components, such as health workers, managers, and legislators.\textsuperscript{105}
It is important to note that various stakeholders see the objective of the system differently, and this can provide new understandings and visions into the way the health system works and try to solve the problems and improve the system through a meticulous understanding of how one element of the system impacts the other components. For example, the health system is viewed as:

- “Revenue generating system” by private providers,
- “Employment system” by healthcare professionals,
- “A distribution system” by pharmaceutical companies,
- “A health resource system” by patients,
- “A social support system” by the local communities,
- “Policy systems” by the government.

Responding to the potential of systems methods necessitates a participatory, supportive setting among the stakeholders. Thus, this entails a renewed method to management, leadership, and connections within and among institutions. In their new book, Social Networks and Organizations, Kilduff and Tsai offer a valuable presentation on the significance of networks. They quote the example of Paul Revere and his famous “midnight ride” in 1775 to warn residents near Boston, Massachusetts, of the forthcoming entrance of British soldiers. This model exhibits the significance and usefulness of networks. Despite good aims, comparable resources, and great enthusiasm, accomplishment in getting things done is often greatly contingent on developing and maintaining an actual social network.

The focus is on social collaboration, connections, partnership, collective action, trust, and teamwork. Here, a network is described as a group of three or more persons, clusters, or bodies linked in ways that are assumed to enable the attainment of a mutual objective. The relations between network partners are primarily nonhierarchical and have restricted, and often, functioning autonomy. Network partners can be interconnected by many kinds of links, such as
information, materials, financial resources, services, and social support. The primary requirement is that organizations involve individuals. Social interaction among organizations eventually occurs principally between persons representing organizations.\textsuperscript{110}

A short outline of the main groups of theories that have been used to clarify network performance is presented below:\textsuperscript{111}

1. Self-interest. This implies that organizations seek network links with other organizations if and only if it is to their benefit (like skills, resources, or knowledge) to do so.

2. Transaction cost economics: network members pursue relations that permit them to function most professionally by reducing the expense of transactions (like overhead expenditures) and augmenting the benefits from transactions.

3. Exchange and resource dependence: According to this perspective, organizations pursue and create network relations with other associations to decrease uncertainty and invite necessary resources.\textsuperscript{112}

4. Collective action. Theories of collective action explain circumstances in which organizations form network relations with other associations, not to pursue or interchange resources with one another, but to expand their combined capability to request resources from or deliver them to third parties. For example, organizations might select to share knowledge to organize more successfully a campaign to endorse smoking end. These concepts are based on public goods theory with the idea that individuals and organizations are motivated to join and work in networks to earn the welfares of collective action. Concepts of collective action are generally valuable for describing why organizations might create and maintain a network.\textsuperscript{113}

5. Social contagion. The outlook of social contagion centers on the influence of network participation on successive behaviors. Contagion happens as an effect of interrelating with
network participants and being “infected” by their manners and actions. In general, more participation ends in greater contagion, resulting in analogous outlooks, principles, and actions amongst network members.114

6. Change and evolution. Theories of organizational change have concentrated approximately exclusively on inner change or the development of organizational populations. Associations generate network links to expand the “qualification” of the whole network and thus to be “nominated” from an ecology of other networks in the society.115

Researchers have applied all of these theoretical methodologies to clarify crucial characteristics of network behavior. In a way, they are opposing theories as they try to describe the same fundamental phenomenon. Nevertheless, networks are multifarious means, and a description of the actions and organizations of network members cannot be summarized in one simple theory. Individuals and associations characteristically connect and maintain their participation in real-world networks for several intentions.116

Building on these theories, researchers have reviewed various networks in a wide range of settings. Several exploratory deductions can be drawn about standards for a successful network. This list is not comprehensive, but it offers a short outline of much of the current understanding of organizational networks.

1. Numerous levels of collaboration. Collaboration should happen at several organizational levels. Encompassing several people in an organization also rises the probability that network links will be retained when someone leaves the organization.117

2. Attentive integration: Successful networks should have adequate levels of incorporation among members, with some disintegration and organizational pits.118
3. Robust links. The strength of connections among network members should be diverse, contingent on critical network needs.119

4. Network governance. Governance of the network should be grounded on the extent and convolution of the network; small linkages can be self-governed.120

5. Involvement. Most network connections should be established on trust and pledge to network objectives.121

6. Legitimacy. Networks must form legitimacy as they develop, both internally and externally. Legitimacy assists in constructing commitment to the network and its objectives and is essential for supporting the network.122

The use of supportive networks of organizations has become a crucial approach for tackling the public’s most demanding health and human services needs. These networks have become significant tools in many states and societies, as well as nationally and internationally. Their functions are as follows:

- Building capacity to identify multifarious health and social problems
- Planning strategies methodically to best encounter critical public health needs
- Developing and executing policy related to public health needs
- Leveraging, and acquiring rare resources
- Facilitating knowledge to tackle multifaceted problems
- Delivering required services.123

By working together as a network, organizations can expand both their effectiveness and the efficacy of the services and plans they offer.124 The prospective benefits of network connection are extensive. They involve enhanced services, better access to services, less repetition of work, better interaction and access to information, improved creativity and novelty,
and ultimately, more consistent indicators of health status. Research has confirmed that networks are particularly appreciated for not-for-profit and public organizations working to address a wide range of problems in the community and local health and human services.\textsuperscript{125}

Organizational networks provide the subsequent advantages to health care providers:
- Deliver a team method to complex public health problems. Networks are specifically advantageous for tackling complex problems. The size of various problems in health services is too great for anyone group to resolve independently. Such problems require a network approach—a structure of organizations that is responsive and can quickly bring together the set of distinct abilities, assets, and capabilities needed to tackle these problems successfully.\textsuperscript{126}
- Tackle numerous needs. Networks can work with customers who have several needs (e.g., education, treatment, and prevention).\textsuperscript{127}
- Respond to the disintegration of numerous-provider organizations. When organizations create a network, nevertheless, disintegrated services can be combined across providers, permitting consumers to fulfill all their needs.
- Alleviate difficulties related to geographic dispersion. Networks deliver an official method to support and enable collaboration, even when face-to-face interaction is not likely.\textsuperscript{128}
- Enhance the use of resources. Networks are effective gadgets for delivering necessary services under the restraints of inadequate resources.\textsuperscript{129}
- Enable knowledge sharing and improve learning. To tackle multifarious health care problems, nonetheless, the extensive sharing of knowledge is crucial.\textsuperscript{130}

\textbf{2. III. Systems Approach in the Healthcare Sector.}

\textbf{2.III.A. Systems in the Healthcare Sector.}

Referring to the definition of the World Health Organization, a health system consists of all institutions, individuals, and engagements whose chief intent is to encourage, reestablish or
preserve health. Its objectives are enhancing health and health justice in ways that are economically fair and using the most effective use of existing resources.\textsuperscript{131}

Based on the present WHO “Framework for Action” on health systems, which portrays six clearly defined Health System Building Blocks that together establish a system. These are:\textsuperscript{132}

1. Service delivery: including successful, efficient, safe, and qualified individuals and non-personal health involvements that are offered to those in need, when and where needed (including infrastructure), with a marginal waste of resources;
2. Health workforce: receptive, rational, and proficient given existing resources and conditions;
3. Health information: ensuring the assembly, investigation, distribution, and use of consistent and well-timed information on health factors and health status;
4. Medical technologies: comprising medical products, and other technologies of assured quality, safety, effectiveness, and cost-effectiveness;
5. Health financing: raising satisfactory finances in ways that guarantee people can use necessary services and are safeguarded from financial misfortune or poverty-related with having to pay for them;
6. Leadership and governance: ensuring tactical policy agendas linked with effectual supervision, partnership building, responsibility, regulations, enticements, and responsiveness to system design.\textsuperscript{133}

These building blocks alone do not establish a system, but it is the many associations and connections among the blocks – how one impacts the others and is in turn influenced by them, and how they empower the system to accomplish the objective of the system.\textsuperscript{134} While that structure may be questioned as skewed towards supply-side factors, it does offer an appreciated
method for conceptualizing the health system and understanding the utility of systems thinking.\textsuperscript{135}

Figure 1. WHO Model: The building blocks of the health system: aims and attributes

The responsibility of individuals must be emphasized, not just at the heart of the system as intermediaries and receivers but as players in pushing the system itself. This incorporates their contribution as individuals, civil societies, and stakeholder networks, and also as crucial players affecting every building block, as health care providers, directors, and legislators. This will further highlight a repeated duty to the values and ethics of primary health care – social justice, involvement, equality, and partnership.\textsuperscript{136}

Most systems, including health systems, are: \textsuperscript{137}

1. Self-organizing – \textit{system dynamics develop naturally from inner structure and the vibrant interaction among the system’s components, and through the system’s communication with other systems.}\textsuperscript{138} “system” is portrayed in this essay as a “complex adaptive system” – one that self-organizes, changes and progresses with time. The way the system is structured reflects the system behavior, which reflects itself by a sequence of occurrences over time.\textsuperscript{139}
2. Continually fluctuating: – systems adapt and rearrange continually. Thus, they can create their behavior; respond to the same inputs in a different way and random ways, and progress through interconnections with other parts of the system.  

3. Governed by feedback – a positive or negative response that may modify the intervention or anticipated results. Systems are coordinated and organized by “feedback loops” that offer information flows on the condition of the system, regulating behavior as elements interconnect with each other.  

4. Non-linearity – connections within a system cannot be organized in a simple linear fashion. System-level involvements are characteristically irregular and nonlinear.  

5. History dependent – Time delays are undervalued dynamisms disturbing systems, especially when this is related to interventions intended to modify people's behavior.  

6. Counter-intuitive – effects might take a long time to happen due to a particular cause and this might result in the failure of effective interventions in a particular setting, and their success in other specific settings.  

7. Resistant to change – some clear and straightforward solutions may weaken or deteriorate the condition due to the complexity of the system and its interactions. Understanding the complexity of the system is very crucial.  

There are three major themes of systems thinking:  

1. **Collaboration across disciplines, sectors, and organizations**: Any method to develop a health system will necessitate that actors extend beyond their zone of knowledge, and cooperate with partners with different practices, experiences, and objectives.  

   **Ongoing, iterative learning**: Systems-level change requires an acknowledgment that the setting is constantly fluctuating. As such, actors demand to continuously adapt, understand, and apply
new knowledge to existing challenges. Learning organizations are needed due to the increased complexity in healthcare, which brings new encounters to the health system. Central values of complex adaptive systems applications such as the vital function of collaboration, and feedback loops. Better participation offers the chance to engage patients and providers, and people and policy makers. Engage the partnership in fundamental values, such as social responsibility and equity.\textsuperscript{146}

2. **Transformational leadership**: Visionary leaders are required to confront the dominant standard; forgo organizational welfares for systemic advantage; improve inter-organizational teamwork and collaboration, and encourage transformation. Health care workers at all levels can be transformational leaders by challenging fundamental anticipations about the way health is brought; a shared vision of fairness and efficiency; and inspiring ethical values for all stakeholders.

Systems thinking to transform health practice.\textsuperscript{147}

**2.III.B. Systems Thinking and Healthcare.**

Based on WHO World Health Report, 2008, it stated that the reactions of various health systems so far have been frequently reflected as insufficient both fail to expect and react properly) and immature ((momentary solutions cannot solve failures of systems).\textsuperscript{148} With the rising occurrence of complexity in the health care sector, they have commenced to embrace and implement systems thinking to confront complex problems such as tobacco control, obesity, and tuberculosis.\textsuperscript{149} Public health problems are not easy, linear cause-and-effect dilemmas. They are systems bound together by a web of elements that interact with each other. Public health problems require dealing with a multifarious interaction of evolving players and factors that must be tackled as a system.\textsuperscript{150} It is crucial to move beyond well-known methodologies and toward
systems methods that tackle essential concerns of interdependency, complexity, information management, and engagement of institutions as a system.\textsuperscript{151}

Nonetheless, few have attempted to apply these thoughts beyond single issues to the health system itself or explained how to transfer from principle to practice – perhaps due to the tremendous complexity of health systems. There is an immense need for new means and tools of thinking to accommodate the complexity of the challenges.\textsuperscript{152} Lately, the recommendation of employing systems thinking to the health system has appeared, supported in some ways by the WHO’s 2007 delivery of the health system building blocks.

Systems thinking itself often transforms insights and opinions regarding the nature of the problems, their limitations, and the selection of the approach used to solve them. Systems thinking encourages the study of complex health-related problems meticulously using proper methods.\textsuperscript{153} To realize improved and more justifiable health outcomes, one has to comprehend the high complexity of health systems. This necessitates a paradigm change from linear, reductionist methods to vibrant and holistic methods that understand both the complicated and interrelated interactions among health system complements, and the benefits and influence of its distinctive stakeholders. Systems thinking changes perspectives by developing the understanding of complex adaptive systems. Thus, this knowledge can be applied to system problems in approaching problems and planning possible solutions.\textsuperscript{154} This is because systems thinking understands well the nature of complex systems as vibrant, constantly fluctuating, ruled by feedback. Moreover, in complex systems, the accountability and effect of stakeholders are significant, and new policies and activities of diverse stakeholders often produce counterintuitive and random consequences.\textsuperscript{155}
System thinking mostly goes in contradiction of the traditional teaching methods in health disciplines (such as medicine), as they focus mainly on causes and elements of health in reductionist terms rather than focusing on the relationships among the elements of the system. This does not underestimate the importance of these classical methods and their effect on wonderful developments in medicine and public health. The desired benefits are, nevertheless, hindered by the complexity problem in the healthcare system. Systems thinking can accompany classical approaches through a holistic approach to tackle complex problems in complex systems. Appreciating the complexity of health systems has increasingly become more common in publications interested in finding solutions to develop the population’s health more effectively and fairly. In 2009, the WHO-based Alliance for Health Policy and Systems Research (HPSR) dedicated its third flagship report to this topic, “Systems Thinking for Health Systems Strengthening.” This report and other the latest publications have catalyzed an augmented awareness and request for moving this way of ‘thinking’ onward.

The so-called disease-specific programs that begun in the 1980s and flourished in the last twenty years have been effective at bringing specific interventions such as immunizations. Nevertheless, the long-term influence of these programs on health systems is uncertain, with the unsystematic indication for constructive and undesirable effects. This recognition of inadequate recognized positive effects on health systems of targeted health investments has led to a repeated attentiveness in ‘health systems strengthening.’ Thus, the perspective of looking at health systems as adaptive systems offers innovative opportunities for collaboration and increasing capability in local societies and organizations.

Systems thinking can supplement and develop the dominant reductionist methods to health improvement by enhancing health practices. New publications, such as Systems Thinking
for Health Systems Strengthening have delivered a valuable presentation to complex systems, health, and social systems. Complex adaptive systems (CAS) change in vibrant and sometimes unpredictable means to alterations within the system itself. CAS has numerous constituents such as residents, patients, communities, providers, policy makers, etc., that are persistently collaborating and adjusting to other element fluctuations and setting changes. The characteristic qualities of health and other complex systems contain self-organization, constant changes, feedback loops, non-linearity, time lags between inputs and outcomes, history dependence, and unintended consequences of policy interventions.\textsuperscript{160}

Systems thinking is a methodology that explains and takes into consideration the features and outcomes of CAS, and endeavors to expand their positive effects while decreasing unintentional negative effects. It is extensively applied to various sectors: engineering, economics, ecology, and business, and it is a developing method in health systems research with remarkable potential to tackle challenges linked to public health issues. Systems science approaches consider vibrant relations between elements varying from entities to organizations, and the influence that those connections have on the whole health system. Implications for research, policy, and practice in public health are substantial.\textsuperscript{161} Many systems thinking methods have been effectively applied to health and other sectors.\textsuperscript{162}

Systems thinking works to divulge the primary features and connections of systems. Systems are vibrant constructions of connections and synergies. It is applied to many fields as distinct as economics, engineering, and ecology. Numerous current projects have embraced and implemented systems thinking to tackle complicated health problems—tobacco control, obesity, and tuberculosis. Systems thinking has a great potential in interpreting the complexity of health systems, and then in employing this understanding to plan interventions that develop health and
health justice. Systems thinking can offer a way forward for managing more effectively and successfully in multifarious, real-world situations. It can open influential pathways to finding and solving health system challenges, and as such is a fundamental component for any corporate social responsibility effort in the healthcare sector.

Systems thinking will help in recognizing, with more accuracy, where some of the actual challenges lie. It will help to:

1) Investigate problems from a systems outlook;
2) Demonstrate possibilities of solutions that work across sub-systems;
3) Promote vibrant linkages of various stakeholders;
4) Encourage learning; and
5) Promote more system-wide planning and research.

The complexity of the modern health care system and technology is the first challenge. Dr. Reason, the dean of safety research, has perceived the huge complexity of health care in terms of relationships, especially in the existence of 50 distinctive categories of medical specialties and subspecialties. The healthcare system is a complex adaptive system in which there is a group of distinct agents with the power to act in modes that are not always entirely anticipated, and whose actions are interrelated so that one individual’s actions modify the setting for other managers. This happens among primary healthcare team members for example. Individuals employ certain rules, characters, theories, and mental models, to respond to their environment. Moreover, complex systems can modify and change their performance over time because agents can also adapt their behavior. Therefore, the health care system in the twenty-first century is characterized by its complex nature. To manage with increasing complexity in health care, the linear models are no longer sufficient; however, a richer approach is required to solve clinical and organizational problems, acknowledge instability, and simultaneously admire autonomy, and react adaptably to opportunities.
In system thinking, the relationship and the connections within a complex adaptive system are often more imperative than the distinct actions of the separate parts. The interactions might generate productive and valuable capabilities that are not intrinsic in any of the parts acting alone. System thinking is used as a method to comprehend actions in complex healthcare organizations. First, the overall standard of complex systems can be described in terms of a hierarchy of levels of the organization. Second, complex systems, such as the healthcare system, are regarded as a set of interconnected subsystems that are kept in a state of equilibrium by feedback loops of knowledge and power. Systems thinking is a method that helps visualize the interconnection of all the elements in the system. This approach overcomes the boundaries of the reductionist approach and helps view the relationships between the distinct components and the effect of any change in the whole system.

In the health sector, the World Health Organization endorsed the approach of systems thinking, as an applied methodology to support health systems. Moreover, this approach was supported by the Institute of Medicine as a way to act in response to an event that significantly exceeds standard burdens on health and medical capability.

A system can be described as a multifaceted whole, the functioning of which depends on its distinctive elements and the dealings among them. Elements may comprise people, actions, or organizations. Each component may have distinctive and opposite interests, thus adding additional difficulty to connections within the system. Systems thinking highlights the various components and their relationships, and also the influence of these relationships on system behavior.

Systems thinking is enlightened by several theories, such as non-linear dynamics, chaos, and complexity theories, and has been accepted in current health systems projects to tackle issues
such as tobacco control, obesity, and tuberculosis.\textsuperscript{175} Three important features of systems will be emphasized as applicable to debates on summarizing the complex nature of HCT.\textsuperscript{176}

1. **Complex systems are not determined by fixed rules**

   A system involves numerous interrelating components that are continuously changing and adapting. The high level of interconnectedness among the various elements implies that any alteration in one part of a system influences other parts. These fluctuations cannot be described by static rules, but rather follow some simple rules that change over time as the elements and their interactions change. Moreover, such connections also create results that are unpredictable and unplanned. Therefore, interventions can be developed via the systems thinking approach to account for both envisioned and accidental results. In addition, systems can be associated with a broader system and may be affected by those systems.\textsuperscript{177}

2. **System behavior occurs through a network of causal loops**

   A network of *causal loops* exemplifies how an element within a system interrelates with others, and how diverse components in the system react and lead back to changes in several components, either directly within a precise causal loop or secondarily through networks to other causal loops. These loops return feedback to the system and affect the arrangements of change within and among the system.\textsuperscript{178}

3. **Recurring patterns of behaviors are characteristic of a system**

   Even though it is hard to foresee how a system will act due to the many casual loops that connect the different components, there often can be a general arrangement and pattern to these connections among components. Systems are attracted to specific patterns of behavior, and thus, the connections in the system seem to thoroughly recur over time.\textsuperscript{179}
The general systems theory approach of von Bertalanffy is the basic foundation for the analytical modeling approach called system dynamics. Jay Forrester at MIT established the fundamentals of system dynamics in his groundbreaking work on “industrial dynamics” The major norm of system dynamics is that structure controls behavior, which means that the manner that the distinct components of any system interact to and affect each other governs the developing performance whole system. The emergent conduct of the system as a whole might be unexpected and unintended. Therefore, analyzing the elements of the system for this behavior is very essential.\textsuperscript{180}

System dynamics has two separate characteristics; qualitative and quantitative aspects. The qualitative part comprises the creation of causal loop or effect illustrations, which describe graphically how the system components are associated. The goal is to improve understanding of a problem state through the arrangement of the system and the interactions prevailing between related variables. The acknowledged system components are represented in the arrangement of a causal loop diagram (CLD), and this is achieved through dialogues with various stakeholders. This is particularly helpful in explaining the unintended significances and results of actions.\textsuperscript{181}

The theory of system thinking is significant to enhance the total functioning of quality in healthcare systems. However, this might be challenging.\textsuperscript{182} System theory, which highlights systems thinking, provides means for quality improvement (QI) in healthcare systems. System thinking is a discipline that permits individuals to comprehend and understand the whole system and the connections and associations of the parts of the system. Quality care mostly happens in systems where connections are regarded as imperative because commitment towards
communication, conflict management, team building, behavioral proficiencies, process management, and education is more likely.\textsuperscript{183}

The methodical use of systems theory can promote quality in healthcare systems. When system theory is used in healthcare systems, special attention will be given to interdisciplinary associations and many of the unexpected interactions can be examined through this approach. Systems thinking enables healthcare professionals to improve communication among the compartments of the whole system, support interdisciplinary relationships and maintain trust among them, form and direct effective teams, embrace continuous education especially conflict management, concentrate on procedures and processes rather than employees, advance morale through autonomy, support problem solving, and reinforce the hierarchical structure.\textsuperscript{184}

Examples of actual and successful systems theory applications involve information technology applied to major medical systems such as medication management, electronic records, patient order entry, and physiological monitoring. Some hospitals have applied systems theory to enable staff participation in taking decisions while simultaneously supporting autonomy and achieving high-quality care and enhanced collaboration among teams.\textsuperscript{185} System thinking accepts the complexity of human conduct and accepts alternative judgments without the fear of punishment. Therefore, the system-thinking approach encourages reporting errors and identifying defective system processes. Redesigning of systems and processes are thus empowered through reconsidering challenging processes and practices. At Duke University Hospital, a transplant mismatch happened, and redesigning the system was facilitated through the system thinking approach to achieve a safer process for an interdisciplinary team to impede comparable errors from happening.\textsuperscript{186}
Organizational leaders are required to cultivate new skills due to the huge interdependence of all disciplines within the healthcare system. The difficulties of the 21st-century healthcare system necessitate the essential need for the development of effective system thinkers.\textsuperscript{187} A concept that is becoming increasingly common thinking in present health care organizations is the learning organization.\textsuperscript{188} System thinking is a major characteristic of any learning organization. Opposite to simple cause-effect series, this approach views the interrelationships of a system and continuous processes of communications between the parts of the system. This approach enables interrelationships between systems and teams and allows the organization to comprehend the cause of and the explanations to contemporary problems.\textsuperscript{189} In learning organizations, leaders are creators, supervisors, and educators. Leaders should endorse the systems thinking notion and support learning activities.\textsuperscript{190}

Healthcare professionals should understand and apply system behaviors because it will encourage learning communities and promote healthcare systems. System thinking offers a planning structure for interdisciplinary patient-centered teams. They support result management by creating teams with comprehensive functioning and foster creativity and innovation. Finally, healthcare professionals can understand the whole system and acknowledge the significance of the relationships among the elements of the system. If quality-care problems exist primarily because of system problems, the deliberate application of systems thinking and systems theory is needed.\textsuperscript{191}

As with every adaptive system, the health system is exposed to particular leverage, meaning a minor intervention can produce significant system-level changes. For example, a minor event (like holding the salaries of health workers) may cause a significant change in the
entire system, crisis (e.g. inciting a health worker strike). However, these connections could also
be handled in a way that leads to collaborations, given that find leverage points is often difficult.
A summary of involvements in other (non-health) systems, implies that high leverage points are
positioned in governance and information sub-systems. These are among the health system’s
building components that take the slightest consideration from health system interventionists.\textsuperscript{192}

The new science of complex adaptive systems may provide new metaphors that can help us to deal with these issues better.\textsuperscript{193} The science of complex adaptive systems offers imperative notions and tools for reacting to the encounters of health care in the 21st century. Systems thinking offers novel theoretical frameworks that integrate a vibrant, evolving, original, and spontaneous outlook of the world and problems.\textsuperscript{194}

Systems thinking can be used as a tool to rearrange the connections within the health system and highlight the importance of new collaborations across the health system – from policymakers to international funders.\textsuperscript{195} A systems method to health and health care challenges necessitates surpassing academic borders and interrelating more effectually across administrative and structural boundaries. This implies that there is an immense need for information interchange and synthesis. Significant projects are implemented to encourage the approach of systems thinking, enhance public health, and synthesizes information from many various sources such as control tobacco use, indicate the onset of disease outbreaks, track the source of foodborne illnesses, and predict the long term consequences of childhood obesity.\textsuperscript{196}

It is very imperative to obtain a better perception of the complex adaptive systems involved in both triggering and resolving public health challenges. For instance, stopping and encompassing pandemic influenza necessitates cooperation across various disciplines and fields such as global surveillance and laboratory labs. Every distinct activity is important to tackle pandemic influenza
but inadequate in itself. Nevertheless, the structures and functions involved in preventing the pandemic influenza characterize an ever-changing multifarious adaptive system whose summation is larger than the individual parts.\textsuperscript{197}

While there is no particular discipline for systems thinking, there are several essential systems-thinking viewpoints and methodologies that are common across various fields:

(1) Improved attentiveness to the way new information is gained, handled, exchanged, deciphered, incorporated, and distributed;

(2) Prominence on a network-centric method that inspires relationship-building among persons and groups across disciplines to accomplish significant goals;

(3) The use of models and projections, exploiting the diversity of analytical methodologies (such as system-dynamics modeling) to develop strategic decision making; and

(4) Systems organizing promote developments in organizational structures and functions.\textsuperscript{198}

The improved prominence on systems thinking, trans-disciplinary and network-centric approach, reveals the acknowledgment that disease causality is vibrant, multifactorial, and nonlinear.\textsuperscript{199} To achieve successful and long-term developments in public health, it is imperative to use the knowledge acquired through the transdisciplinary sciences and systems thinking approach that Senge named a “fifth discipline.” And this fifth discipline is extremely coherent with the guidelines of systems thinking and cybernetics that were examined long ago by von Bertalanffy, Wiener, and Ackoff, and more recently by Leischow and Milstein, Sterman, Midgely, and Green.\textsuperscript{200}

Despite the assurance that systems approach have for better comprehending the compound factors that impact health and disease, limited systems initiatives have been established at one of the leading U.S. centers for health research—the NIH—to tackle chronic
disease or its fundamental elements. The pilot Initiative on the Study and Implementation of Systems (ISIS) is an exemption, funded by the National Cancer Institute (NCI). It planned to investigate how systems-thinking methodologies might advance the understanding of the causes leading to tobacco use; to enlighten strategic decision-making about which plans might be very successful for decreasing tobacco use rate and incidence of tobacco-related disease, and to serve as a standard paradigm for tackling other public health challenges. Moreover, ISIS was projected to develop a long-term, multi-agency alliance to build and apply trans-disciplinary-systems standards and approaches for the innovation, expansion, and delivery of program and strategy interventions within a research-to-practice model.201

During the first year of ISIS, system-dynamics expert George Richardson leads a process of focus groups and formal meetings to investigate and study the meaning of a tobacco control system. Two imperative conclusions materialized:

(1) Appreciating and applying complex systems is all about the connections among persons, gatherings of knowledge and thoughts;202

2. Without actual knowledge exchange, social linkages do not work effectually; and when social networks concerned with public health issues are not performing successfully due to insufficient or dysfunctional information exchange, systems that could be operational are compromised and even prohibited from accomplishing their probable positive effect.203

On the other hand, when information flow is effectual, system functioning is better, and system-level modification is conceivable. Community-driven policy change is an example. During the past few years, there has been an improved common attentiveness that higher cigarette taxes and constraints on smoking in public places would cause a major decline in smoking incidence.
Accordingly, several states and countries concentrated their tobacco-control efforts on rising tobacco taxes and legislating prohibitions on smoking in public places.²⁰⁴

The ISIS group recognized four significant areas that together act as a synergistic groundwork for understanding and developing the public’s health from a systems outlook. These areas reflect both theoretical and practical areas that together result in a sum bigger than their singular influences.²⁰⁵

1. Managing systems knowledge—The organization and transfer of common information form the foundation of collaboration between stakeholders in a systems setting. This knowledge setting must be cooperative and must be capable of meeting the varying needs and methodologies central to a systems approach to tobacco control.²⁰⁶

To validate the capabilities of a web-based, collaborative-knowledge setting for tobacco control, the NIH and other associates formed a cyber-infrastructure to enhance the sharing, study, and distribution of tobacco data. This tobacco web portal presently called the Tobacco Informatics Grid (TobIG), uses state-of-the-science information technology and networking software to connect tobacco data, researchers, and resources. TobIG was regarded as a significant part of the multicomponent strategy to accelerate the development and distribution of groundbreaking approaches to tobacco control.²⁰⁷

2. The influence of trans-disciplinary and multidisciplinary systems networks—Networks shape the backbone of a system by utilizing the power of connecting various stakeholder individuals and units. Understanding the creation and organization of networks and using that knowledge to nurture beneficial linkages in tobacco control are constituents of a system setting in public
health. To improve the understanding of how multidisciplinary and organizational interaction and partnership were happening in tobacco control, the ISIS team implemented many network projects. These projects included Mapping the Tobacco Harm Reduction Network, the Global Tobacco Research Network (GTRN), and the Social Network Mapping of Tobacco Control at USDHHS. For example, The GTRN is a virtual web of interrelated scientists and associations cooperating in the management, synthesis, and distribution of tobacco control. Operative through its web interface, the program offers network consolidation, information management, and information sharing.208

3. Approaches for studying complex systems—System dynamics contain methods that support a more constructive investigation of complex adaptive systems by modeling the performance of actions and their effects, both envisioned and unintentional. These approaches form tools that aid in tackling complex and dynamic problems.209 To investigate this approach within the ISIS initiative, system-dynamics modeling approaches were used to simulate tobacco incidence rates and consumption over a 40-year stage throughout diverse age groups. The ISIS system-dynamics model used a participatory team process among stakeholders to define fundamental causes in tobacco prevalence, as well as to offer estimations of empirical model data. A causal-loop model of causes in tobacco prevalence was constructed via the VENSIM simulation language.210

4. Systems organizing—Systems organizing reveals progress from conventional management theory to a learning organization. Its chief significance is the development of existing models of managing and organizing by changing conventional top-down structures to include network-centric sharing methodologies, the actual assessment of system complexity and dynamics, and clear responsiveness to knowledge flow and management. This dynamic procedure of systems
organizing nurtures not only better cooperation to tackle a specific problem but also an intrinsic acknowledgment that complex problems necessitate trans disciplinary groups that will transform as the challenges change.\textsuperscript{211}

To investigate the way systems-organizing methodologies could be employed in public health contexts, the ISIS project looked at models that used a cooperative, participatory, organized conceptualization approach known as concept mapping to demonstrate and graphically represent combined groups of notions held by groups of stakeholders. Concept mapping facilitates various groups of stakeholders to brainstorm a comprehensive range of precise subjects that tackle a mapping focus, classifies these issues through individual categorization and evaluation, and then generates this input across persons, using some multivariate statistical methods. The results are graphically presented as conceptual maps.\textsuperscript{212}

As a result of the ISIS effort, the NIH Office of Behavioral and Social Sciences Research has acknowledged systems thinking as vital to its strategic planning. Moreover, the President’s Cancer Panel presented a translational model that replicates a systems approach (discovery, development, and delivery), the success of which is contingent on cooperation and collaboration both among and between scientists and, just as prominently, among researchers, clinical providers, community providers, policymakers, and the public to certify that novel discoveries can be fulfilled to progress health in the fastest way conceivable.\textsuperscript{213}

Most importantly, the ISIS team concluded that the formation of an integrated systems-thinking background, which necessitates a robust emphasis on new methodologies to team science and has a transdisciplinary emphasis, is a fundamental objective to tackle health issues.
Such approaches are concerned with the understanding of complex connections and the
promoting of teams to address public health challenges as complex adaptive systems.\textsuperscript{214}

**Conclusion:** Applying Systems Approach in the Dissertation.

Setting the boundary of the system is very crucial and sometimes difficult because it
depends on the perspective of the person watching the system. For example, whether the
borderline of a corporation should increase to comprise its natural environment, its local society,
unemployed individuals, etc. are all very much issues open to further deliberation and
examination. At this level, the role of principles and ethical values become very important
especially that the welfares and resources will be risk. Therefore, the role of power, ethics, and
politics will have a very substantial influence on purposeful systems.\textsuperscript{215}

There are four transformations presently ongoing that will alter health and health systems. These
are: a) life sciences; b) information and communications technology; c) social justice and
fairness; and d) systems thinking to surpass the vast complexity in healthcare.\textsuperscript{216} Investigation
and consideration of systems approaches has the prospective to tackle crucial inquiries and
difficulties faced by the several stakeholder groups involved in community problems.\textsuperscript{217}

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Chapter 3: Systems Approach in Ethical Decision-Making

3. I. Vulnerability in Research and Health Care

3. I.A. Vulnerability in Research and Health Care

Vulnerability and Vulnerable Populations

“Vulnerability” term is a fairly new one in the discourse of bioethics; it was used in the Belmont Report in 1979 for the first time. The meaning of the concept has gradually evolved. At first, the vulnerability was reflected as a special deliberation in the application of the bioethical principles of respect for persons, beneficence, and justice, mostly applicable in the framework of research with human beings. In the 1993 CIOMS guidelines, the notion of “vulnerability” developed to include a distinctive application of the principle of justice and the principle of respect for persons, considered as a guideline for research itself. Vulnerability became a vital idea related to the HIV/AIDS pandemic in the early 1990s. It is regarded as an applicable ethical principle that must lead the practice of clinical research. Onora O’Neill has presented a distinction between persistent vulnerability as a key feature of being human, inherently vulnerable, and variable vulnerability that results from conditions. The efforts should be directed towards circumstances that make people vulnerable. Protecting the vulnerable from exploitation through certifying their consent to participate was informed and voluntary and creating an ethical review of research procedures by independent committees, and other protective means is very significant.

The Revolution against the exploitations of research on imprisoned populations in World War II by the Nazis greatly affected the development of international codes of research ethics. In the early 1970s, the most influential disclosures were related to the destructive use of unfortunate African-American men in a “natural history” research trial of syphilis. Such scandals
shaped a regulatory environment in which the essential need for protection was vital. After these issues, the National Commission was specifically responsible for creating guidelines that tackle ethical issues related to human subjects, and this resulted in the Belmont Report, which lists the moral foundations for the present federal regulations concerning the conduct of human subjects. Since Congress formed the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research in 1974 as a response to national research disgraces, the importance of the notion of vulnerability in research ethics grew.

The Belmont Report emphasized the obligation to protect the autonomy of individuals and connected it with the ethical principle of respect for persons. The Belmont report addressed a vulnerability in the context of the principle of justice, which requests for allocating the benefits and burdens of research. The report asserts that vulnerable populations involved in research shall be protected due to their compromised capability of free consent; nevertheless, the report did not prevent the allocation of the vulnerable including the economically disadvantaged, the minorities, and the very sick in research trials.

The US code of federal regulations does not explain the term vulnerability, but it offers special safeguards for vulnerable populations such as children and pregnant women. Moreover, the Institutional Review Board (IRB) Guidebook presented by the Office of Human Research Protections does not define the term. The U.S. regulatory system attributes vulnerability to diminished ability to give free consent, however, the principal focus in developing countries has been attributed to a more general focus on inequities of power and resources. The Council for International Organizations of Medical Sciences’ (CIOMS) guidelines for biomedical research
define vulnerable individuals as those people who are not able to protect their welfare due to inadequate education, resources, strengths, and intelligence.8

The CIOMS guidelines in 1993 described vulnerability for the first time as significant incapability to protect one’s own welfare, and this concept is similar to Levine’s formulation, Robert J. Levine is a prominent bioethicist. This implies that the decision-making may be compromised, hindered, impaired, or lacking by particular internal and external circumstances. The Belmont Report states a requirement for an additional validation for comprising vulnerable populations in research. The underlying supposition is that vulnerable individuals are easy to enroll in research; therefore, ethical review committees should be mainly attentive when these populations are included. This is also emphasized in the 1991 CIOMS guidelines. Moreover, vulnerability requests distinctive protection, and this could be achieved through stricter consent requirements. This is further stated in the 1993 CIOMS guidelines and the 2000 Declaration of Helsinki. Additionally, the 2002 CIOMS guidelines specify that vulnerability stresses that research should be receptive to the needs and requests of vulnerable persons. This receptiveness of benefits for research with vulnerable individuals is more strictly communicated in the 2008 Declaration of Helsinki. The Declaration of Helsinki states that medical research should abide by ethical principles that support respect for all human subjects and protect their welfare and wellbeing. Some research subjects are chiefly vulnerable and need extraordinary protection. These involve people who cannot give or refuse consent for themselves and those who may be vulnerable to coercion or influence.9Coercion may result from several causes, including the simple omission of significant information about probable research risk.10

To better protect vulnerable populations in research sponsored by the developed world and conducted in the developing world, it is suggested that exceptional examination and review
should be performed by the institutional review boards (IRBs) or Institutional Review Board (IRB) in each country. The documentation of research ethics committee authorization is the final phase in certifying the utmost scientific and ethical standards, and an obligatory stage in safeguarding research subjects and sustaining public trust. A selected ethics review committee, similar to an institutional review board in the United States, in South Africa, and other developing countries, is frequently required to review ethical issues of any proposed research study in organizations involved in biomedical research. Such committees follow guiding principles that are based on universal ethical principles. Four principles of bioethics reinforce ethical norms in biomedical research: Autonomy, nonmaleficence, beneficence, and justice. These principles are grounded in the 1975 Declaration of Helsinki and the 1947 Nuremberg Codes. They generally seek to confirm that the research subjects fully comprehend the research satisfactorily to make a rational decision, that the participant tolerates no harm, and that the research ends play a role in improving the general wellbeing and public health, and that recruitment admires the notion of justice. The ethical principle of respect for personal autonomy endorses the person's freedom and capacity for intended action, upon which the concept of informed consent can be grounded.

**Vulnerability Types**

In clinical research ethics, specific groups of people are assumed to have more tendency than others to be abused and taken advantage of as research subjects. These are labeled as “vulnerable”, and this status creates responsibilities and obligations for researchers and ethics review committees to offer special safeguards for them. Persons who lack decisional capacity or who rely on other people necessitate constant protection. Inherent sources of vulnerability comprise human interdependence and emotional and social natures, which are an inevitable component of the human condition. There are situational sources of vulnerability which are
circumstance specific and include ‘the individual, social, political, economic circumstances of an
individual or social group.'

In a paper appointed by the National Bioethics Advisory Commission, Kipnis examined
the types of vulnerability. He defined a classification of six types of vulnerability, which he
defined as a limit on the capability to offer informed consent. These are:

1. Cognitive: the capacity to comprehend information and make decisions;
2. Juridical: being under the lawful authority of someone such as a prison supervisor;
3. Deferential: regular compliance to medical or other specialists;
4. Medical: having an illness for which there is no medical management and cure;
5. Allocational: poverty, educational scarcity; and
6. Infrastructure: limits of the research setting to carry out the protocol.

In a reviewed version of his paper, Kipnis added a seventh type: social vulnerability, which is,
belonging to a socially underestimated group. The most recent revision of the World Medical
Association’s Declaration of asserts that some research subjects are vulnerable and need
protection.

Vulnerable populations are people who have diminished competence, weakness, or
disadvantaged standing, and thus are prone to be abused, controlled, coerced, or mislead by
researchers. They are incapable of protecting themselves by effective informed consent. These
individuals may involve those with acute, chronic, and terminal sicknesses; prisoners; racial and
ethnic minorities; the elderly; the poor; women; children; and those with weakened reasoning
functioning. Thus, health care providers may function as protectors and choose an individual's
involvement in a study. They consider that the ethical principle of beneficence is the foundation
for their actions to limit a person’s participation. Beneficence offers a risk-benefit ratio that
enables potential benefits for study participants and for society, which offsets the risk of participation.\textsuperscript{19}

3.I. B. Respect for Human Vulnerability and Personal Integrity

Article 8: Principle of Respect for Human Vulnerability and Personal Integrity

UNESCO’s International Bioethics Committee (IBC) released the Report of IBC on the Principle of Respect for Human Vulnerability and Personal Integrity. Article 8 of the Declaration involves both a ‘negative’ duty to abstain from doing something and a ‘positive’ duty to endorse solidarity and to share the advantages of scientific advance. In its Report, the IBC looks at human vulnerability as an enduring risk to the physical and mental truthfulness of the human, and thus it is an inevitable feature of all human lives.\textsuperscript{20} There is a fundamental association between respect for the integrity and dignity of individuals on the one hand and the vulnerability of individuals on the other.\textsuperscript{21} This principle aims to safeguard the wellbeing of all individuals in the face of advances in the fields of medicine, life sciences, and associated technologies. By doing so, it highlights the significance of an extensive assortment of principles including autonomy, beneficence, justice, equity, and dignity. The principle of respect for vulnerability and personal integrity also ascertains that the final objective of the progress of knowledge cannot exclusively be profit. Vulnerability is an intrinsic characteristic of all human beings, especially those who must progress knowledge.\textsuperscript{22}

IBC’s report on vulnerability makes two main distinctions: general and special vulnerability. Special vulnerability is further categorized into two major categories: This first group includes children, the elderly, persons with diminished mental and physical capabilities, “persons with disabilities,” and “persons with mental disorders.” The second group is even more varied: the poor, comprising the homeless, the unemployed, and the illiterate, as well as people involved in ethically dubious research; prisoners, or others who lack mobility and liberty; people
subject to “hierarchical relations,” such as students, employees, or members of the armed forces; marginalized persons; victims of war, climate change, or natural disasters; and victims of the “exploitation of resources in developing countries.” “Gender discrimination” is incorporated in this list, as one entry amongst others.23

It is essential to shedding the light on the vulnerability of research subjects because it helps to clarify the problematic nature of the issue and suggest a solution. The research subjects in developing countries are vulnerable because they come from socially underprivileged groups. They are vulnerable because their dignity and autonomy are exposed to being threatened. There is an obligation to defend, protect them, and respect their personal integrity. Society ought to respect the integrity, the “untouchable core” of the subjects, and should not interfere, touch, or destroy their coherence. In this case, the participants are vulnerable and are exposed to many and various forms of exploitation and the researchers disrespected that virtue and responsibility to care for others. The human dimensions of vulnerability and integrity deserve uttermost respect and the participants’ bodies should be treated as a subject, and not an object, that is inseparable from the person it compromises. The human body should never be commercialized in bioethics24.

The Ethical Significance of Human Vulnerability

Vulnerability is a fundamental notion in protecting human subjects in research. The guidelines for medical ethics in the 1949 Nuremberg Code, World Medical Association Declaration of Helsinki, and the 1979 Belmont Report to protect human subjects involved in research introduced the term vulnerable populations. The US federal regulations for the protection of human subjects, in 45 Code of Federal Regulations Part 46 (45 CFR 46) necessitate special protections for three groups of vulnerable populations: pregnant women, fetuses, and
neonates; prisoners; and children. In addition, 45 CFR 46, the Common Rule, asks the institutional Review Boards (IRBs) to reflect extra protections for those who are ‘‘economically,’’ ‘‘educationally,’’ or ‘‘decisional impaired’’. However, this approach which collectively identifies vulnerable individuals does not provide satisfactory direction about what further protections should be taken with each of the groups listed. Additionally, the terms, ‘‘educational, economic, and decisional impairment’’ in the Common Rule are not precise enough to assist HIV/AIDS researchers to classify and protect subjects whom they consider vulnerable.  

Article 8 of the UNESCO Universal Declaration on Bioethics and Human Rights (2005) recognizes the ethical significance of taking human vulnerability into account while improving scientific knowledge and medical practice. The declaration also states that persons with special vulnerability should be protected and their integrity should be respected. The IBC defines special vulnerability to people who are prone to disrespect of their autonomy and harm of their integrity due to exploitation, dishonesty, and coercion. 

Health care professionals should be receptive to social, political, and environmental causes of vulnerability as well as to vulnerability stemming from disabilities and illness. Furthermore, while health-care professionals may be accustomed to recognizing vulnerabilities associated with the physical and mental condition of their patients or research subjects, it may require more conscious effort to identify and explore how social, political, and environmental factors not only result in or aggravate vulnerabilities, but how this later set of elements affects the former. 

The protection of vulnerable research participants is a fundamental concern in research ethics. The concept of vulnerability is extensively used in guidelines that offer ethical analysis
for research. First, the Nuremberg Code has an inherent supposition that all research participants are vulnerable and thus the code instructed the worldwide ethical obligation of informed consent as a protective means for all research participants. Moreover, the Belmont Report comprises the obligation for the informed consent of all research participants. This report defines the vulnerable as the economical disadvantages, the very sick, and racial minorities. In addition, it states three features that indicate special vulnerability including an increased inclination to coercion, lack of capacity to consent to research, and increased likelihood of injuries. Given the manifestation of these vulnerability markers, additional protections are essential, and exclusion of vulnerable groups might be necessary in some cases.

3. II Informed Consent

3.II.A. Informed consent Applied by Research Institutions as a Protective Mean to Protect the Vulnerable

Informed Consent and Exploitation of the Vulnerable

The appearance of the human immunodeficiency virus (HIV) pandemic and its related negative social effects has employed new requirements on ethical standards concerning informed consent for medical investigations. Informed consent is a vital ethical principle that was first systemized in the Nuremberg Code in the wake of the Nazi experiments. It has subsequently been duplicated in all major ethical codes including the International Covenant on Civil and Political Rights, the Declaration of Helsinki, and (CIOMS) guidelines.

In 1986, the Belmont Report was accepted by sixteen federal organizations and departments and codified the Common Rule, which commands researchers draft a consent form and has all research subjects sign it. The informed consent includes a statement that participation is voluntary, no penalty or loss of benefits would occur in case of refusal to participate, and the subject may terminate participation at any time without penalty or loss. Organizations getting
federal funding to conduct research trials must affirm that they will comply with the Common Rule requirements including informed consent. The Office for Human Research Protections (OHRP) is accountable for guaranteeing that institutions conform to their assurances and the Common Rule through conducting site visits. Before permission is given to researchers to conduct trials using human subjects in the United States or be funded by the United States government, they must submit a research protocol to their Institutional Review Board (IRB). IRB reviews all written research protocols and ensures that the proposed studies are ethical.

To put an end to the exploitation of the economically disadvantaged, in 1979, voluntary informed consent was made with the drafting of the Belmont Report. The respect for persons” principle protects the rights of research subjects and necessitates them to be knowledgeable about the prospective risks and burdens of participating in clinical trials before consenting to involvement. This respect of autonomy is achieved when researchers enlighten all research subjects about the risk of involvement in the research trial and obtain the subjects’ voluntary consent to participate, should be free of unwarranted influence (excessive, unjustified, improper reward which induces participants to give their compliance). According to British philosopher Onora O’Neil, the key objective of informed consent is to ensure that a research subject has not been unduly inclined into taking part in clinical trials. This principle was made because of the abuses of the economically disadvantaged, minorities, and children. One of the key drivers for the formation of this kind of protection was the underprivileged research participants of the Tuskegee Syphilis Study.33

Informed consent is one of the cornerstones of research ethics. It may be impossible for potential subjects who are ill or at risk of disease to refuse research involvement, informed
Inadequacy of Informed Consent with Vulnerable Populations

Informed consent is one of the cornerstones of research ethics. It may be impossible for potential subjects who are ill and lack health care services to refuse research involvement, informed consent is strongly compromised in such cases. However, informed consent fails to fully protect vulnerable research subjects. Due to gaps in knowledge and authority between researchers and their subject’s, informed consents are not sufficient by itself as means of protection.

The quality of informed consent depends on several factors including the type and quantity of information revealed, sufficient understanding of trial information, and a voluntary judgment to participate. Oyewale Tomoori’s, a Nigerian professor of Virology, reflection establishes the dynamic association between exploitation and autonomy, the requirement on which informed consent is grounded. In informed consent, the rationality of the subject is deemed sufficient to confirm his or her autonomy. However, this kind of justification disregards the significant link between autonomy and freedom. Research subjects in developing countries who are deprived of basic human rights should not be considered autonomous just because they are rational. Therefore, the autonomy of subjects is not enough to have appropriate informed consent.
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In most settings in Africa and other developing countries, voluntary informed consent is problematic because research participants, who do lack access to medical care, will be inclined to engage in research trials thinking that their medical care is dependent on their consent to participate in the research trial.⁴⁴ Therefore, the therapeutic misconception poses a real challenge to the sufficiency of the informed consent process and the ethics of clinical trials. Moreover, vulnerability is not the same as diminished autonomy, Ten Have argued. However, vulnerable research subjects in developing countries cannot give free and voluntary consent because their decision-making capacity is compromised due to social and economic conditions and their limited access to health care services. Vulnerable participants have insufficient power, resources, education, resources, or other attributes needed to protect their interests.⁴⁵

Therefore, since the informed consent process might be compromised due to unequal economic and social conditions in developing countries, the value of justice is fundamental to the practice of international HIV research.⁴⁶ The researchers usually come from relatively wealthy and developed countries to research poor, uneducated, in debt, homeless, and in desperate need of money potential research subjects. This tradition reinforces inequalities. Hence, the emphasis should be on the issue of global justice and the main drivers of vulnerability and not exclusively
on individuals’ autonomy. More powerful and richer states have greater moral responsibility because they make use of inequalities for their interest. This requires a wider view of the person and more profound concepts of society and bioethics.\textsuperscript{47} The decision-making capacity of the research subjects is diminished. Usually, they are in extreme poverty and do not have access to health care services. Unevenness in social, economic, political power creates vulnerability and causes health inequity. Thus, it is important to make systemic changes. Justice and equity can only be achieved if all the individuals are treated equally in their rights and dignity, which is intrinsic to the human being. There should be more efforts directed toward reducing poverty, accessing clean water and food, and access to quality health care.\textsuperscript{48}

Rather than focusing primarily on informed consent and individual autonomy, the vulnerability of research subjects can be diminished when the basic needs of individuals are given to everybody as a right based on justice.\textsuperscript{49} It is commonly accepted and fully desirable that humans shall be considered equals in terms of dignity, justice, rights, chances, liberty, welfares, and duties. Therefore, justice and equity are only probable if all human beings are treated equally in their rights and dignity.\textsuperscript{50} AIDS and HIV patients suffer from discrimination and inequities in terms of access to the essential treatment they need. Despite the significant programs developed by the United Nations and despite the current advances in new treatments, only about 20% of people in low- and middle-income countries who need retroviral drugs receive them.\textsuperscript{51}

**3.II.B. Informed consent in Developing Countries Applied by Research Institutions and Pharmaceutical companies**

**Informed Consent related to Conducting Research in Developing Countries**

Based on the American Medical Association, informed consent is a fundamental policy in both ethics and law that health care professionals must respect. It is a method of communication between the researcher and the research participant that eventually ends in the approval or
negation of a specific intervention or research study. It includes several components, including disclosure, comprehension, voluntary choice, and authorization. In theory, research investigators release comprehensible material to patients and research participants to assist in the process of informed choice. Research subjects utilize this information to think and decide whether the intervention presented is well-suited with their benefits. Cultural, socioeconomic, and educational elements might also influence the process of informed consent. In developing countries, there is a lack of understanding related to terminology in the presence of low literacy levels. Another challenge to informed consent arises from the complexity and uncertainty of the information created by developed technologies and extended research prospects.

Ideally, individuals must possess the capability to comprehend the information and should decide to consent or not. Neither medical nor research interventions should start until valid consent has been attained, except under limited circumstances such as emergencies. When the research participant is a child or an incompetent adult, permission for research is regularly pursued from a substitute decision-maker such as a parent.

Research consent forms keep on increasing in length, difficulty, and integration of legal language. This makes them difficult to be read and understood them by potential research participants. Studies also demonstrate that research participants do not fully comprehend the study information, especially information related to the research methods. Research participants often believe that they will receive therapeutic care by enrolling in research studies, and this is called “therapeutic misconception”, which poses a risk-informed consent. First described by Appelbaum and colleagues in 1982, therapeutic misconception means that the participants face challenges related to the understanding of trial benefits and risks of clinical trials. The federal regulations necessitate most research informed-consent papers to contain a consistent set of
informational components, and this has to be accepted by an institutional review board. Pharmaceutical companies and organizations participate in activities designed to nurture the idea that research is equivalent to treatment. This is because clinical research is a big business that depends mostly on recruiting a great number of participants to prove the efficacy of new medicine, especially that only 20% of clinical trials result in a marketable product, based on FDA reports. Berkwits has argued that the clinical-trial brand names can serve practical and expressive functions. He argues that branding research trial serves the purpose of both describing the product and provoking a positive reaction from the potential research participant. Examples include “MAGIC”, and this term stands for MAGnesium in Coronaries. Given that the terms of the clinical trials are including on the informed consent forms, potential research subjects may believe that they will have access to the latest medical therapy if they consent to participate. This is often called “therapeutic misconception”, as participants profoundly believe that the research trial has been designed for their advantage, and they tend to ignore the risks posed to their wellbeing by participation in the trial. In most settings in Africa and other developing countries, voluntary informed consent is problematic because research participants, who do not have access to any medical care, will be inclined to engage in research trials thinking that their medical care is dependent on their consent to participate in the research trial.

Therefore, the therapeutic misconception poses a real challenge to the sufficiency of the informed consent process and the ethics of clinical trials. To address these issues, researchers should have direct and honest conversations with potential research participants. They should inform the participants that research is not equivalent to treatment and placebo-controlled trials may prevent the patient’s receiving the medically required treatment he needs. Since evidence suggests that research participants in clinical trials do not fully comprehend the fundamental
concepts in the informed consent process, there is fear that future participants in HIV/AIDS cure research will confuse research with clinical care. Research ethics committees play an essential role in confirming that participants comprehend the elementary concepts deliberated in the informed consent process, that clinical care is different from research trials.

Informed consent, in principle, is the approval of an activity based on comprehending what the activity entails and in the absence of control by others. Laws and regulations rule the existing informed consent requirements, but the fundamental morals and values are extremely culturally rooted — specifically, the value of respect for persons’ autonomy and their right to define their objectives and make choices designed to achieve those goals. Commentators and empirical evidence have shown that culture influences moral values and that other key values such as loyalty, compassion, and solidarity may be more dominant than autonomy in some cultures. Respecting persons includes respecting their cultural values and may require adapting the specifics of information disclosure or obtaining authorization for treatment or research accordingly.

**Major problems with Informed Consent related to Conducting Research in Developing Countries**

Major problems have been faced when researching developing countries that have different cultural perspectives than that of developed countries. Guarding the rights of the most vulnerable while corresponding to the needs of the many. The relevant informed consent should balance an institutional review board’s (IRB’s) rules: addressing the needs of the host country, balancing the principles of ethical research recognized by developed countries, suitable for the culture of the developing country. Beneficence, justice, and respect for the rights of each human being should be conveyed.
The pre-enrollment part of the research trial includes conveying the significance and rules of the research study, evaluating the target community for concerns that may influence the research study, and representing respect for the prospective research participants. An ethical challenge for the person researching a multicultural setting, often within a vulnerable population, is to ensure “truly voluntary and fully informed” consent. According to Igoumenidis and Zyga, informed consent is the foundation of modern ethics, however, it loses its true significance when used in the setting of a developing nation. Low education levels frequently affect the participant’s full comprehension of the research. In sub-Saharan Africa, researchers contributing to the HIV/AIDS Prevention Trials were confronted to find methods to improve informed consent.

In predominantly oral societies where it is limited or no formal schooling, meticulous translation of the informed consent, preparation of the translators about the research process and significance of completely informing the participants, and giving participants the chance and time to ask questions related to the research study are very important points to consider. Isles and Pearn’s clinical trial commentary reflects on the impact of using positive descriptors and acronyms used to define a range of clinical trials in informed consent forms, where their use may apply unjustified influence on the sensitivity and opinion of potential participants. These positive words and descriptions might create unrealistic anticipations for potential individuals who benefit from involvement in research.

Informed consent is a procedure and necessitates the involvement of community input based on the culture of the society. For several nations, autonomous decision-making is a shared social organization perception. The standard practice for informed consent necessitates a description
of the study, benefits, risks, incentives, privacy, confidentiality, and contact information of the sponsor. The Western notion of confidentiality often conflicts family-oriented culture of some developing countries. Moreover, language differences create significant obstacles for true informed consent.\(^7\) In addition, cultural practices occasionally oppose the treatment and inventions of the study.\(^7\)

**3.II.C. Moving Towards a Better-Informed Consent Process**  
**How to Improve Informed Consent**

Ground-breaking strategies and rigorous studies are greatly required to help the development of informed consent, and thus better fulfill one of the central obligations of ethical research.\(^7\) Fifty years after Nuremberg, it is evident that the law by itself is inadequate to control unethical medical experimentation and protect vulnerable human research subjects.\(^7\) There should be a collective effort to comprehend the motivations, preferences, and needs of people in developing countries to participate in HIV clinical studies.\(^7\)

Externally sponsored research should be revised by an independent reviewer from the host country and the sponsoring country. Firstly, the researcher should understand and plan methods to offer cross-cultural care over the period of the study. This would include cultural and participant factors, such as the cultural context, education level, and socioeconomic status concerning informed consent, translation needs, compensation, and benefits to the participants. Before the start of the enrollment process, researchers should learn the expectations of the community. To realize such cultural determinants, formal and informal community leaders and representatives should be involved. This will improve the general comprehension of the whole research process for both the researchers and the participating subjects.\(^7\) To better equip community members, training materials must be adjusted to the beliefs, language, and education level of the developing country. It is also suggested that nurse scientists deliver educational
courses to any international researcher before the start of global health research. The course should address the ethical and cultural implications of researching a developing country to make use of the standards of a developed world. Adult learning methodologies and developing materials, such as exemplified booklets, videos, can be used with illiterate research subjects to enhance their understanding of the research trial and scientific interventions and express social aspects of problems associated with the particular research project.

Moreover, researchers should study the length of the consent form while incorporating all the crucial information to achieve ethical standards and integrate the cultural perceptions of the country. Researchers may conduct a preliminary study with the consent form to define its effectiveness in the target community. In some cultures, societies emphasize the shared decision-making process where the family members will be included to decide on the informed consent. This would conflict with developed countries’ IRB policies which emphasize the rights of the individual. However, informed consent should be formulated in a way that can be culturally accepted by such cultures. Giving involved family members enough time to ask questions and to be involved may be more consistent with the standards of the culture. The use of interpreters who are fluent in the languages used will improve communication and culturally proper interactions during the research period. Meticulous translation of the informed consent in the language of the participants will permit a high comprehension level.

Other ways that might aid in improving the process of informed consent include exploring the decision-making and health behavior theories that offer a methodical context to explore health-related actions applicable to clinical trial decision-making. Scientific clinical researchers and scholars can collaborate with social researchers to integrate decision-making studies into
their research. Studies that follow participants from consent to trial completion will offer profound insights related to the ethical concerns faced by individuals through the clinical research period. Therefore, improved comprehension and knowledge of the perceptions, involvements, and decision-making of trial participants will help researchers make better-informed choices and clinical designs, to protect participants and create better ethical research environments.

The framework of Improved Consent Process by HIV Prevention Trials Network (HPTN)

Through domestic and global studies conducted by the HIV Prevention Trials Network (HPTN), funded by the National Institutes of Health, a framework of the improved consent process is presented after the researchers in the study faced many scientific and ethical challenges. The HPTN is an international collaborative clinical trial network that develops and tests the safety and efficacy of non-vaccine trials intended to stop the spread of HIV. HPTN researchers have found it critical not to go beyond the subject’s absorptive capacity. Thus, researchers must increase their efforts and spend more time with potential research subjects. They should explain the informed consent process and the array of responsibilities the subjects have to abide by during the research period. HPTN researchers proved that translation of informational resources by the assistance of community leaders aided in ensuring that the translations are culturally proper. Some HPTN sites have benefited from developing a reference book that includes slang and metaphors for sexually transmitted infections, sexual practices, and health disorders. This can be very useful if frequently updated and consulted by research staff. Supplementary materials may be used to clarify medical procedures. For example, at the HPTN site, preceding research pointed that participants did not understand the 5 vials of blood needed for HIV testing. Through the trial, staff who manage informed consent now display real unfilled vials to potential participants during the administration of informed consent, signifying the
volume each vial holds. An informed consent leaflet provided to participants contains a scale drawing of a vial to further enrich the understanding of potential research individuals.  

HPTN researchers documented the requirement to respect cultural standards, yet they were dedicated to not strengthen gender inequalities that oppress women. Training staff to manage a fully understandable consent form in a private setting encourages and enables prospective research subjects to ask questions. Furthermore, giving a brief, quiz-like interview to each potential participant is crucial before their enrollment to exhibit comprehension of consent components before enrollment. The responsibility for accomplishing this improved method of informed consent will depend mostly on the researchers and community representatives. Moreover, this approach has the capacity to reinforce the research effort through enrollment and retention of participants who better comprehend their duties in the study and adhere more to the study procedure.

3. III. Clinical Ethics Consultation

3.III.A. Clinical Ethics Consultation (CEC): Background Information

Historical Development of CEC

In response to the requests of the patients and their families and practitioners for support in tackling the ethical dilemmas they face in attaining and delivering health care, the practice of Clinical Ethics Consultation (CEC) has appeared over the past 30 years. Concerns in clinical ethics are usually of great significance in the lives of the involved parties because the outcomes of illness and healthcare options (like healing, disability, suffering, and death) are among the most important life occurrences. Moreover, these events are often complicated and challenging to solve as they involve complex notions and foreseeable uncertainty. CEC help in finding,
investigating, and assessing potential solutions, a range of suitable moral choices from which those with the decision-making expert may select.\textsuperscript{92}

Healthcare professionals have always been anxious about ethical problems; nevertheless, the social consideration of healthcare ethics is a new one. For numerous years, ethics was seen as a subject best left to the areas of religious studies and philosophy where it was publicly discussed only in the lecture halls and churches. At the beginning of the 1970s, medical schools began to employ religious studies and philosophy instructors to teach formal courses in ethics within the medical course. These ethics researchers worked attentively with their clinical associates in both academic and clinical locations, and the first accounts of clinical ethics conferences and CEC commenced to emerge in the early literature of the field of bioethics. In the popular case of the 1976 right-to-die case of Karen Ann Quinlan, the New Jersey Supreme Court supported the practice of ethics committees. In the 1980s, the federal Baby Doe regulations recommended that “infant care review committees” assume the role of reviewing decisions to limit life-sustaining treatment of disabled newborns as an alternative intervention by federal investigators. In 1986, SBC was officially stabled later, SBC merged with SHHV and AAB to form ASBH.\textsuperscript{93}

In 1991, the Joint Commission on Accreditation of Healthcare Organizations approved new patients rights standards that necessitated hospitals looking for accreditation to create means to tackle ethical questions in patient care. With funding from the Agency for Health Care Policy and Research, a summit on the assessment of ethics case consultation in clinical ethics was gathered in September 1995 to explain and describe systems and approaches for assessing CEC and to issue a consensus account on the objectives of ethics case consultation. The Core Competencies report presented a description of HCEC, recommendations on the HCEC process, and a listing of the skills and knowledge needed for an effective clinical ethics consultation.\textsuperscript{94}
Bioethics is different from clinical ethics consultation in many aspects. At the end of the 1960s, the multidisciplinary field of bioethics appeared principally out of the curiosities of university-based academics, researchers, and clinicians. Academic journals rapidly emerged and concerned researchers started to gather in particular learned societies. In 1969, The Society for Health and Human Values (SHHV) appeared, followed by the American Society of Bioethics (ASB) in 1994. The discipline of bioethics had appeared, combined by associated academicians in medical humanities. On the contrary, clinical ethics consultants have had a more applied focus rather than an academic one. In 1984, they began meeting in an emergent professional association: The Society for Bioethics Consultation (SBC). In a multilateral union, SBC was folded into the American Society for Bioethics and Humanities along with SHHV and ASB. Those in CEC had been evolving and working on the grounds of multidisciplinary hospitals. While the clinical ethics consultants greatly extracted from the work of researchers in the two other predecessor organizations, they had to foster and create specific skills and considerations that were fairly diverse from those of their academic associates: for instance, the competencies called for in enabling family discussions and in facilitating disagreements.95

Considering itself as an academic society, ASBH – the umbrella organization – was relaxed to recognize and identify the distinct concerns of CECs. In 2008, CECs who were members of ASBH systematized themselves into the Clinical Ethics Consultation Affinity Group (CECAG). Weeks after its organization, over 200 joined on its listserv. End of 2008, Robert Baker and Kenneth Kipnis lead the development of ethical practice standards. In early 2009, the ASBH leadership founded a committee to manage the investigation of problems related to the professionalization of clinical ethics consultation, involving certification and accreditation and the development of professional standards. Anita Tarzian was selected Chair of the Clinical Ethics
Consultation Affairs Committee (CECA). The practice of Health Care Ethics Consultation (HCEC) has become an ordinary way for hospitals to tackle ethical challenges and problems while delivering healthcare services.

3.III.B. Clinical Ethics Consultation (CEC): In-Depth Overview of Clinical Ethics Infrastructure Development in Different Countries

In the US, CECs have been set up succeeding the compulsion of the Joint Commission on Accreditation of Health Care Organizations (JCAHO) to create organizational mechanisms and solve any ethical problems that may arise in the institution. By 2007, nearly 81% of the hospitals in the United States had an ethics consultation service of some nature, and 100% of hospitals with 400 beds or more, hospitals that are members of the Council of Teaching Hospitals, and federal hospitals were found to Ethics Consultation Services (ECS).

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presence of 149 CECs, 86 illustrations of other forms of ethics consultations, and 77 hospitals in the phase of execution of some kind of ethics consultation service.\textsuperscript{101}

Other nations followed a different methodology. In the UK, the primary incentive to establish CECs originated from local clinicians in distinct organizations rather than from central leadership within the Health Care Service. The number of CECs in the UK has amplified from 20 in 2000 to 87 in 2010; in addition to CECs, the UK Clinical Ethics Network has been created to offer CECs the needed means to combine the knowledge and support for their development.\textsuperscript{102}

The 2008 survey performed in Norway can function as an illustration that discloses cases and matters frequently debated by the CECs. The most ordinary issue, emerging in 56\% of all cases deliberated by the committees, was controlling the treatment of extremely ill patients. Other matters deliberated were: the will/wishes of next of kin, patient autonomy, coercion aimed at patients, prioritizing and resources, information and communication, the promise of professional privacy, and ethical challenges associated with reproduction.\textsuperscript{103}

\textbf{Typical Problems that Necessitate the Use of HCEC}

Although clinical ethics consultation typically deals with ethical problems taking place in association with dynamic real-world cases in hospitals, non-case consultation can concentrate on other kinds of challenges such as doing an autopsy on a case that is no longer dynamic or contributing to discussions about expected cases. In concept, CECs are specialists whose role is facilitating conflicts and uncertainties related to the principles and standards that are implicated in health care decision-making. The CEC’s work can be particularly perplexing when a patient’s wellbeing is jeopardized and when there is inadequate time to resolve the issue.\textsuperscript{104} People conducting HCEC come from diverse professional and personals backgrounds such as nurses, physicians, social workers, chaplains, administrators, philosophers, and theologians.\textsuperscript{105}
The characteristic “problems” that necessitate the use of clinical ethics consultation can occur at three main levels.

**Level 1.** This includes the straightforward, uncomplicated, and most typical scenario: someone is doubtful about an ethical inquiry arising in the care of a patient. For example, a medical doctor may want to know the treatment options for a patient who does not have a surrogate, or whether the physician should adhere to the conditions mentioned in the patient’s advance directive when the family asserts on ignoring an incapacitated patient’s commands. The CEC must be an instructor where he combines academic skill with an extensive and profound consideration and knowledge of the related subject topic. The consultant should use bioethics knowledge to evaluate the reasons behind all applicable options and examine the justification of the arguments to clear out any doubts and uncertainties.\textsuperscript{106}

**Level 2.** For cases at the second level, the absence of united lucidity is cluttered by the dispute between two or more parties. In these circumstances, the CEC needs also to have a mastery of negotiation and conflict resolution skills. The CEC must investigate the principles and rationalizing of the parties to the disagreement, paraphrasing questions as needed, and working toward a conceptualization within which disagreement stops to be the focus phase.

**Level 3.** Cases at the third level highlight a critical or recurring difficulty that may indicate inadequacies within the structure of the healthcare setting itself. In this case, the CEC may need to be a mediator of organizational change: working with crucial managers, planning and applying for educational programs, drafting corrective strategies, navigating a path within a rigid and difficult administrative structure. These tasks would eventually redirect a hospital’s response to challenging cases. In particular cases, the effort to influence variation will necessitate resources outside the
organization’s boundaries such as state organizations, the government, professional associations, and the courts.\textsuperscript{107}

Clinical ethics committees have usually been involved in various activities such as case consultations; drafting ethics-related strategies and policies; and training of healthcare staff in clinical ethics.\textsuperscript{108}

\textbf{3.III.C. Ethics Consultation Forms and Goals}

\textbf{Forms and Models of HCEC}

While ethics consultation can take numerous forms, ethics committees are the principal approach to tackling ethical problems in hospitals in the US. Ethics consultation comes in many forms:\textsuperscript{109} First, the individual ethics consultant, with or without the assistance of health care professionals with ethics education, offers direction and leadership concerning specific cases upon demand.\textsuperscript{110} Second, the capacity-building consultant concentrates on educating and guiding health care staff in ethical decision-making, frequently exploiting a specific framework.\textsuperscript{111} Third, in facilitation methodology, an ethics consultant (accountable for ethics exploration), and a facilitator (responsible for the procedure and certifying processes are followed), and a recorder who mostly tackles an ethics subject.\textsuperscript{112}

Three Models of HCEC:

- Independent Consultant: this model offers a fast answer to crucial consultation requests, and offers fewer logistical requirements. However, the consultant should have all the essential skills, knowledge, and wisdom, and he should be very cautious not to impose his standards and favoritisms.\textsuperscript{113}
The consultant should have good communication and networking skills. He should work hard to build many strong and interconnected relationships within the healthcare organization and seek assistance from other ethicists when in need. Learning from the Montefiore experience, the individual consultant meets with the whole health care team where they share collective skills and knowledge. Moreover, they enter a note in the patient’s chart where it can be read by practitioners, lawyers, administrators, and managers. This note notifies different people who have different functions and responsibilities in the organization and encourages them to share perspectives and feedback.114

- A Standing Interdisciplinary Committee: a constant group of typically 6-20 individuals who together conducts the consultation assignment.115 Ethics committees play a role in developing, executing, and evaluating organizational policy. They might, for instance, introduce a policy in end-of-life care.116

This model enables joint expertise and exposes various perspectives and multidisciplinary proficiency. It can be especially beneficial for organizations that are fairly new to ethics consultation, lack focused ethics proficiency, and handle a low size of consultations. However, this model demands a great deal of employee time and does not respond rapidly to emergent cases. Moreover, family members might feel overwhelmed by a big number of healthcare specialists117

- Team Model: the duty of ethics consultation is shared by a small team of individuals carefully chosen from a pool of experienced consultants based on the skills and knowledge necessitated by the conditions of the case.

This model is the most widespread consultation model, utilized by more than two-thirds of hospitals in the United States. It offers rapid responses and ensures diverse perspectives and
expertise. Moreover, it accommodates an extensive range of conditions and levels of consultant proficiency.\textsuperscript{118}

Irrespective of the shape ethics consultation takes, it appears extremely important that its role goes past the provision of knowledge and the facilitation of debate for challenging and demanding cases. Ethics consulting should be a fundamental element in persuading and supporting the ethical existence of a healthcare organization. It can support employees and leaders and enlighten their moral creativity via the use of ethics language in ways that make them comprehend others’ insights, views, and concerns.\textsuperscript{119}

**The Goals of HEC**

Healthcare ethics consultation (HEC) is a service offered by an individual or a team to assist patients, families, surrogates, healthcare givers, or other interested parties tackle doubt or conflict concerning value-laden topics that arise in healthcare.\textsuperscript{120} The goals of HEC should be first outlined before articulating the skills of ethics consultants. The functions of HEC are categorized under four general categories.\textsuperscript{121}

1. To self-educate: to teach the whole hospital staff, and possibly educate the local community. A result of this function is to develop communication among patients, families, and healthcare providers families, and the different members of the healthcare team.\textsuperscript{122}
2. To assist in the development of guidelines and strategies for approval by the hospital’s management and trustees;  
3. To examine and evaluate distinct patient cases actively and retrospectively; ethically and legally.  
4. To consult with healthcare providers, patients, and their families by assigning a representative or two from the HEC to represent it when not in the full conference.

In their work outcome from the Conference on Evaluation of Case Consultation in Clinical Ethics, Fletcher and Siegler suggested that the fundamental function [of CEC] is to
enhance the process and consequences of patients’ care by aiding to recognize, study, and resolve ethical issues and that the objectives of CEC consist of: 123

• Maximizing benefit and diminishing harm to patients, families, Healthcare givers, and organizations by promoting a reasonable and encompassing decision-making process that respects patients’ preferences and personal and cultural differences among all parties to the consultation.

• To enable the resolution of disputes in a courteous and considerate environment regarding the interests, rights, and duties of those involved.

• To enlighten organizational efforts at policy development, quality improvement, and appropriate use of resources by recognizing the origins of ethical dilemmas and endorsing practices coherent with ethical rules and standards.

• To help individuals in managing existing and upcoming ethical difficulties by offering education in healthcare ethics.124

Lately, the American Society of Bioethics and Humanities (ASBH), in its report named “Core Competencies for Health Care Ethics Consultation,” deliberated the nature and aims of HCEC, the process of HCEC, and essential skills and knowledge for HCEC The general goal of HEC is to:

• develop and enhance the delivery of healthcare and its consequence through the recognition, examination, and resolution of ethical issues as they arise in clinical cases in health care organizations. This overall objective is accomplished if consultation achieves the below intermediary goals:
identifying and analyzing the value uncertainty that triggers the consultation process;
facilitating the resolution of conflicts in a courteous environment while giving significance to the interests, rights, and duties of those involved;
enlightening organizational efforts at policy development, quality improvement, and proper use of resources by recognizing the origins of ethical challenges and encouraging practices coherent with ethical rules and standards;
supporting individuals in managing the present and future ethical problems by providing education in healthcare ethics.125

Thus, the goals of healthcare ethics consultation can be combined into four main points:

1. Stimulating and promoting an ethical resolution of the ethical case. Requesters of ethics consultation have a precise need or inquiry, typically focused on clinical, research, or organizational dimensions. The ethics consultant should strive to reach the hoped-for-outcome and ethically tolerable resolution, in a cooperative approach.126

2. Reinforcing peaceful and courteous communication among the parties involved, especially that ethical problems and questions are intensified by failures to communicate. Some of the skills acknowledged in the ASBH core competencies document can impact the accomplishment of this objective; for instance, the skill to form a moral agreement; the ability to heed well and to communicate interest, respect, support, and sympathy to all groups; the capability to facilitate involved parties to interconnect successfully and be understood by other parties; and the skill to acknowledge and respond to several interpersonal barriers to communication.127

3. Helping and supporting those involved in the case to work through future ethical doubts on their own. This objective relates to the educational prospect that complements demands for ethics consultation. This educational development can take place in various ways, including through participants noticing and watching the abilities, attitudes, and conducts that are being exhibited by the ethics consultant; hearing comprehensible
expressions of ethical justifications for possibilities and actions being considered, and accepting published literature applicable to the case at hand.\textsuperscript{128}

4. Assisting the organization to recognize patterns of problems and questions that necessitate responsiveness. Good documentation of the crucial interrogations debated and tackled during consultation increase the probability of recognizing patterns of concerns that may need to be tackled by education, organizational policy, or other means. This would permit ethics consultants to also proactively contribute to the organization’s mission, vision, and values, and of course reactively contribute to an individual case.\textsuperscript{129}

Pursuing resolution of ethical issues through impartial, courteous teamwork will offer the encouragement and education essential to enable experts and families to achieve ethically appropriate decisions. This would make continuous participation at the bedside possible without viewing ethics consultants as the ethics police.\textsuperscript{130}

\textbf{3.III.D. HCEC: Process and Approaches}

\textbf{Process of Ethics Consultation}

Individuals, small teams, or whole ethics committees can offer ethics consultations. Many theoretical and methodological methodologies are present to people offering HCEC at the bedside including principlism, casuistry, virtue-based ethics, pragmatism, feminist ethics, narrative ethics.\textsuperscript{131} Consultants should know well the various approaches to structuring and offering ethics consultations and the possible consequences of choices that can be made individually or institutionally.\textsuperscript{132}

HCEC usually starts with an intake process following a consultation request. In this stage, the consultant should evaluate whether the case is suitable for ethics consultation, determine realistic expectations for the whole process, and decide the next steps.\textsuperscript{133}
1. Information gathering: the consultant should know well how to distinguish and recognize information sources, evaluate medical records, attain the standpoints of different parties, and form a balanced description explanation of the collected information.134

2. Narrative Reconstruction, Issue Clarification, and Ethical Analysis: successful consultation includes more than obtaining information from individuals who demand the service. It should involve assessment, understanding, and examination of the collected data along with a mindful acknowledgment that the nature of the ethical issues or questions acknowledged at the beginning of the consultation service may greatly differ during the process itself. Moreover, the consultant should master communication skills and find points of agreement and misunderstanding while presenting an assortment of ethically acceptable options. Successful consultation should include creating possibilities to seek the outlook of all involved parties while recognizing that they may have very different viewpoints and understanding of the ethical issues involved.135

3. Communication: The primary process of information gathering actions promotes communication among the interested parties and elucidates the facts. To lead to an ethically acceptable solution, the consultant should be able to summarize narratives and points of view, listen actively, reinterpret different perspectives. To excel in these, the consultant should undergo direct practice and attend to critical and sincere feedback.136

4. Implementation of the Plan of Action: Due to the nature of the ethics consultation, which is a strictly facilitative and counseling role, the primary duty for executing any agreed-upon plan of action stemming from it lies with the care team members and others immediately affected in the case, the primary decision-makers. In addition, documentation and a summary of the results of the consultative process are very
essential. Moreover, ethics consultation should have a structured procedure for follow-up in cases where they require a follow-up consultation when circumstances change.\textsuperscript{137} Consultation services should be formally integrated into organizational policy because many elements play a significant role in creating quality consultation services. They should have leadership support, accountability, staff time, organizational learning, access, and proficiency.\textsuperscript{138} The VHA primer Ethics Consultation: Responding to Ethics Concerns in Health Care describe these vital factors.\textsuperscript{139}

- Integration of Ethics Consultation Services: responds to the entire range of ethics concerns encountered by the whole institution. By fostering and sustaining constructive relationships with diverse people and programs that affect the health care organization’s ethical environment and practices. This integrated service can build continuous working relationships with departments that frequently face ethics-related problems such as patient advocacy and risk management programs. This incorporation will improve staff comprehension and appreciation of each other’s skills and roles and ultimately positively influence the general organizational efficiency.

- Access to the consultation service is a critical factor in the concept of integration. The presence of a policy that encourages any employee member to demand the service is a very important assumption that the physician is informed about that request as an initial step in the process.

- Clear Organizational Leadership Support: organizational leaders found institutional strategies and assign the resources to execute those strategies. Therefore, leaders must certify that HCEC has the essential expertise, skills, character traits, and knowledge required to achieve the capable and successful ethics consultation.
• Assigning Ethics Consultation as Part of the Consultant’s Job Description: this would ensure that ethics consultation is not an optional activity, but a required task that requires time and effort. Some consultation cases tasks typically require several hours, while other more complex cases may require twenty or more hours by many people. In addition, consultants handle various activities such as evaluating documents, collecting required information and evidence, and interpreting of policies.

• Offering Required Resources to Ethics Consultants: leadership should provide education support such as library materials and opportunities for continuous education. This is very important because it helps consultants develop, sustain, and enhance their knowledge and skills.

• Making Ethics Consultation Accessible to all: including the patient, his family, and all employees. Leadership should ensure that ethics consultation services are available in all care settings.

• Giving Ethics Consultation: A Clear System of Accountability to Organizational Leadership: all duties and responsibilities linked to ethics consultation should be clearly defined in the job description of all involved employees, from senior leaders to managers to frontline staff.

• Offering the Opportunity of Ethics Consultant to Contribute to Organizational Learning: Ethics Consultants have rich experience and knowledge, and thus they should educate and engage clinical staff. This can be done through giving sessions where they discuss actual cases of ethics consultation and their insights and perspectives. Moreover, they can publish significant ethics topics in a monthly newsletter or post some news on the
website. Additionally, such activities improve the visibility, reliability, and significance of ethics consultation services.

- Ongoing Evaluation: where the ethics consultation service goes through a methodical assessment of the process and/or results of a program compared to a set of standards. Some specialists such as quality managers can help in forming suitable ways to assess these factors and guarantee that the procedures are effective and the data are collected and examined in a marginally bothersome manner.\(^\text{140}\)

**Approaches of Clinical Ethics Consultation**

The main office of the VHA, the nation’s major integrated health care delivery system, is the National Center for Ethics in Health Care, which is responsible for tackling the difficult ethical dilemmas that arise in patient care, research, and health care management. This center developed The Cases Approach for use throughout the VHA system, as they have a duty of clarifying and promoting ethical health practices within the VHA.

This approach is a step-by-step method to offering reliable and successful ethics case consultation at VHA facilities. The steps guide ethics consultants through multifarious serious thinking which is essential for ethics consultation. It includes five major steps:

- Clarify the Consultation Request.
- Assemble the relevant information.
- Synthesize the information.
- Explain the synthesis.
- Support the consultation process.

Even though these steps are portrayed linearly, ethics consultation of an adjustable process and one should not differentiate between the steps as they may distort in the precise setting of a specific case. Moreover, the repetition of the steps should sometimes be required, or performing the steps in a different order might be demanded in certain circumstances.\(^\text{141}\)
- Clarify the Consultation Request.

First, the consultant should determine the appropriateness of the case for ethics consultation. The request should include uncertainty or conflict over which options are ethically reasonable. Moreover, the request should refer to an active case, not for education, document review, or ethical study.142

After this step, the consultant should gather basic information including the requester’s demographics and his role in the case. Additionally, setting realistic expectations about the consultation process is very important.143

Afterward, the consultant should articulate the ethics question with precise clarity and care. This helps all involved parties to work successfully toward the resolution of the ethical issue.144

- Assemble the relevant information.

The CASES approach categorizes four categories for defining the topics that should be reviewed in every ethics consultation: medical facts, patient’s preferences and interests, other individuals’ preferences and interests, and ethics knowledge.145 This method builds on the effort of Jonsen, Siegler, and Winslade.146

Ethics consultants should collect information from the patient’s medical records, and they also should converse straight with healthcare physicians to try to find out applicable papers such as advance directives and health records from other providers. Collecting data about the patient is very imperative, and face-to-face interaction can offer the best means for that step.147

Furthermore, gathering data about the patient’s family and friends may deliver a distinctive perspective about the case and add to the complexity of the ethical problems.148

- Synthesize the information.
This step requires many strong analytical skills, moral reasoning, and rich supervised practical experience. Analyzing and synthesizing the information can be achieved in various ways including formal meetings, face-to-face discussions, or telephone meetings, or some kind of electronic communication. During this stage, the consultant should identify the ethically justifiable range. However, in case of unresolved conflict, bioethics mediation or other conflict resolution techniques should be considered.¹⁴⁹

- Explain the synthesis.

The completed synthesis should be communicated to others involved in the case through direct communication to key participants and documentation in both the medical record and consultation service recorded. The medical record communicates important information to involved staff, promotes accountability, and transparency, and serves as an educational purpose.¹⁵⁰

- Support the consultation process

This can be achieved by following up with participants and learning from each case, completing a critical self-review, and collecting feedback from colleagues.¹⁵¹

**Bioethics Mediation: The Montefire Medical Center Model

In 1978, The Montefire Medical Center Bioethics Consultation Service. By the mid-1980s, bioethics consultants (a lawyer and a philosopher) were responding to a growing number of demands for clinical consultation. Over some time, the consultants noticed a certain value-added, which they approached the cases as an "unbiased field." They followed a "facilitation" approach where they typically urge the consultation staff to think specifically about the dynamic
of the discussion and the organization of the decision without instructing the medical staff about what must be done in the clinical setting.

Initially, the care team members had conflicting perspectives of the patient's diagnosis, prognosis, and care plan. They often used to communicate these opinions to the patient and his family, which ultimately led to misunderstanding and conflict. Although the consultation service might have presented the opportunity of some disagreement resolution especially regarding contradictory views about the diagnosis, contradictory opinions about the prognosis persisted. On these occasions, the value added by mediation would be identifying and clarifying the areas of agreement and disagreement. Over the years, ethics consultants realized that they are doing some kind of alternative dispute resolution rather than ethics analysis. Therefore, they realized that facilitation skills are essential. The ethics consultant should be able to facilitate discussion and decision-making; nevertheless, other essential skills should be learned. Moreover, in addition to conquering bioethics principles as a crucial knowledge base, mediation enhances skills for handling and solving conflict should be learned. Some skills can be taught by training such as building a working hypothesis, framing questions, categorizing fundamental interests, concerns, and options, and attainment points of agreement.152

Mediation is a method that is most appropriate for use in conflict resolution in the health care setting. Bioethics medication is not the same as bioethics consultation. They can be both used for the same case at different parts in the process. Mediation is more comprehensive and empowering, while the consultation is more controlling and hierarchal. Bioethics medication brings together both the clinical bioethics perspectives using the techniques of mediation to recognize, comprehend, and resolve conflicts. While bioethics consultation implies a more directed practical process; where the consultant attends to the parties and assists them in moving
towards an ethical resolution of the conflict through elucidating ethical principles and applying them to the evidence and details and presenting the social agreement on the acceptability of various practices.\textsuperscript{153} Mediation can result in a solution approved by all parties who feel a sense of ownership and accountability for the agreed plan. The mediator or more likely to guarantee the respect of the patient and his family, highly consider the parties' differences, and appreciate the religious and cultural constraints, within the structure of bioethics theory.\textsuperscript{154}

3.III.E. Ethics Consultants: Essential Character Traits and Required Competencies

Character Traits for Ethics Consultants:

Wisdom: The healthcare ethics consultant should have intelligence, knowledge, and prudence to argue and think through the many phases of debate and decision-making safe toward ethically justifiable decisions, recommendations, and activities. Ethics consultation is an explanatory and informative activity that necessitates the analytical and applied presentation of capability and experience. In all ethics consultations, the consultant should realize "what is going on?" and "what is the right thing to do, all things considered?".\textsuperscript{155} The consultant should meticulously know the essence of the ethical problem to know exactly how to solve it. Therefore, examining evidence about the fundamental, interrelating, complicated and occasionally clashing motivations that account is very critical.\textsuperscript{156}

This entails, of course, defining the thoroughly comprehensive description of events and relations and a sharp clarification of the purpose(s) and significance(s) of precise incidents and connections.\textsuperscript{157}

To make the process of ethics consultation beneficial and valuable, various scholars debate that the health care ethics consultant should be a supporter and promoter for the main decision-
maker(s) which characteristically will be the patient and her/his family. This apprehension of the responsibility of the ethics consultant assumes a more dynamic part than that one assumed by Bliton, who places a great emphasis on the quality of interaction of the people involved.158

- Justice: Justice is vital to protect the collaboration of, and shared trust among, health care providers, patients, patients' families, and others. Justice is the virtue that guides the ethics consultant in her/his communications with others. It assumes objectivity, impartiality, and honesty.159

- Courage: The health care ethics consultant should have the courage to face ethical challenges and serious wrongs, and not to follow and obey the terrific pressure of someone’s orders. However, he should abide by clear practices, judgments, institutional structures, or strategies.160

- Compassion: The health care ethics consultant must be compassionate and caring, capable of understanding the desires and needs of others, and displaying authentic concern for those who are in misery. He should not detach himself from the emotional characteristics of the given ethical problem but should struggle to appreciate the sorrow of those who are suffering, and their demand for solace and assistance. This trait describes the ethics consultant as a healer, one who observes, elucidates, and alleviates suffering. Compassion pushes health consultants from the theoretical and detached experience towards a real and engaged involvement of the suffering. This is the core of connexional experience (974).161

- Humility: The health care ethics consultant should be modest in recognizing and accepting his restrictions and abilities. This enables him to learn new ways to develop essential skills and capacities.162
Hospital Ethics Consultants: Competencies and Skills

Hospital ethics consultants are those who offer guidance about how to deliberate and discuss debatable decisions concerning medicine and the biomedical disciplines, within the limitations of the philosophy and attitude that is recognized at law and in public policy. Building on this fact, fundamental competencies related to healthcare ethics consultation arise:

1. Healthcare ethics consultants must have a respectable knowledge of relevant law and public policy in their specific area.

2. Healthcare ethics consultants ought to recognize how to successfully negotiate the grey zones of public policy and law and to advance the goals of those who engage their services.\textsuperscript{163}

3. Healthcare ethics consultants must work as intermediaries with those who are in disagreement to accomplish high-quality care.

4. Healthcare ethics consultants working for religiously affiliated hospitals should have proficient data of relevant religious norms, along with authentic religious devotion and commitment.

5. Due to the service-oriented nature of the field of healthcare ethics consultation, consultants ought to know that their professional truthfulness and character that are dependent on their organizations and hospitals.\textsuperscript{164}

Braddock and Tonelli have argued that clinical ethics consultants should have adequate clinical knowledge and proficiency to comprehend the clinical context and clinical consequences of their actions. On the other hand, in other roles of ethics consultation, such as education or clinical resolution, the requirement for clinical knowledge is less crucial. Therefore, they described two groups of ethics consultants:
1. The “clinician-ethics consultant”: must have the official clinical training and is characteristically a physician, nurse, or other healthcare providers.

2. The “non-clinician-ethics consultant” characteristically has formal training in law, philosophy, religion, or related subjects of the humanities. Non-clinician-ethics consultants can teach, facilitate discourse, negotiate, and clarify and explain ethical issues. They should abstain, however, from offering precise recommendations concerning the care of patients.\textsuperscript{165}

Clinical ethics consultants come from various personal and professional backgrounds. They should be familiar with working in the clinical environment and through several specialties. This refers to an elementary understanding of the clinical context, including but not limited to basic clinical terminology, a comprehension of the roles and range of practice of several types of health professionals, the routines and procedures of clinical care, and how information is documented and transferred among caregivers.\textsuperscript{166}

It is important to note that CE consultants must be mindful of the limitation of CEC. First, they should realize those good solutions for ethical challenges depend on many factors such as efficient communication skills, precise truthful information, and the understanding and perceptions of many experts.\textsuperscript{167}

Referring to the American Society for Bioethics and Humanities’ Core Competencies Update Task Force, healthcare ethics consultants should possess three main skills to conduct successful ethics consultation services:

1. Ethical evaluation and analysis skills: the consultant should first know how to collect relevant psychological and clinical information related to the case, evaluate the interpersonal dimensions and social aspects of the consultation service, clearly convey the ethical issues involved, identify the complex and various ethnic, cultural, religious factors involved, and identify the values and beliefs of each person involved including the
consultant’s own moral standards and intuitions while knowing how to prevent these from interfering in the ethical assessment and analysis.\textsuperscript{168}

2. Process Skills: the consultant should first create accurate expectations about the consultation process and know if other departments/individuals should be involved in the process, make use of other institutional structures to enable a better consultation process, collaborate and communicate effectively with others, document consultations clearly in patient health records and internal consultation records, facilitate formal meetings, evaluate precious engagements of ethics consultations.\textsuperscript{169}

3. Interpersonal skills: the consultant should listen well and communicate with utmost respect and empathy to the involved individuals, facilitate involved parties to communicate successfully as well, and educate people concerning the ethical aspects of the consultation.\textsuperscript{170}

**Conclusion**
The practice of Health Care Ethics Consultation (HCEC) has become an ordinary way for hospitals to tackle ethical challenges and problems while delivering healthcare services. The role of HCEC can be summarized by helping involved parties to address ethical concerns that arise in patient care. This assistance can take place in various shapes such as:

- Assisting the parties to communicate with one another more efficiently.
- Assisting the parties to comprehend the core of the ethical dilemma, related concepts and facts, alternate option of action, and their likely outcomes.
- Assisting the parties to assess moral motives for different alternatives and attain understanding on a course of action.\textsuperscript{171}

Healthcare ethics consultants have many diverse academic backgrounds, including nursing, philosophy, medicine, religion, and social science. They typically circulate liberally in hospitals; consult with doctors, patients, and families; enter comments and notes in medical records;
mediate disagreements, and frequently contribute to a setting in which healthcare is provided with due respect to prominent social values.\(^{172}\)

Pellegrino has discussed that a sine qua non of the professional is a pledge to two things – “one is competence and the other is to use that competence in them best [medical] interests of the patient”.\(^{173}\) Therefore, consultants should have the necessary skills and competencies needed to serve the patients and their families and solve ethical dilemmas in the healthcare setting.

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Chapter 4. Systems Approach in Clinical Ethics

4. 1. Patient Safety

Introduction
The patient safety movement has been unsuccessful in accomplishing the main objective in decreasing errors because of an inappropriate emphasis on healthcare professionals, patient-level issues, and inadequate emphasis on the organizational elements that affect patient safety (including bad management choices and ineffectually structured institutions). Improving patient safety is one of the most extremely broadcasted and significant topics facing the healthcare industry today. Patient safety, as defined by the National Patient Safety Foundation, is the prevention and improvement of adverse events originating from the process of healthcare. This essay attempts to reflect on the way leadership in healthcare organizations can impact and encourage patient safety culture and create a patient-centered organizational culture.

4. 1. A. Towards a Safer Health System
Medical Errors

The influential Institute of Medicine (IOM) report, To Err, Is Human: Building a Safer Health System, found medical errors annually kill between 44,000 and 98,000 people in U.S. hospitals. Using the lower estimation, more people die from medical errors in a year than from breast cancer, highway accidents, or AIDS. Preventable patient harm expenses are estimated as 15,000 lives and $350 million per month for Medicare and Medicaid patients in the United States. Preceding the first IOM report (2000), most endeavors to decrease rates of medical errors and advance patient safety concentrated more on persons rather than processes and systems. In 1984, Perrow claimed that about 70% of adverse events were related to human error. Although healthcare professionals often contribute to the incidence of errors, the first IOM report used the general popular expression of Alexander Pope – to err is human – to highlight the point that
condemning persons for being human is not a successful approach to advance patient safety. Current research now indicates that the bulk of errors are caused by system and process failures and not by human failures. Adequate staffing and computerized provider order entry are examples of effective resources proven to reduce medical error and costs.

The Institute of Medicine stated the high occurrence of medical errors and planned great efforts to progress patient safety, a vital characteristic of health services delivery. The Institute of Medicine committee recommended that healthcare organizations must work to build a setting in which a culture of safety is a well-defined organizational objective that should be driven by leadership. In response to the recommendations of the IOM, healthcare organizations started the process of improving patient safety and centering more on organizational safety culture. Based on the definition of safety culture from the Agency for Healthcare Research and Quality (AHRQ), the safety culture of an organization is the result of individual and group morals, attitudes, capabilities, and patterns of conduct that define the promise to, and the proficiency of, an organization’s health and safety management. As a proactive approach, failure mode and effect analysis structure for acknowledging probable failures and their effects, evaluating their risks from the combination of probability and severity, prioritizing the possible failure modes founded on those risks, and restructuring the system to reduce the probable risks. Such analysis methods are predominantly applicable when considering new programs, tools, and purchases.

**Measuring Medical Errors**

The most common process for measuring errors and safety is incident reports, self-report of errors by healthcare providers. They are regarded as the “gold standard” because they include rich detailed clinical information. However, many doctors do not report errors through incident reporting systems, while some nurses are usually inclined to do so. Another method of measuring
safety is through a sequence of patient safety indicators collected from large organizational datasets. The Agency for Healthcare Research and Quality’s Patient Safety Indicators is the most extensively used one. Nevertheless, these indicators do not relate very well to actual safety.\textsuperscript{10} Furthermore, the use of trigger tools, developed by the Institute for Healthcare Improvement, has appeared as a preferred method to measure the frequency of unfavorable events in numerous healthcare settings. These tools shifted the emphasis from errors to unfavorable events as targets for measurement and interventions\textsuperscript{11}. Nonetheless, these tools are neither perfectly specific nor sensitive. They are also labor-intensive unless they become fully automated.

McFadden et al. Identified numerous impediments to the accomplishment of patient safety initiatives in hospitals, including an absence of top management support, lack of resources, lack of motivations, and lack of information. On the other hand, recognized significance and prominence of patient safety intuitive was exhibited to enable the execution of patient safety initiatives.\textsuperscript{12}

4. I.B. Creating a Patient-Centered Culture

\textbf{Patient Safety Culture}

A blame culture (which makes use of punishment, criticizing employees for error) has been unsuccessful to develop patient safety results. On the contrary, it leads to ineffective counter processes such as more inspection, corrective action, and introducing new processes that do not persuade highly skilled and specialized healthcare professionals. On the other hand, safety culture stresses a more comprehensive systems tactic to dealing with medical errors. The modern patient safety movement is more of a system thinking oriented.\textsuperscript{13} This standard acknowledges the human condition; it recognizes the fact that most errors are made by proficient, careful, and considerate providers. It concludes that the establishment of systems that predict errors in
advance and prevent them determines safety. This paradigm focuses on all the fundamental circumstances that made an error probable. The system thinking approach underlines the assumptions that humans are imperfect, and they are expected to make some errors, and thus the systems and circumstances under which healthcare professionals work can be improved. The focus on safety culture is on the adverse events and errors that happened, and not on the person who committed that error. This focus encourages communication of mistakes and positively influences organizational learning within an environment that is supportive of open discussion to enable safe practices. Most importantly, this approach inspires and encourages leaders to promote a culture of safety. Leaders should make their employees feel empowered, learn from each other, and support better groundbreaking employee behavior. Learning initiatives encourage structural members to report all medical errors and explore comprehensively their causes in an open and trusting setting. Therefore, cultivating and promoting a patient safety culture positively affect adverse event reporting, better decisions, general developments in care, and enhanced financial organizational performance.

Most adverse events result from system failures in healthcare organizations. One approach to manage systemic defects is to cultivate an organizational culture, a safety culture, in which healthcare professionals regard patient safety as of high significance. Present literature emphasizes safety culture as a performance-shaping element, affecting both clinicians’ safety actions and patient results. Safety culture is the approach by which safety is accomplished and managed in the healthcare system, and it divulges the behaviors, perspectives, moral values, and principles of employees concerning safety issues. A culture of safety can be defined as a combined structure of individual and organizational behavior, based upon joint principles and moral standards that constantly pursue to diminish patient harm. Culture also outlines
clinicians' and employees' insights and views about expected and good conduct and practices related to patient safety in their work domain. It enlightens views about what is admirable and what is punishable, and thus culture affects one’s incentive to participate in safe practice until this motivation turns into everyday practice.\textsuperscript{19} A culture of safety is the one that increases one’s attention to the duty and encourages people to speak up about anxieties and issues; team training, so that each employee is fully conscious of the goals.\textsuperscript{20}

Patient safety climate is one characteristic of the safety climate, which can be measured and developed. Safety climate survey outcomes comprise the sum of healthcare professionals' approaches towards many aspects of patient safety, such as teamwork, work conditions, and leadership support.\textsuperscript{21} Safety Attitudes Questionnaire (SAQ) and AHRQ Patient Safety are the two most acknowledged tools for measuring safety culture. These instruments have been administrated to tens of thousands of healthcare leaders and workers, and this implies that benchmarks have been well-founded. There is gradually influential verification that safety culture scores associate with clinical outcomes, including infection and readmission rates. The Joint Commission now necessitates that accredited organizations manage and evaluate safety culture surveys, each year. Measuring safety culture is crucial, but also planning out a strategy and implementing it is more substantial.\textsuperscript{22}

**Characteristics of a Culture of Safety**

There are seven main characteristics of the culture of safety:

1. Leadership: A common theme running through the literature suggests the role of senior leadership is a crucial component to planning, promoting, and fostering a culture of safety. This was predominantly exemplified when the National Quality Forum (NQF)
embraced “Improving Patient Safety by Creating a Culture of Safety” with an emphasis on leadership structures and systems (NQF, 2006). Many scholars acknowledged administrative leadership as one of the most noteworthy enablers for creating and endorsing a culture of safety. Dickey, in an editorial on “Creating a Culture of Safety,” suggests a culture of safety must start with the chief executive officer but must also but it must also infiltrate throughout every layer of the healthcare system.

2. Teamwork: A spirit of collaboration exists among managers, staff, and practitioners. Relationships are open, safe, respectful, and flexible. The increasingly multifarious disease procedures and complicated treatments and technologies, this fact necessitates greater efforts toward applications of teamwork practices among caregivers to achieve a system-wide culture of patient safety.

There are two significant practices and strategies that are required for effective team training. First, the case for cultural change toward a safety culture should be openly communicated from physicians, nurses, and hospital executives at the top of the authority hierarchy. Second, make use of other applicable non-healthcare analogies, as they might help reduce errors and improve culture. Checklists endorse compliance with safe processes of care but also enable culture change by cultivating communication and teamwork.

3. Evidence-based: Patient care practices are based on evidence. Standardization to reduce variation occurs at every opportunity. Processes are designed to achieve high reliability. Healthcare organizations that exhibit evidence-based best practices, including standardized processes, protocols, checklists, and guidelines, are thought to show a culture of safety. Because the medical standard of physician autonomy and the “art” of
medicine is still prevalent, integrating best practices and standardization maybe the leadership’s utmost task to building a culture of safety. However, as new generations of doctors are educated, the use of standardized procedures may become more extensively recognized.30

4. Communication: An atmosphere exists where any staff member has the right and the accountability to speak up on behalf of a patient.31 Frankel et al. (2003) and Leonard, Graham, and Bonacum (2004) suggest applying forms of communication such as briefings and debriefings. Briefings are very short deliberations at the start of procedures to confirm all parties are presented and that tools, medicines, and accompanying documents are in place. A debriefing happens again at the end of a procedure to allow for an evaluation. Moreover, managers should provide feedback to frontline staff to achieve open and transparent communication.32 All healthcare team (CRM) programs focus on cultivating communication skills, forgoing a more unified environment, motivating caregivers to speak up when they have apprehensions, applying tools, and tackling errors in a broad-minded fashion.33

5. Learning: The hospital learns from its mistakes and pursues innovative opportunities for performance development and integrates this with the care delivery process. Learning should be appreciated among all staff, including the medical staff.34 Learning can begin when leaders exhibit a readiness and determination to learn from a variety of sources including those that are outside healthcare, such as those that have pursued and achieved successful safety cultures. A learning culture forms safety mindfulness among employees and medical staff and endorses an atmosphere of learning through educational opportunities.35
Learning cultures make use of root-cause studies to examine medical errors. Nevertheless, as a hospital safety culture develops, learning cultures will become more proactive in finding and improving potential insecure processes to avoid errors.\textsuperscript{36} Assessment of the learning process inspires opportunities to share lessons learned and considers the education procedure to be unceasing and advancing. Moreover, a learning culture rejoices and rewards success.\textsuperscript{37}

6. Just: A culture that acknowledges errors as organization and system failures rather than individual failures and, simultaneously, does not shrink from holding individuals responsible for their actions.\textsuperscript{38}

7. Patient-centered: Patient care is positioned around the patient and family. The patient-centered approach views the patient not merely as a dynamic contributor in his care but also serves as a connection between the hospital and the community. A patient-centered culture embraces the patient and family as the exclusive motivation for the hospital’s being. This approach pledges to value the patient by delivering a healing setting during the hospitalization and to foster health and well-being as a continuum of care.\textsuperscript{39}

It is the accountability of the leadership to pledge to patient-centeredness as a fundamental value. Leaders should challenge the medical professionals and all employees to make a great effort toward focusing on the patient and offering an excellent experience marked by caring and benevolence. The patient-centered hospital permits and inspires patients to be involved in their care decisions. Moreover, leaders that share their patient-centered vision with their society permit them to feel some pride and possession of their hospital.\textsuperscript{40}
4. I.C. Moral Responsibility of Leadership
Patient Safety and Morally Imperative Responsibility of Leadership

Health care is a multifarious and complex system. Some organizations have been able to achieve prominent consistency in safety-related programs, predominantly high-reliability organizations such as the aviation industry and nuclear power. High-reliability organizations (HROs) indicate systems or organizations that work in multifarious and risky settings and yet reliably attain approximately error-free performance. Failure rates in healthcare organizations are much higher than those found in high-reliability organizations. The promise of leadership that safety is a primacy and responsibility of the organizational structure and systems is very important. In high-risk businesses, leadership is acknowledged as an indispensable feature of safety management, and thus particular safety leadership programs are typically delivered for all levels of managers. Interventions that focus on safety-related monitoring, reward managers’ activities, and persuade employees to make the workplace safe, have been proved to increase the safety behaviors of workers and decrease work-related injuries. Leadership at health care organizations should follow the same path because safety is fundamental.

Presently, patient safety is a strategic and fundamental driver in healthcare. It is described as the absence of avoidable harm to a patient during the process of healthcare delivery or as the prevention of errors and adverse events caused by the facility of healthcare rather than the patient’s primary disease process. Nevertheless, finding and categorizing the particular components of what makes a healthcare organization safe is challenging. There is a noteworthy emphasis on advancing patient safety results, and a request for an administrative or system-wide solution to advance patient safety. Healthcare administrators have significantly acknowledged patient safety during the last decade, and the role of management in forming a patient safety
culture has become a crucial point of importance.\textsuperscript{44} From an ethical perspective, the objective of a healthcare system in terms of patient safety can be deliberated in two main ways. First, patient safety has a practical significance: where the benefits, results, efficiency, and economic factors of care provided are taken into consideration. Second, the objective of patient safety is seen as a moral worth, the patient has intrinsic human dignity. Thus, the tangible and moral reasons for patient safety are linked and form the main crucial point for patient safety movement.\textsuperscript{45}

Despite this significance, the ethical features of patient safety have not been described. As a concept, patient safety has an intrinsic essentially ethical nature. Henceforward, ethical patient safety can be seen as associated with nursing management in terms of protecting human dignity and authorizing and managing the application of ethical protocols.\textsuperscript{46} Ethical issues are considered as the intrinsic theoretical groundwork for patient safety and also as a value-bound basis of healthcare delivery and safety culture. The underlying standards of patient safety are found in its operational culture and incorporated into organizational culture, which results from the essential assumptions of the primary purpose of a healthcare organization.\textsuperscript{47} From an ethical viewpoint, the duty of patient safety is shared by all healthcare specialists and organizations, but also incorporates patients and families to some degree. The provision of safe care involves cooperation between healthcare practitioners.\textsuperscript{48}

Patient safety and preventable harm are regarded as serious public health matters by the NPSF (National Patient Safety Foundation). In the report, eight strategic recommendations are forwarded to achieve patient safety, including the morally imperative responsibility of leadership in creating a culture of patient safety and rearranging efforts into synchronized efforts. Moreover, nurse leaders have a remarkable opportunity to achieve patient safety improvement. However, the transformation will only materialize if leaders are deliberate about making a
positive change with patient safety. Patient safety must be at the focus of health care and be incorporated into the leader’s practice both in the direct delivery of health care and in the supportive and practical tasks of the overall patient care experience. NPSF (2015) reports the vital role of education in the basics of safety science as crucial for all leaders to guarantee accountability and application of the science of safety. To attain the necessary results and improve patient care, a culture of safety, teamwork, the appropriate culture, and patient engagement are important. Nevertheless, culture change is very challenging for leaders, and they should first address the corporate or cognitive culture. The cognitive or thinking culture comprises mission statements, values, and behaviors. This culture depends on intellectual values and norms that determine the competitiveness of the organization. For that, many organizations dedicate incredible resources to the advancement of this culture with processes, standardization, etc. However, leaders should also tackle emotional culture and manage it to achieve a culture of safety. Barsade and O’Neill (2016) confront leaders to manage emotional culture equally as the cognitive culture. The emotional culture of the unit is often created and supported by the emotional gestures and activities the leader implements. Leaders should strive to achieve a positive joyful healthy environment that praises examining values and high moral standards.

**Common objectives between Ethics Committees and Patient Safety Team**

Ethics committees usually involve a multi-disciplinary group of health care professionals, who have experience and knowledge in applied ethics, and they work together to advance the quality of health care and address ethical issues. The fundamental functions of ethics committees include ethics education, institutional policy review and development, and case consultation. The prominence of having a method to tackle ethical encounters in health care
organizations has been acknowledged by JCAHO in setting up of “Patient Rights and Organizational Ethics” standards.\textsuperscript{53}

During the past couple of years, there has been a developing turn from this conventional style of the ethics committee to a profound focus on the existing health care delivery setting. The focus is broader than before including concentrating on organizational topics besides clinical engagements; managing activities toward the organization’s mission, code of ethics, and value statement, not merely patient rights; using a proactive method; instituting clinical and organizational ethical standards of protocols; monitoring and evaluating ethical practice procedures; increasing the proficiency and diversity of ethics committee involvement; being directly connected to managerial leadership among others.\textsuperscript{54} These transformations reveal a mounting acknowledgment of the existing organizational ethics needs and the significance of ethics to the success of the health care organization. Comprehending and appreciating that patient safety is a crucial element of quality care, ethics committees can be a valuable contribution to the patient safety program.\textsuperscript{55}

A close collaboration between the patient safety team and the ethics team would improve patient safety practices, especially those directly ethical conflicts, and progress the quality of patient care.\textsuperscript{56} By collaborating, professionals from patient safety and ethics departments can tackle the issues in a systematized and proactive system-oriented approach. Such kind of collaboration would improve the organization’s general setting by assisting staff to recognize the right thing to do in different ethical encounters.\textsuperscript{57} Patient safety directors and ethics boards can develop procedures that incorporate a well-defined system for determining the proper management of common ethical conflicts, a system that integrates ethical principles and patient
safety goals.\textsuperscript{58} A systematic procedure that incorporates ethical practice procedures can be a significant tool to foster that final objective of quality health care.\textsuperscript{59}

\section*{4. I.D. The Organization and the Process of Patient Safety}

**Challenges Facing Health Managers in Promoting Patient Safety**

Insights from the Executive Session on Patient Safety, a working group of hospital and health system managers and other participants who work together for the sole purpose of understating and improving patient safety, the challenge of endorsing safe care is presented in this essay. The members worked to comprehend why the problem of medical error had not yet been extensively acknowledged as a difficulty among healthcare leaders.\textsuperscript{60} Executives believed that the organization and culture of the hospital contribute significantly to the level of patient safety. Nevertheless, board members have significant roles to play by setting the management team’s objectives, reviewing and monitoring operational performance, directing financial resources to patient safety practices, and setting incentive compensation.\textsuperscript{61} There are many challenges for healthcare leaders in the promotion and advancing patient safety:

1. Monitoring and Measurement: Because there is no readily decided metric for evaluating the safety, it is challenging for leaders to assess the care their organizations offer. For instance, incident reporting is a valuable source of data about errors and harms, but it is problematic to understand reporting rates as high rates of incident reporting may suggest the presence of a culture that is open and responsive to improvement rather than a hazardous setting.\textsuperscript{62} There are many approaches for measuring and monitoring patient safety. Prospective audits of high-risk processes are one approach. In this method, leaders observe processes for deficiencies that could lead to harm. Analysis usually focuses on settings where the volume is large (for example
emergency departments), the hazard is high (for example in chemotherapy and surgery), or the patient is vulnerable (for example in newborns). 63

2. Expanding and Maintaining Change: Expanding improvements are among the toughest challenges for healthcare leaders. Leaders find it extremely demanding and challenging to expand a prosperous patient safety innovation initiated in one unit to other divisions in the same hospital or other practice settings in the health system. 64 Difficulties to the spread of improvement are embedded in the professional principles of healthcare providers, in the physical separation of hospital units, and by the lack of organizational means for sharing lessons learned and creating change. Moreover, leaders should have a good level of consistency, and try to incorporate patient safety goals into the richer cultural goals. 65

3. Multidimensional and Complex Patient Safety: Mostly, healthcare is a high-risk activity, and therefore unsafe practices will always happen, and it is not possible to eliminate practice errors from healthcare systems entirely. It is hence unethical to form the illusion of absolute safe care in the healthcare industry. 66

Numerous research papers discussing patient safety issues have highlighted the significance of visible leadership in improving patient safety and reducing adverse events. 67 The attitudes and actions of healthcare professionals toward safety can change; nevertheless, for this transformation to be sustainable, it needs strong organizational commitment to safety. In small hospitals, formal leadership is critical; leaders in larger hospitals should find more means to efficiently communicate and validate their safety obligation and support to managers to better involve them in inpatient learning activities. 68

**The Role for Leaders of Health Care Organizations in Patient Safety**

Safety culture encompasses far more than what happens in the operating rooms and on the wards. It is influenced and determined by the organizational culture, leadership, context,
incentives, and other related aspects. For this reason, there has been a growing emphasis on the engagement of healthcare boards and other leaders.\textsuperscript{69} As Carillo discussed in his research paper, sustaining safety as a primary and fundamental significance in individuals’ minds is a demanding task for leaders in organizations. Many factors play a role in determining the significance assigned to safety including communication structures and leadership style.\textsuperscript{70} Safety is a validated commitment by leaders to generate and sustain a system that delivers satisfactory knowledge, training, and resources to achieve the task well.\textsuperscript{71} In a 2009 Sentinel Event Alert, the Joint Commission examined the association between leadership and the creation and endorsement of a safety culture. It established an incompetent leadership as a contributing factor in 50 percent of sentinel occasions stated in 2006. Since then, the Joint Commission has declared that leadership must go beyond reinforcing safety involvements and must also play a fundamental role in creating a safety culture.\textsuperscript{72} Therefore, the establishment of a culture of safety vastly depends on leadership and communication in healthcare settings. For instance, root-cause analysis of sentinel events from the previous 8 years in the United States verified that poor leadership and communication failures are regarded as important factors that contribute to adverse events. Hence, healthcare leaders must prioritize patient safety when allocating inadequate resources. They should conduct proactive identification of hidden safety risks.\textsuperscript{73}

The supporting leadership activities align the framework for the clinical processes and identity main clinicians' mindsets towards a safety culture.\textsuperscript{74} Thus, a patient safety climate can be considered because of leadership procedures and activities. To achieve excellence, the clinical leaders must be well educated, experienced, and well trained in enabling group communication, solving conflicts, building enthusiasm and progress. Training physicians should involve a
succession of contemplation, application, and experience. Moreover, leadership profiling and coaching can be successful ways to help leaders construct a safe setting for patients.\textsuperscript{75}

Many governmental and other agencies are applying regulatory and financial pressures on health care organizations to develop patient safety. The federal government approved the Patient Safety and Quality Improvement Act of 2005, which offers confidentiality for health care systems’ reports of medical errors to patient safety organizations. Leaders of health care organizations can plan and execute various plans to lead and monitor the advancement of their health care systems toward safe care.\textsuperscript{76} Managers in healthcare have a legal and ethical duty to confirm great excellence of patient care and to attempt to advance care practices. These managers are in a crucial spot to command policy, systems, practices, and organizational climates. Correspondingly, many scholars have debated that it is apparent that healthcare managers have an imperative and clear role in the quality of care and patient safety. Moreover, patient safety must be of the utmost significance to healthcare managers.\textsuperscript{77} Leaders of healthcare organizations must do a wide array of actions to ensure that the correct intervention will lead to improved patient safety across the organizations. They should be willing to commit their time and efforts to patient safety and form an inclusive setting to encourage different perspectives and open discussions.\textsuperscript{78} Moreover, to enable progress and inspire positive change, they should guarantee that all employees are included as part of the organization’s vision.\textsuperscript{79}

Endorsing a patient safety culture can best be comprehended as an array of involvements rooted in values of leadership, behavior change, and teamwork. Promoting a culture of safety does not include a single team or a single process. These interventions may comprise system-level modifications (like team training and executive walk rounds) and unit-based approaches. Team training signifies arranged organized schemes for improving teamwork processes
(communication, collaboration, and leadership) and enhancing the skill set and knowledge of employees. Based on the literature, leadership walk rounds, and multi-faceted unit-based strategies are the two approaches for which some good evidence could be established to support a positive influence on patient safety culture. An interventional approach that incorporates organizational leadership straightforwardly with frontline caregivers is called executive walk rounds. Directors or senior managers oversee frontline patient care zones to detect and examine existing or possible risks to patient safety, as well as backing frontline staff in tackling such dangers. Walk rounds intend to reflect leadership obligation and pledge to safety, promote trust and emotional safety, and deliver encouragement for frontline caregivers to proactively tackle threats to patient safety. Leadership walk rounds involve managers and clinical leaders and make use of open communication methods to try to solve difficulties surrounding patient safety, and at the same time incorporating frontline caregivers and establishing organizational commitment. Thomas et al established that the positive influence on patient safety culture was mainly due to the nursing staff who essentially contributed to the leadership walk rounds. Many factors affect the efficiency and effectiveness of leadership walk rounds in improving patient safety culture such as the rate of staff turnover and frequency of rounding.

Multi-faceted unit-based programs are another method for cultivating patient safety culture in a particular unit and patient outcomes. These programs use an organized framework to evaluate, recognize, report, and advance patient safety flaws. There is a vibrant and well-defined association between this strategy and patient safety culture and this will reinforce the observed positive effects. Leaders can also adopt the “Schwartz rounds” approach because it fosters shared learning across the organization’s levels. In this method, leaders produce discussions across professional teams where they can mirror the emotional dimensions of their work. By this
method, they can improve communication between care providers, nurture healing relations, and cultivate the relationship between patients and their care providers.\(^8\)

Healthcare leaders are responsible to patients as well as to regulatory and accreditation bodies for the quality and safety of care carried in their institutions. Patient safety depends critically on the integrity of schemes of care, thus it is the duty of both clinicians at the bedside and the managers who administer the health system as a whole. Executives endorsed the view that healthcare organizations should make a public pledge to patient safety as it contributes to the trustworthiness of their organizations and tackles patient expectations.\(^4\) Moreover, the behaviors, attitudes, and skills of the executives affect the development of patient safety missions in their organizations as the general management codes apply also to safety leadership. For example, the executive should standardize anticipations and form trust with other employees. Additionally, they should assign time for teaching and mentoring, set clear goals for managers in terms of safety and tie enticements to the achievement of these goals, and assess and embrace best practices and technology and investigate the real value-added of automated medical archives.\(^5\)

In general, healthcare leaders should work on four main areas:

I. **Building better communication**

Leaders of other high-reliability organizations have promoted a culture of open and transparent communication about error without condemning. The National Aeronautics and Space Administration (NASA) has shaped a culture in which every worker is empowered and applauded for reporting safety concerns and problems. The NASA Aviation Safety Reporting System (ASRS) includes frontline employees where they employ the use of voluntary documents of event. Specialists in the field of the incident follow-up these reports and offer insightful advice
on prevention. In the end, results are published through the aviation community. Hospital leadership should learn from this industry and encourage a setting in which employees do not fear the effects of sharing mistakes but encourage discussion that improves patient safety and create a culture of transparency by creating enriched communication.\textsuperscript{86} Additionally, leaders should endorse a culture where people are encouraged to communicate among team members if they notice or detect risky practices or near misses.\textsuperscript{87}

II. **Building better delivery Systems**

Leape and Berwick note that medicine’s culture is embedded, both by practice and training, in extreme morals of autonomous individual functioning. This organizational standard can impede the nature of organizational problem solving needed to encourage and establish a safety culture. Research on quality improvement in the hospital setting has classified two kinds of responses to problems categorized as first-order and second-order problem-solving. In first-order problem solving, temporary solutions to issues are used, and without an effort and determination to recognize the fundamental issue. On the contrary, second-order problem solving combines the short-term remedy with an examination targeted at prevention a repetition of the same issue. Other high-reliability institutions have incorporated second-order problem-solving. For example, The Toyota Production System makes use of this tactic, known as kaizen or continuous incremental improvement, to inspire and encourage employees on the shop floor to solve troubles in real-time. Dr. Kaplan, CEO of Virginia Mason Medical Center (VMMC), embraced the values of the Toyota Production System to instantaneously respond to reports and stop processes until they were solved. Therefore, other hospital leaders should enable and persuade their employees to participate in second-order problem solving and root cause analysis.\textsuperscript{88}

III. **Building Better Teams**
Research validates that 70 to 80 percent of medical errors are correlated to damaging relations within the health care team, and this is mainly due to medicine’s hierarchical power configuration which forms a challenging hurdle to creating successful teamwork. For example, Kaiser Permanente methodically endorsed teamwork and communication in the high-risk field such as labor and delivery and surgery. At several northern California Kaiser Permanente medical centers, physicians engaged in team training principles mainly related to multidisciplinary patient rounds to ensure deliberate contemplation of the care plan systematized communication methods aimed to endorse precise situational briefings, team briefings, and debriefings that follow unfavorable events among many others. After hospital leadership accepted and implemented these and other team training topics, there was a substantial rise in error management performance, such as better readiness to discuss any safety issues and to report medical errors. Leaders and senior managers should know how to enable teamwork to achieve better and improved safe patient care delivery. Working collaboratively could impact staff efficiency and advance patient safety. Moreover, this approach also supports learning from errors in an open and safe cooperative group setting.

### IV. Building Better Accountability

Leaders should move their organization from a culture of dispersed accountability for safety to a culture of combined responsibility by creating better and clearer accountability. A network of hospitals and clinics in Utah and Idaho, Intermountain, has adopted the model of employee responsibility for safety and quality. This was made possible through the use of electronic medical records that deliver figures on protocol observance, which permits this health network to hold professionals responsible for their work performance. Moreover, it helps the network to plan, set, and accomplish clinical development objectives. It makes the use of a reward system
applicable where healthcare professionals who achieve good results are qualified for bonus packages, and those with the greatest outcomes are included in the decision-making process of how protocols will be achieved to improve patient safety standards. Healthcare providers who prove unsuccessful are directed for additional teaching. Accountability and responsibility act to reflect the organization’s vision, bring workers in different divisions toward a shared objective and inspire them toward accomplishing that objective.\textsuperscript{91}

4. I.E. A Greater Leadership Role
How Hospital Leaders Promote Patient Safety Through Building of Trust

Another dynamic and fundamental element of patient safety culture is trust in hospital management. To shape and sustain trust, indispensable management features are required such as integrity, kindness, and proficiency. Trust is crucial in creating and maintaining a positive safety culture and patient safety as the foundation of the leader-member relationship. For instance, nurses who trust their hospital managers are more tending to engage in safety-oriented actions. Nonetheless, open and fair communication is needed to establish high trust levels in the management team. Blame-free management responses to other members reporting errors are perquisites for open communication.\textsuperscript{92}

The analysis confirmed that higher hospital management support for patient safety is linked to generally higher perceptions of safety and trust in hospital management; many characteristics of safety-related communication operating as partly facilitating factors. The results of the analysis established that higher hospital management support for patient safety was linked to general greater perceptions of safety concerning communication honesty, organizational knowledge and feedback, and communication of errors. To gain and cultivate trust, hospital leaders must take a sincere and ongoing attentiveness in building a patient safety
culture. This might include systematic safety meetings, where hospital leaders and frontline staff can cooperate on patient safety concerns. For example, proactive learning activities are promising methods to develop safety communication concerning risks and safety worries and to resolve systemic problems.  

**The Ethical Responsibility of Nurse Managers**

Clinical leaders offer motivating visions and promote behavioral change. The implementation of safe and high-quality practices depends on outstanding leadership. Clinical leaders should have a high degree of leadership competence to provide quality clinical care and managerial duties. For instance, intentional rounding, an official procedure of patient checks lead by trustworthy and responsible nursing staff every one to two hours, is considered an important method to improve quality care as nurses would concentrate on patients’ needs and concerns rather than tasks. Physicians must be at the heart of facilitating the development of the organizational culture of quality and patient safety improvements. Physicians should play crucial roles in safety efforts. Formal and informal organizational leaders play critical roles in running safety improvement endeavors.

Leadership is not limited only to healthcare professionals but includes also administrative and business leaders. Nevertheless, the role of a senior nurse or healthcare professional staff member is essential to developing employees' performance levels to advance the performance of the group, systems, and the whole organization.

From the standpoint of the nurse manager, the responsibility of the organization is to construct the fundamental infrastructure for ethical patient safety and guarantee continuous excellence in patient safety practices. This potentially promotes a systems-oriented proactive approach to
ethical issues. Nurse managers must form mental and physical settings for an ethics-based patient safety culture.\textsuperscript{101}

Nurses’ accountabilities that are related to ethical patient safety mostly include error prevention and notifying patients and practitioners about practice errors. Nurses are ethically responsible not only for reporting and recording their errors but also for censuring patient safety in teamwork. They also have an ethical duty to guarantee the capability and expertise of their staff. In addition, nurse managers must assess the insufficiencies in knowledge and technical skills of healthcare practitioners that might threaten patient safety, and offer customized training and education to solve these gaps. Moreover, they must provide patient-centered care as a core value of ethical care. Managers who understand and appreciate the requirements of their staff, engage inspiration processes, inspire other nurses to follow ethical safety protocols, ensure equitable working conditions are more tending to be successful in promoting cultural change.\textsuperscript{102}

Protocols and guidelines aim to improve and maintain patient safety from an ethical perspective because they prevent harm and endorse safety. Protocols can enable communication between top managers and leaders and eliminate organizational barriers to ethical patient safety. In this regard, nurse managers are accountable for regulating procedures, protocols, checklists, and standards. Accordingly, safe systems should be founded within healthcare organizations that enable open reporting and solutions to patients’ safety.\textsuperscript{103} In summary, nurse managers play a tactical and moral role in promoting and maintaining patient safety. The role of nurse managers includes integrating ethical morals of patient safety into all decision-making in their healthcare organization.\textsuperscript{104}

\textbf{Conclusion}
In summary, leadership knowledge and skills appear to be fundamental to improving patient safety climate. Subsequently, leaders should recognize their significant role in constructing a safe and caring culture. Leaders must pay close attention to low ratings of job satisfaction, disclose the reasons for it, and act accordingly. Leaders should focus on system enhancement, and this implies that the focus should be on processes associated with unfavorable events. Patient safety must be at the focus of health care and be incorporated into the leader’s practice both in the direct delivery of health care and in the supportive and practical tasks of the overall patient care experience.

4. II. Corporate Social Responsibility & Epigenetics

This section discusses epigenetics, defined as the structural change of chromosol areas to register, signal, or disseminate transformed activity conditions, and its relation to the social responsibility of health. It suggests that bioethicists need to widen the extent of bioethics reflection about justice, a scope that is more articulate with the extremely complex and interconnected character of human health.

4. II.A. Bioethics and Social Responsibility

Bioethics: Emphasis on Individualism

In the primary indications of bioethics, during the 1960s, researchers and doctors started to raise inquiries about the influence of technology on life. Meetings and discussions addressed two specific interrogations: population explosion (due to enhanced agriculture and the success of medicine (predominantly antibiotics) in increasing life expectancy and the control of the human genetic heritage). Nevertheless, neither topic moved in that direction. The population interrogation drifted off the agenda of the evolving bioethics as it became a controversial issue for domestic and global politics. The genetics inquiry, while continuing to be on the bioethics plan, rapidly turned in favor of an ethic of personal autonomy. The distinguished philosophical
inquiries fostered by genetic engineering were assessed by most pioneer bioethicists as innovative, while the direct inquiries of genetic testing and screening, made possible through breakthrough research, obligated intense ethical examination. That study and a reversion to eugenics created a genetic ethic that emphasized the right of persons to guard their genetic data and control their heredity. Consequently, the emerging bioethics could not create a field established toward a social ethic.

Moreover, the ethics of HIV/AIDS rapidly took the ethics that highlighted the importance of personal autonomy. This was mainly due to the prevalent worry that the disgrace of homosexuality would influence the social behavior, financial standing, and health care of HIV-infected individuals. Several of the standard public health measures, like screening and surveillance, either was not employed dynamically or were altered to protect individual personal privacy. Methods such as education and personal responsibility were endorsed.

The emphasis on individualism bioethics is reflected in the clinically-oriented focus of many bioethics graduate programs and the demonstration of the Principles of Biomedical Ethics by Beauchamp and Childress as the main reference textbook. This method should be interrogated since such a reductionist concept of bioethics is essentially challenging. A rich literature in public health has proved that health is strongly affected by and associated with several environmental influences that can differ based on social, economic, geographic, cultural, or physical settings. According to Jacqueline Azétsop and Stuart Rennie, such “medical individualism” presumes that persons willingly and freely select health actions in relative separation from their social settings. Therefore, poor health is perceived to follow from exposures to health hazards (such as cigar rete smoking) that the individual patient chose not to evade, and from personal tasks for health. Moreover, the disease-centered medical model of
health permits individualistic research in bioethics and nurtures a prominence on individual focus over health in politics.\textsuperscript{110} Additionally, this medical model makes it harder to see the association between health problems on one hand and the social and economic inequalities on the other hand. Consequently, it may prevent people from considering the socioeconomic disparity as a cause of poor population health. The autonomy-centered bioethics and the medical model of health lead to neglecting the environmental and social dimensions of health and the nonpathological bases of poor health.\textsuperscript{111}

Based on the perspective of Albert R. Jonsen, the discipline of bioethics lacks a social theory. Jonsen claims that the majority of bioethicists tend to regard individuals as rational decision-makers and disregard the social setting of human choices and decisions. Settling in its “well-known area of personal autonomy and interpersonal beneficence and non-malfeasance”, bioethics deems justice only as a secondary inquiry. Jonsen thinks that bioethics, from its origins, contributed to the ethical context of clinical medicine, was devoted to the treatment of individual patients, and somehow ignored the wider cultural and social framework within which medicine and individuals exist.\textsuperscript{112} Treatment of patients is the main focus of clinical medicine, as such, bioethics established its foundations on this specific part of the moral world (personal autonomy and interpersonal beneficence and nonmaleficence) and neglected others. Bioethics rarely discusses other domains such as the problems of distribution of scarce resources.\textsuperscript{113}

According to Peter J. Whitehouse, in the very beginning, bioethics was concerned with large ecological and societal issues, but this dimension has since been overshadowed by more individual-oriented endeavors.\textsuperscript{114} According to Jonsen, the stress on individual autonomy and the de-emphasis on social inquiries can be partially clarified by the urgency of individual-related moral inquiries. For instance, research and clinical trials exploiting persons, such as the
Tuskegee Syphilis Study, enforced the obligation of informed consent as the focus of the debate. Similarly, the danger of eugenics, carried by the developing potentials of genetic testing and screening formed an immediate need to highlight the importance of individual rights and consent. Moreover, based on the perspective of Jonsen, the approach of personal autonomy turned out to be even more important in the shift of the discussions on life-sustaining treatments in the 1970s.\textsuperscript{115}

Even though Jonsen crucially perceives the power of individualism in bioethics, he does not state that there has been no scope for social responsibility in bioethics. He emphasizes that social responsibility often emerges in bioethical deliberations and that several bioethicists are strongly enthusiastic about it. Nevertheless, he claims that bioethics as a discipline considers social responsibility as a side interrogation and does not offer it the essential deliberation. Jonsen argues that bioethics as a discipline and discourse has yet to assimilate the principle of social responsibility into its schooling and language.\textsuperscript{116}

**Bioethics: Attempts Aiming to Embrace the Notions of Social Responsibility**

Even if social responsibility is not at the center of bioethics, there have been several efforts to develop theoretical models that would embrace the notions of social responsibility for health. The deliberations on access to healthcare in the 1980s introduced social and political philosophy into bioethics. Moreover, social responsibility for health is the specific crucial aim of the UNESCO International Bioethics Committee’s report (2010). The report states that, following UNESCO’s Universal Declaration on Bioethics and Human Rights (2005)\textsuperscript{117}, which dedicates a whole article to social responsibility and health, there is an essential need for novel viewpoints that go outside mere medical ethics and bioethics, and expands toward a wider concept of social responsibility.\textsuperscript{118}
Justice has always been recognized as one of the fundamental principles of bioethics, the hypothetical part of this topic of ethics remains mostly in the background. Many bioethicists cite John Locke and John Rawls with respect, but very few have requested these distinguished philosophers to cause a greater impact in the field of bioethics. Professor Norman Daniels remains one of the few bioethicists to explore and examine the multifaceted inquiries of health policy within a profound philosophical theory. Norman Daniels offers a thorough outlook on social responsibility for health. He refers to many theories of justice asserting that society has a responsibility to guard the opportunities of its members. Daniels asserts that health is of distinct moral significance as it offers a range of prospects. He deliberates the effects that, for instance, education, housing, and living conditions, nutrition, income have on health. Daniels’ fundamental statements imply that the social factors of health are very unevenly allocated among subcategories that differ by ethnicity, gender, and class among other factors.

It is fascinating to observe that the extent of the significance of environmental issues in bioethics differs based on the medical methodology promoted by diverse cultures. To exemplify this variation, an assessment of North-American and Latin-American perspectives of bioethics is useful. In the United States, the medical approach is mostly therapeutic and centers predominantly on the medicalization of health. This approach was significantly influenced by the advancement accomplished in early 20th-century microbiology, which helped promote the knowledge that disease happens through the introduction of a pathogen from the environment into the human body. This externalization of the sources of disease has formed the insight that the environment is the main cause behind the health of the individual, rather than as a likely cause of individual well-being and health. Consequently, this perspective has shaped the vision of North-American bioethics. Consideration is mainly given to the individual patient who
becomes the focal point of all benefits, and the principle of autonomy often dominates in ethical discussions.\textsuperscript{121}

Although this individualistic perspective of bioethics and its emphasis on autonomy is prevalent, other cultural settings have directed the promotion of more communitarian notions of bioethics. For instance, research from Ibero-American societies, mainly from Brazil, supports the development of an ecosystemic model of medicine and bioethics, involving three important factors: health, environment, and the intersection between the two (the circumstances and lifestyle of a specific community). This illustration of bioethics highlights the significance of solidarity and downgrades individualism to second place. It endorses an ‘ethic of life’ that brings together biomedical ethics, ecology, and human values, such as the case in the novel Potterian perspective.\textsuperscript{122}

During the previous two decades, the appearance of environmental worries such as global warming has caused amplified consideration to the environmental elements of health. In public health, similar concerns arise and so should enhance consideration to the connection between human activity, environmental fluctuations, and human health.\textsuperscript{123} The next section aims to highlight the very close connection that occurs between the environment and gene expression. This implies that the environment is of high significance in shaping both individual and population health. Therefore, bioethics needs to shift its focus towards a Potterian outlook that endorses a communitarian-based sense of accountability for the environment, to entirely acknowledge justice's significances and expand public health.\textsuperscript{124}
4.II.B. Epigenetics

Epigenetic Studies

After the completion of the sequencing of the Human Genome Project in 2003, the functional study of the human genetic code appeared to be a comparatively simple duty. It resulted in great progress and knowledge of the genetic foundation of diseases. However, the full understanding of human genetic processes has turned out to be far more multifaceted than originally anticipated. Perhaps the most significant of these intricacies is epigenetics, which plays a main part in the expression of human genetic traits. Epigenetics is a developing field, particularly as applied to humans. Abnormal DNA methylation profiles were first documented in human cancer about twenty-five years ago. Currently, epigenetic regulation has been proven to be predominant in the genome, and information known might only be the tip of the iceberg.

From cancer to environmental toxicity to maternal behavioral effects to in vitro fertilization risks, epigenetic effects play a vital, formerly under-appreciated role in the interaction of nature and nurture. The epigenome is extremely sensitive and receptive to environmental stimuli, such as toxic exposures, dietary influences, and behavioral influences. While the nature of at least some epigenetic variations is well-established, many of the inferences and processes of epigenetics remain unclear. The word "epigenetics" was first presented in 1942 by Conrad Waddington to illustrate the connections of genes with their environment. Today, epigenetics denotes alterations of the genome that do not include a change of DNA sequence; they alter the timing and quantity of the production of certain genes in tissues at crucial points. Such changes in defining which genes are expressed and their level of expression can have dramatic outcomes on the development of an organism.

Epigenetic changes are comparable to genetic mutations in that they can both produce heritable changes in gene expression and function. Yet, there are several exceptional
characteristics of epigenetic changes that vary from traditional genetic mutations, including the following:\textsuperscript{130}

1. Epigenetic changes incline to happen at a greater frequency than mutations in the DNA sequences. For example, toxic agents acting through a genotoxic mechanism will usually only result in mutations in less than 0.01\% of offspring; however, epigenetic processes often affect the majority of offspring. Epigenetic changes permit a quicker evolutionary change when compared with typical genetic mutations, and this provides room for quick variation and a greater ability to respond more rapidly to variations in environmental conditions.\textsuperscript{131 132}

2. Susceptibility to epigenetic change is very sensitive to the amount of some environmental agents, and as well as to the phase of development at which introduction happens. Specifically, exposure at crucial stages of early development such as neonatal development is extremely inclined to cause an adverse effect.\textsuperscript{133} Moreover, a person’s predisposition to epigenetic change is extremely dependent on the amount of the environmental agent and the phase of development at which exposure happens. Specifically, exposures at crucial phases of early development, including the embryonic and neonatal stages, are much more expected to result in an unfavorable response. Yet, the sensitivity of the genome inclines to stay constant during the life cycle.\textsuperscript{134} they are reliant on the environment, like intrauterine or postnatal environment (microflora), physical environment (nutrition, temperature), and social environment (stress, quality of life). Environmental factors that may disturb the processes of epigenetic modifications include, amongst others, the introduction of toxins, drugs, and physical activity.\textsuperscript{135}
4. Different than genetic mutations, which happen very infrequently and are chiefly irreversible, epigenetic modifications are dynamic and reversible. Third, genetic mutations tend to be irreversible, subject to reverse mutation only at tremendously low frequencies; nonetheless, epigenetic changes are reversible. This specific characteristic forms an opportunity for epigenetic interventions via the use of drugs or diet to reestablish regular epigenetic levels, and proposes that diseases triggered by epigenetic irregularities may be more easily remediable and avoidable than diseases triggered by more permanent genetic mutations.

5. Epigenetic changes incline to be tissue-specific and consequently can vary from one cell type to another within the same creature. However, germ-line genetic variations are commonly constant and consistent throughout the tissues of an organism. This tissue-by-tissue changeability of epigenetic variations could have vital practical effects, such as differential outcomes of drugs in different tissues. Epigenetic modifications are also inter-dependent, a focus that makes it extraordinarily difficult for genetics research, to the level that the identification of the human epigenome or ‘histone code’ is expected to be a more significant task than the mapping of the human genome.

6. Fifth, epigenetic changes incline to be species-specific, so a toxic response in a research laboratory study using rodents may be less prognostic of a comparable risk for humans. This evidence highlights the need for epigenetic epidemiology to examine the effects in humans.

7. The last feature of molecular epigenetics, and possibly the most astounding, is that some modifications may be heritable and passed from one generation to another. Certainly, it has been revealed that the patterns of DNA methylation of cells are spread through
mitosis (cell division), but also through meiosis and gametogenesis (making of spermatozoids and ovum). Consequently, it seems that some epigenetic changes can have an intergenerational effect.\textsuperscript{142}

Different than the genome, epigenetic processes and variants are regulated partially by living conditions and lifestyles. Alterations to the three-dimensional structure of DNA at particular genes in particular cells impact gene expression and therefore health. Altering the extent of accessibility of the transcriptional machinery to certain genes has a consequence on the making of proteins that tissues need to perform their ordinary biological functions.\textsuperscript{143} For instance, Rothstein has reasoned that epigenetic changes may to some degree be extraordinary when contrasted with genetic variants at the scientific level because they high incidence of occurrence, dose-dependent, reversible, tissue-specific, and species-specific.\textsuperscript{144}

**Human Epigenome Characteristics**

Epigenome-wide association studies (EWAS) and vast collaborative projects such as the US National Human Genome Research Institute (NHGRI) Encyclopedia of DNA Elements (ENCODE), the US National Institutes of Health (NIH) Epigenomics Roadmap, and the International Human Epigenome Consortium (IHEC) are research projects directed toward the task of describing the human ‘reference epigenome’, that is, the ‘methylome’, the ‘histone acetylation code’ \textsuperscript{24}—considered to be the main portion of a larger ‘histone code’—and the ‘non-coding RNAome.’ The expected result of these research groups aims towards a greater understanding of the role of epigenetic mechanisms in normal human functioning and the development of disease. The aforementioned studies are anticipated to produce a list of detrimental epigenetic variants that may offer causal relations between living conditions and health/disease. By plotting these ‘harmful’ variants, these research studies control what a
‘reference’ or ‘normal’ epigenome is, that is, what epigenome is related to health or at least not related to particular diseases. Additionally, this might yield results related to some promising preventive and therapeutic prospects—and consequently its possible implications for assigning new responsibilities for epigenetic health.\(^{145}\)

At least three biological characteristics of the human epigenome contribute to making its characterization a very overwhelming task when compared with Human Genome Project represented 20 years ago. First, in contrast to genomic information which is exceptional and ever-present in all the cells of an organism, each cell line—therefore every tissue and biological system—has its epigenome. Second, the many epigenomes of an individual are comparatively plastic and subject to numerous alterations that depend on several factors (e.g., prenatal environment, lifestyle, age).\(^{146}\) Contrasted with genetic modifications, epigenetic modifications are very dynamic biochemical reactions, this is often called the plasticity of the epigenome. Simultaneously, it is increasingly documented that several epigenetic variants are very constant over time and that they can be transferred to daughter cells through mitosis or even to forthcoming generations through meiosis and embryogenesis.\(^{147}\) Epigenetic mechanisms depend on an assortment of enzymes, such as histone acetyltransferases, histone deacetylases, and DNA methyltransferases. Histone acetylation may last only a few hours, while DNA methylation may be persistent over a lifetime and may even be spread across generations. Moreover, noncovalent epigenetic mechanisms, such as RNA interference and histone addition, cause further diversity in levels of plasticity.\(^{148}\) Third, epigenetic variants interrelate with each other and are highly shaped by the microenvironment in which these exchanges take place. Considering these biological features, it becomes a very multifaceted attempt to name and identify the reference epigenome.\(^{149}\)
The mismatch model of disease development is another—perhaps bigger—challenge of describing epigenetic normality. Referring to this model, an adverse phenotype is not contingent merely on the presence or absence of a particular epigenetic variant, but somewhat on the mismatch between the formerly programmed variant and the person’s lifestyle or living circumstances. This implies that the initial programming of some distinct epigenetic patterns is responsive to the developmental setting and intends to better plan the organism for the setting it will most likely be encircled by in the future. The mismatch model of disease has been proposed to be responsible for the interpretation of the fact that a definite lifestyle can be more or less damaging to different individuals, contingent on the environment in which the early epigenetic programming happened.\textsuperscript{150} The mismatch model was validated generally by research on obesity. It was advised that the epigenetic programming of obesity-related genes during fetal development was affected by the accessibility of nutrients in the womb during pregnancy; low nutrient accessibility would result in programmed augmented effectiveness of the body for storing calories in the lipid tissues later in life, to enhance their consumption and use. Afterward, if the environment transforms during the life course and nutrients become more accessible, this epigenetic programming may become unfavorable and may cause an increased risk of obesity and its correlated metabolic syndromes. consequently, epigenetic programming can be seen as an active biological mechanism that intends to develop an individual’s ‘fit’ to its environment. On the other hand, this programming can convert to a maladaptive one when the environment changes and thus become damaging to health.\textsuperscript{151}

4.II.C. Epigenetics and the Environment
Features of Epigenetic Changes
Current advances in the field of molecular epigenetics are altering the traditional understanding of genetics and the influences that affect human growth and health. The origin of
the word ‘epigenetic’ is often credited to geneticist and philosopher Conrad Hal Waddington, who in 1942 used it to label the ‘subdivision of biology which studies the fundamental connections between genes and their products, which bring the phenotype into existence.’ The study of the strictly linear nucleotide structure of DNA, exemplified by the mapping of the human genome in 2003, changed into the research of gene expression control methods—interpretation of genes and succeeding creation of associated proteins. This then increased the interest of several scientists in the field of molecular epigenetics; the study of biochemical modifications that change chromatin structure and gene expression. Epigenetic modifications have a crucial consequence on the variability of gene expression amongst persons and based on diverse situations. Contrasting the genetic code, the linear arrangement of the nucleotides A, G, C, and T— which is constant and whose variation is mainly described by random mutations, the epigenome is directly affected by environmental factors. Epigenetic modifications can be categorized into three main types, dependent on the kind of chemical modification they involve:

1) DNA methylation

2) chemical modification of histones,

and 3) interference at the RNA28 level.

The three-D structure of chromatin and gene expression are strongly controlled by these modifications. Therefore, the genetic code is not the only biological factor of the individual; differences in environmental exposure play a critical part in shaping gene expression, protein synthesis, and disease development in people. Unlike the genome sequence, which remains fundamentally constant throughout life, the epigenome may be transformed by environmental exposures. Additionally, a change initially
triggered by environmental exposure (such as diet, ionizing radiation, tobacco smoke, air pollution) may be transmitted to offspring for an unspecified number of generations.\textsuperscript{154} Epigenetic changes are formed through numerous biological processes, including methylation, acetylation of histone proteins, transposable elements, RNA interference, and imprinting. These processes impact the timing and number of gene products. Epigenetics disturbs the expression of certain genes.\textsuperscript{155} For instance, methylation suppresses gene expression; more methylation means less gene expression. This might cause harm or benefits, and this depends on the type of gene affected. Methylation changes are heritable both from an ancestor cell to its progeny cells through mitosis (cell division) as well as from a progenitor organism to its progeny organisms through meiosis (sexual reproduction). Consequently, epigenetic effects caused by methylation may be transgenerational, which results in the heritability of acquired characteristics.\textsuperscript{156}

To this date, epigenetic biochemical modifications have been discovered to be included in normal development (cell differentiation, extinction of chromosome X), an adaptive response to the environment (stress resistance, personality traits), and in the development of pathological phenotypes. Some research studies have confirmed the influence of environmental toxicity (heavy metals) on epigenetic processes, and the interference of these mechanisms has been linked with diseases such as cancer, hypertension, type 2 diabetes, and asthma. Psychological disorders such as bipolar disorder, schizophrenia, and Alzheimer’s have also been associated with transformed epigenetic mechanisms.\textsuperscript{157}

The Barker effect is one broadly acknowledged evidence of the effect of the environment on gene expression and the development of disease. It displays that one’s distinct history of nutrition and exposure to environmental toxins is biochemically carved in gene expression pathways and that humans somehow hold this ‘biomemory’ of the close biochemical connection
with the environment. A few research studies in molecular epigenetics are now starting to assist in identifying the biochemical pathways behind this biomemory. For example, an analysis of the methylation of the gene Ifg2 in individuals whose mothers lived through the Dutch Hunger Winter in 1944–45 found that a deficiency in maternal caloric consumption influenced the methylation pattern of their children 60 years later. Another study has revealed that exposure to pollution (diesel exhaust) and allergens (aspergillum fumigatus) can cause abnormal methylation of genes, triggering inflammatory lung hyper-reactivity in the first generation, and uncommon patterns of methylation of other genes linked with asthma in the second generation.

Several studies have found that some cancers and common diseases are regulated both epigenetically and genetically. At this point, researchers are uncertain of how several substances produce epigenetic changes; whether fundamental factors can be identified. Answers to such questions can be investigated through the interpretation of the fundamental mechanisms of epigenetic regulation associated with age, diet, lifestyle, environmental toxicity exposure, and other factors. Nevertheless, the gene-specific DNA methylation linked with cancers and common diseases is now being explored for possible use as biomarkers for molecular diagnosis, prognosis, and forecast of clinical receptiveness of disease treatment. With retrospective studies of DNA methylation patterns and the availability of screening and analytical methods, the list of methylated genes as biomarker options is constantly increasing. Nevertheless, clinically applicable biomarkers to detect diseases are still inadequate. One prominent finding is that a methylation biomarker for colorectal cancer has a seventy percent precision rate in finding cancer in patients. Nowadays, there is no FDA accepted DNA methylation-based molecular test kit for diagnostic functions. In the meantime, epigenetic therapies are being launched to reverse gene deactivation due to abnormal DNA methylation. The first FDA-approved hypomethylating
agent drug is 5-azacytidine is the to cure myelodysplastic syndrome, a disease involving abnormal gene promoter hypermethylation events.\textsuperscript{160}

With better consideration to the role of epigenetics, a more comprehensive image will show the all the causal factors that affect the occurrence of complex diseases, involving but not limited to the genetic elements of health.\textsuperscript{161}

\textbf{Molecular Epigenetics: Linking the Environment to Gene Expression}

Over the past few years, there has been a paradigm change in the knowledge-gene expression. More specifically, there has been acknowledgment that mechanisms occur for the transmission of hereditary changes in DNA expression that do not include mutation of the DNA coding per se.\textsuperscript{162} This manifestation is known epigenetics, defined as the structural change of chromosomal areas to register, signal, or disseminate transformed activity conditions.\textsuperscript{163} Epigenetic alterations in gene expression are fundamentally accomplished by the addition (or deletion) of an array of small molecules to the DNA and/or to the proteins within the histone complexes, around which the nucleic acid is enfolded. For example, methylation of the DNA at “CpG islands”, positioned adjacent to the transcription start site for a gene can influence whether or not it is expressed in specific cells. Histone proteins can be changed through post-translational methylation, sumoylation, acetylation, or ubiquitination.\textsuperscript{164} All these modifications can be reversible; environmental influences (such as in utero exposure to biomolecules) are known to affect gene expression via epigenetic modifications.\textsuperscript{165}

Over the previous decade, epigenetic studies have been offering more indication of the molecular interaction between gene expression and its health results on one end, and the social and physical environments in which people are conceived, born, and live on the other end. As a consequence of a better understanding of the associations between gene expression, lifestyle,
living conditions, and health, anticipations of medicine and public health have been raised. As a result, this relatively new field of epigenetics has recently urged some researchers to question the likely inferences of this new scientific information regarding moral duty related to health.\textsuperscript{166}

There are many practical examples to support the significance of social determinants on health. For example, poverty in childhood greatly forecasts unhealthy habits as a grownup.\textsuperscript{167} Current studies on epigenetics have extended the range of the effect that environmental factors have on health. The health of an individual is a multifaceted interrelated effect of interconnected systems involving genetics, epigenetics, social structures, and personal choices. Regarding the last factor (personal choices); nevertheless, as Daniel Wikler comments, personal actions only barely have all the characteristics that are essential for entire personal accountability because they are rarely entirely informed, voluntary, uncoerced, and thought. Holding people exclusively accountable for their own health is not a rational conclusion because some elements of health are outside the person’s control. Many of these can be reinforced or countered by social and public policy decisions.\textsuperscript{168}

The normative justifications of epigenetics do necessitate a good bioethical consideration, especially given its possible influence on the political concept of the family and its connection to social justice. Epigenetics opens a much broader array of opportunities for health involvement compared to genetics. In opposite with genetic mutations, unfavorable epigenetic variants may be more easily avoidable or treatable, since they are plastic and reversible. In addition, genetics are mainly controlled by biological inheritance—where individuals and society have little straight influence—a greater and better compression of epigenetic programming could suggest new prospects to expand and enhance individual and public health, and therefore more influence and control on one hand and new duties and responsibilities on the other hand. Henceforward, it
discloses a group of moral agents (such as people, parents, corporations, governmental agencies, international organizations) that could to some extent be held morally accountable for epigenetic health, and consequently significantly widening the range of possibilities for holding these agents accountable for voluntary negligence when it results in epigenetic harm to others.¹⁶⁹

There are many ethical dangers of assigning the epigenetic duty to individuals, or defining epigenetic responsibility to the government is distorting because it is simple as it encloses the tension of the debate between the state and the citizens, whereas other actors may have an important role to play (such as corporations, international organizations. Moreover, it is ethically challenging in the sense that assigning epigenetic tasks entirely to the State fails to identify that over paternalistic health policies might turn into forced measures that greatly compromise individual autonomy.¹⁷⁰

4.II.D. Epigenetics: Some Implications to Bioethics

Epigenetics: New Insights Toward the Social Responsibility for Bioethics

Though the term ‘bioethics’ was first employed by Van Rensselaer Potter, a biochemist, and professor of oncology at the University of Wisconsin, in the early 1970s, to highlight the relationship of ecology, medicine, and human values, the concept promoted by Andre Hellegers, a physician and professor of obstetrics, physiology, and biophysics at Georgetown University, and colleagues at Georgetown University encompassed narrow biomedical importance. Hellegers’ idea envisioned to concentrate on the actual moral ‘problems’ confronted by health professionals, such as the rights and duties of patients, health professionals, researchers, and research participants, and the ethical questions connected to health policy. According to Reich, Potter’s vision was perhaps condensed due to the limited medical setting of the time. In the 1970s, topics such as the right to die and patient autonomy were dominant, while inquiries associated with public health and protecting the environment were still developing. According to
Potter’s vision, bioethics should have founded a wider area of debate that combined the connection between humans and nature and the effect of this relationship on health and the future of humankind.\textsuperscript{171} In the late 1980s, Potter attempted to combine biomedical ethics with environmental issues using the notions of ‘acceptable survival’ – denoting sustainable means of living for humanity – and ‘global bioethics’ to link environmental issues within bioethics discourse.\textsuperscript{172} Potter founded a concept of bioethics that comprised a central notion of some kind of sense of responsibility on the part of human beings as vibrant members of a universal system that is the biosphere. Based on this vision, people should be responsible for the multitude of environmental factors of health.\textsuperscript{173}

Genetic and other biomedical advances focus almost entirely on individuals, their options, and their features and disregard the multifaceted environmental and social context. Although the social factors of health are rarely discussed, and these in conjunction with social responsibility are left in the margins. This means that the subsequent bioethical deliberations are established, at least implicitly, on an inadequate social theory of health. Thus, bioethicists should seek to find the link between the individualistic approach of bioethics and the social dimensions of health.\textsuperscript{174}

Suggestions would entail necessitating political and economic decision-makers to reject the discussion of individual accountability for health and to undertake, instead, have a more social mindset toward resolving problems that are mainly caused by social phenomena.\textsuperscript{175} Ethics always has dealt with such issues. The history of ethics in Western nations is rich with such examples. For Plato, the moral life of persons was a minor reflection of the moral life of the whole nation; for Aristotle, ethics was the introduction to politics, where protecting the good of the community is of great importance.\textsuperscript{176} Bioethicists have not established a satisfactory social
theory; nevertheless, many issues push bioethics onto these paths such as renewed worry over the ethics of genetics, the organization and funding of health care, and the promotion of public health cannot be practiced without a more vigorous comprehension of social ethics.\textsuperscript{177} The latest findings and research in epigenetics expand our understanding of how individual health is affected by primary developmental events and previous generations’ environmental settings.

Many legal and ethical topics are induced by epigenetics, particularly those related to individual and societal responsibilities to stop toxic exposures, monitor health status, and offer health care services. Epigenetics signifies a new class of biological effects from harmful exposures and adds a multigenerational aspect to environmentally-caused adverse health effects. Epigenetics serves to emphasize the effects of inequality in living and working conditions, as well as a range of disparities in access to health care and other societal outlooks. Finally, epigenetics raises difficult questions about the responsibilities of society to preserve the wholeness of the human genome and epigenome for the sake of future generations.\textsuperscript{178}

Three characteristics of epigenetic traits that make them important for a normative study of health inequalities:

- **Sensitivity to social structures**: Some epigenetic phenomena are extremely receptive to environmental changes, which are affected by social institutions.
- **Early programming**: Several epigenetic qualities are recognized early on in development, and their consequences on health develop through the life course.
- **Trans-generational transmission**: There is evidence in both animal models and epidemiological studies that epigenetic traits can be transgenerationally heritable.\textsuperscript{179}
Epigenetics offers new data that should assist as an additional explanation for developing the range of bioethics to encompass public health and environmental concern.\textsuperscript{180} The fairly new field of molecular epigenetics offers new evidence that should assist as extra justification for widening the extent of bioethics to comprise public health and environmental issues.\textsuperscript{181} The scientifically evident effect of the environment on epigenetic mechanisms offers a supplementary argument – at the molecular level – for the better manifestation of the environment as a significant element of health. Moreover, it increases the scope of analysis of justice in bioethics to contain environmental deliberations. Living conditions directly affect the regulatory mechanisms of gene expression and can cause epigenetic alterations that may be inherited.\textsuperscript{182}

Molecular epigenetics highlights the importance of considering the external factors affecting a system (the human body system in this case) in the resolution of a systemic dilemma, a health disease in this case. The close biochemical interaction between genes and environment, explained by recent scientific research in epigenetics, illustrates the ecosystemic connection that human beings are part of.\textsuperscript{183} The genome forms the biological features that humans are born with and are largely unchanging. However, the epigenome is a biological element that contains multifaceted and dynamic relations with the environment. In this context, molecular epigenetics implies the essential need to adopt more complex perspectives of bioethics. While epigenetic asserts the direct effect of the environmental factors on individual health, it also emphasizes the capacity and limits of individual responsibility, and thus the obligation for shared action and community accountability. Individuals may be partly accountable for actions that health of others, due to pollution for instance; nevertheless, they have partial individual control and responsibility. Therefore, blaming the underprivileged people for being undernourished or for living in toxic settings is not an option. Yet, individuals through joint action can lobby decision-
makers, governments, and healthcare organizations to solve environmental problems that are revealed to have an adverse consequence on the epigenome and health; the obligation of municipal clean air protocols is one example. Due to the close association between introduction to epigenetic risk influences and questions of social justice, bioethicists need to widen the extent of bioethics reflection about justice, a scope that is more articulate with the extremely complex and interconnected character of human health.¹⁸⁴

**Epigenetics and Health Justice**

There are some public health inferences of epigenetics when presenting epigenetic mechanisms within the wider context of the social factors of health inequalities. For example, the frequency of some diseases is negatively associated with socioeconomic status (SES), as measured by income, wealth, and educational level, and separately from the universal public delivery of health services. This noticeable epidemiological occurrence is exemplified by the city of Glasgow, UK, where people in the underprivileged districts expect to live 12 years less than their counterparts in the richest areas of the city.¹⁸⁵ Poverty clarifies only a fraction of these differences: a steady slope of health results across social classes has been observed for various conditions, even amongst groups that are entirely above the verge of poverty.¹⁸⁶

The accumulation of several factors contributes to the establishment of social health inequalities such as material (e.g. poverty), behavioral (e.g. diet), biological (e.g. blood pressure), and psychosocial (e.g. stress).¹⁸⁷

Several features of epigenetics raise thought-provoking and significant ethical concerns, including the following:
1. Environmental justice. Epigenetic effects have been associated with exposure to several toxic chemicals, airborne pollutants, pesticides, and other harmful substances. Several of these exposures are associated with poverty and inferior working and living conditions. Simultaneously, many people with such exposures are medically vulnerable because of previous conditions and poor clinical management. Therefore, epigenetics emphasizes the need to consider the association between environmental exposures with health effects as well as wider social issues in the differential health risks from several exposures and co-morbidities.

Epigenetic effects have been associated with exposure to several toxic chemicals, airborne pollutants, pesticides, and other elements. Several of these exposures are linked with poverty, unfair land use, and inferior working conditions. Moreover, several people with these harmful exposures are deemed as medically vulnerable due to pre-existing health conditions; which are normally confounded by poor clinical management. Both the introduction to environmental hazards and the social, dietary, medical, and mental pressures of low-income groups can cause epigenetic changes that place unprotected populations at augmented risk. Thus, epigenetics offers new insights for understanding and probably tackling the comorbidities related to various environmental exposures.

Environmental justice also is linked to issues of economic justice, human rights, social equality, and public health. It is disputed whether evolving scientific evidence of epigenetic effects, including transgenerational effects, will be a facilitator for environmental justice.

The influence of epigenetic changes can be transferred to the next generation, provoking worries about transgenerational effects. Current studies have acknowledged that epigenetic
changes can occur as the outcome of introduction to environmental contaminants such as cigarette smoke, arsenic, alcohol, benzene, dioxin, phthalates, BPA, DES, as well additional hazards. Excitingly, other studies show that nutrition, methyl content of the diet, consumption of folic acid and vitamins, or even social and maternal conduct towards children have epigenetic significance. Given the new records from epigenetic studies, it is proper to reflect on the ethical associations of epigenetics. The escalating appreciation of the effect of development on epigenetics will have a thoughtful result on our ethical reasoning and assessment of possible adverse effects. Therefore, the concept of epigenetics offers the scientific and biological groundwork for the requirement of “doing good”. This notion is called “epiprecaution” to indicate the requirement to move above and beyond preventing exposures to harmful material but to one that is nurturing and supportive.¹⁹²

There are both epidemiological and investigational (e.g. animal models) indications of transgenerational effects due to epigenetics phenomena. The public health inferences of these findings are being researched by epidemiologists who try to find and comprehend the significance of population-wide environmental introduction and assess the wider results of public health interventions, involving their long-term effects on future generations. Epigenetics aids epidemiologists in offering a clear and longer-term picture of the effects of the environment on disease risks, providing significant influences for public health policymakers when planning and implementing strategies for population health.¹⁹³

Therefore, epigenetics highlights the consequences of inequality in living and conditions and further adds a multigenerational aspect to environmentally triggered adverse health effects. Epigenetic research emphasizes the importance of societal responsibilities in preventing hazardous contacts, screening health status, and delivering treatment.¹⁹⁴
2. Equitable Access to Health Care

Greater understanding of the link between environmental exposures and epigenetic effects will broaden the significance of unprotected people receiving health services for prevention, supervising, and treatment. Unfortunately, several of the people most possible to live and work with risky exposures (e.g., indigent, minority) are among the least possible individuals to have consistent, timely, and all-encompassing access to health care. Therefore, the subject of access to health care for individuals subjected to substances probable to induce epigenetic harms is simply a subsection of the topic of access to health care for vulnerable populations.\textsuperscript{195}

One of the strongest arguments is that health care endorses justice by stopping health difficulties that would damage the optimum performance and functioning of healthy individuals and by reestablishing unhealthy persons to a state similar to the societal standard. health care prolongs life, lessens suffering, delivers data and pledge, and advances the quality of life. Nonetheless, it has one major and significant function that overrides significance for purposes of justice: it sustains, reestablishes, or compensates for the loss of functioning. A just society must not permit future generations to experience the devastating health effects triggered by existing environmental exposures especially when the health outcomes are known and the environmental settings are avoidable or remediable.\textsuperscript{196}

\textbf{Conclusion}

Several studies have found that some cancers and common diseases are regulated both epigenetically and genetically. At this point, researchers are uncertain of how several substances produce epigenetic changes; whether fundamental factors can be identified. Answers to such questions can be investigated through the interpreting of the fundamental mechanisms of epigenetic regulation associated with age, diet, lifestyle, environmental toxicity exposure, and
other factors. Nevertheless, the gene-specific DNA methylation linked with cancers and common diseases is now being explored for possible use as biomarkers for molecular diagnosis, prognosis, and forecast of clinical receptiveness of disease treatment. With retrospective studies of DNA methylation patterns and the availability of screening and analytical methods, the list of methylated genes as biomarker options is constantly increasing. Nevertheless, clinically applicable biomarkers to detect diseases are still inadequate. One prominent finding is that a methylation biomarker for colorectal cancer has a seventy percent precision rate in finding cancer in patients. Nowadays, there is no FDA accepted DNA methylation-based molecular test kit for diagnostic functions. In the meantime, epigenetic therapies are being launched to reverse gene deactivation due to abnormal DNA methylation. The first FDA-approved hypomethylating agent drug is 5-azacytidine is the to cure myelodysplastic syndrome, a disease involving abnormal gene promoter hypermethylation events.

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Chapter 5: Systems Approach in Organizational Ethics

I. Social Responsibility

The challenge for the health care sector, the government, medical profession, health care provider, as well as for health care business managers, is to continually explore ways to ensure that the welfares of individual patients remain the utmost primacy and promote health care equity via corporate socially responsible activities. There is an essential need to truly embrace corporate social responsibility (CSR) and ethical principles that would promote equal distribution of health care resources. Relevant CSR activities would be achieved by making the most significant health problems in a given society the uppermost priority of health care organizations.

5. I.A. Organizational Ethics
The Moral Status of Organizations

Organizational decisions are taken by the employees, with various particular roles, on behalf of the organization to represent its mission and purpose. Health care organizations (HCO) are granted the same official rights as individuals and are treated as legal persons under the law. This implies that these institutions have legal obligations and moral obligations as well. HCO are moral agents in several senses:

- Like individuals, they have organizational goals that are detailed in their mission statements.
- Organizations act, like people, but their decision-making processes are formed by a group of people rather than an individualistic decision.
Organizations, just like persons, are normatively assessed. They have moral responsibilities and are anticipated to meet them. Organizations are judged on how well they treat their employees and how well they achieve their mission.²

It cannot be argued that organizations are full-fledged moral agents. The actions of the organization depend on the individuals who collectively make decisions. These individuals are also accountable for organizational action. They, however, act as agents for the organization deriving their direction from the mission and objectives of the organization. In summary, organizations are moral agents, like individuals, who can be held morally responsible, yet they are different from individual moral agents because they do not make choices and act.³ Therefore, institutions are exposed to several ethical expectations by society.

**Stakeholder Theory**

This theory considers the interests and rights of the comprehensive range of individuals and organizations who cooperate with and are affected by business decision-making. It emphasizes the role of various stakeholders in the long term and the success of the organization. This theory is important to business ethics because it recognizes many values and moral agency on diverse levels. A stakeholder is any individual or group of people whose role is essential to the survival and well-being of the organization or cooperation. Stakeholders are mostly affected by the cooperation or organization and its activities and guide it in defining objectives and mission. Management, employees, shareholders, customers, suppliers, society, and the community are examples of stakeholders.⁴

This theory argues that the goal of any organization or company is to prosper the firm and all its stakeholders. It implies that profit maximization is not a problem in itself; it only becomes an issue if managers give profit-maximizing actions a preference over activities that promote the
well-being of primary stakeholders including society. The theory challenges the argument that a manager’s chief obligation is to maximize profits and encourages the firm to coordinate stakeholder interests. The father of stakeholder theory, R. Edward Freeman, believes that the corporations and stakeholders have reciprocal relationships in the sense they can affect each other in terms of benefits and harms and terms of duties and harms.

5. 1.B. Corporate Social Responsibility: Past and Present

Background History of CSR

While CSR was broadly examined in the last forty years of the twentieth century, the notion that business has social responsibilities was apparent at least as early as the nineteenth century. In Britain, idealistic business managers as the result of the Industrial Revolution built factory towns, such as Port Sunlight (founded by William Lever in 1888), which was planned to offer employees and their families accommodation and other facilities when various parts of the newly industrialized towns were slums.

Early examples of CSR referred to obligations above and beyond economic and legal responsibilities and CSR was mostly identical to philanthropy, and there was difficulty distinguishing business philanthropy from individual philanthropy. The 1960s saw the spread of the CSR notion when researchers started to focus on it and define it. Philanthropy was met with improvements in terms of the employee as well as customer relations. The following period mainly highlighted the role of management, the need to estimate, plan, and shape CSR as well as evaluate social performance. During the 1980s, a sequence of ethical disgraces affected the public view, and the CSR topic was carried to the public and communities. In the 1990s, the CSR notion was highly accepted and companies with good reputations were known to have good CSR practices. Nowadays, CSR is known as a rising business strategy that companies are integrating
into their core activities, plans, and operations. With such growing consideration, and despite some enduring unwillingness from the management to entirely embrace the model, CSR is predicted to further improve in strength and significance, becoming a central management issue of the 21st Century, and ultimately a part of standard business practice.\(^\text{10}\)

**CSR: Present Day**

Many factors including economic and social globalization, scientific and technological development, and better access to information emphasized the fact that ethical behavior and social responsibility are vital to an organization’s practices. Social responsibility should tackle and meet other stakeholders’ interests while simultaneously increasing shareholders’ profits.\(^\text{11}\) Re-interpreting the view of social responsibility means that an organization should not only accomplish its economic and legal requirements but also dynamically contribute to the social good.\(^\text{12}\)

Legal regulation is an essential condition for respectable corporate social performance but an inadequate one. Legislation and its application confirm the legality of management decisions.\(^\text{13}\) National and international laws associated with social responsibility are already used, but law by itself is inadequate to endorse such ethical conduct. Certification of social responsibility under international norms—Social Accountability SA 8000 and ISO 26000 are international norms that plan to apply better work settings based on the principles of the International Labor Organization, the United Nations Convention on Children’s Rights, and the Universal Declaration of Human Rights.\(^\text{14}\) Companies must adhere to a legal and ethical framework regarding business then manage and implement CSR initiatives and activities.\(^\text{15}\) The World Business Council for Sustainable Development (WBCSD), a coalition of 120 international companies, asks the business to undertake broader duties in the social area and asserts that CSR
is decisively on the universal strategy agenda. The International Business Leaders Forum (IBLF), Business for Social Responsibility (BSR), and Business in the Community (BITC) are organizations that are promoting greater consideration to CSR.

CSR is thought of as an enduring responsibility demanding organizations to act ethically. Simultaneously, they should support the financial strength of the organization, which would ultimately improve the quality of life of employees, their families, and the community. The number of organizations that carry out socially responsible behavior is greatly increasing, meaning that citizens, and investors, are deeply aware that profit and ethical values are compatible. Embracing socially responsible conduct can be tactical worldwide, contributing to the competitiveness of a company and protecting its reputation and brand image. CSR is achieved only if a new model of corporate governance is put in place that uses internal mechanisms of control and takes into account the public and stakeholders’ accountability.

CSR is supported by theories that signify organizational decisions and activities influence more than just stockholders. This perspective believes that the duty of a manager goes beyond making wealth; it also includes guarding the welfare of the environment, the community, and society as a whole in which the organization operates. Carroll suggested a Pyramid of Corporate Responsibilities that had economic duties at the bottom of the pyramid, then legal responsibilities, then moral responsibilities, which meant doing what is right, just, and fair, and avoiding or minimizing harm to stakeholders, and finally, on the peak, philanthropic responsibilities, which refers to contributing to refining the quality of life in a community.

5. I.C. Corporate Social Responsibility

CSR Concept
There are many definitions for CSR; all imply that CSR is influential to the achievement of a firm’s purposes such as profit maximization, long-term success, and survival. Davis argued for the importance of socially responsible decision-making. Johnson (1971) affirmed that social responsibility was compulsory since businesses needed to balance various stakeholders’ interests and benefits to confirm the accomplishment of several goals and long-run profit maximization. In 1973, Davis argued businesses and organizations will ultimately lose the power and legitimacy granted by society if they do not behave socially responsibly. This idea gained support from many researchers who started to argue for a normative approach to CSR. Researchers emphasized that organizations and companies have moral obligations and have to meet societal expectations, as they are similar to individual moral agents.23

For this research, CSR is defined as a business approach that generates long-term shareholder value by taking up opportunities and managing risks originating from socially responsible decisions.24 Early subjects in CSR conceptualization highlighted the fact that business volunteerism was important to accomplish social responsibilities duties. Moreover, CSR was regarded as a business cost that might adversely impact affect the bottom line. Nevertheless, the emerging pattern that visions CSR and shareholder wealth as harmonizing goals is driven and inspired by a different school of thought. Drucker (1984) was the first to argue that social opportunities could be transformed into business opportunities. He suggested that businesses can turn social problems into economic benefits.25

**CSR and Health Care Organizations**

For HCOs, the new consideration for CSR should take into consideration the global vast poverty-related health challenges. Nowadays, society expects more from corporations and organizations due to hard social and economic realities. They expect businesses to have a
responsibility to stakeholders, society, and future generations. Since these expectations are different, the business enterprise or organization should identify, analyze, and prioritize the stakeholder demands to establish a realistic and practical corporate duty. The social, health and environmental problems facing global society today suggest that more and different responsibilities have been allocated to other actors, including corporations.\textsuperscript{26}

Many leading stakeholders in health care hold the research-based pharmaceutical companies accountable for the deaths of millions of people living in poverty because such companies retain their prices for life-saving medicines high. These companies consider financial profits more important than human life. It is noteworthy to note that many actors are responsible for social problems, and they all share a duty to contribute to society prospering. Duty refers to definite responsibilities stakeholders are bound to respect and follow. Each stakeholder has a particular duty depending on its role. However, the assigned responsibility has to be limited and definite, adapted to each stakeholder’s resources and role. The important responsibility of any health care organization or pharmaceutical company is to enlighten itself about its effect on society's numerous needs and objectives and to be thoughtful and responsive to the demands of stakeholders. Through this tactic, the business enterprise or organization will have a practical and defined social responsibility that is based on corporate values, resources, technical know-how, and enlightened leadership.\textsuperscript{27}

There are three types of CSR:

- Required of business by society-the "must-do" aspect of social responsibility. This aspect is required for a corporation's sustainable existence. Examples include the delivery of products or services in good quality and at a fair price, compliance with laws and regulations, employment at fair and living wages and in decent working conditions,
profit-making, and wise strategic decisions. For pharmaceutical companies, which are seen as the primary drivers of globalization and its main beneficiaries, are highly expected to accomplish responsibilities that go beyond what laws require—such as correcting vulnerabilities. Moreover, they are expected to aid in donations in cases of an acute emergency and perform differential prices for patients in poor countries.\textsuperscript{28}

- Expected of business by society the "ought to do" aspect of social responsibility: this is less binding than the first obligation, but it equates to "good corporate citizenship". Examples include extra-legal obligations like avoiding questionable practices and being fair and responsive to legitimate concerns of fair-minded stakeholders as well as working legitimately beyond legal requirements where local legal conditions do not meet enlightened standards, such as concerning social and environmental conduct. This dimension relates to the ten principles of the United Nations Global.\textsuperscript{29}

- Desired of business by society—the "can do" aspect of social responsibility, the self-actualization of which justifies public praise. Examples of the "can do" dimension include corporate philanthropy, community and neighborhood programs, volunteerism, and donations. “Desirable" actions cover a dimension of social responsibility that is neither required by law nor by standard industry practice. Delivery on the "can-do" norms of social responsibility will not protect a company whose actual operations do not comply with the law or other aspects of the "must-do" dimension. However, this dimension can offer people substantial social and other advantages. Examples include free training opportunities using company structure, scholarship for children in low-income groups, psychosocial care for employees with specific diseases. Corporate philanthropy, expenditure beyond a corporation's concrete.\textsuperscript{30} Business activities without any direct
relation to corporate gains and any financially computable rewards in return. HCO and pharmaceutical companies, possessing both financial capital and knowledge and experience, can donate medications for poor people or treat disadvantaged vulnerable people. 31

5. I.D. Central Ethical Values and Obligations of Health Care Organizations

Ethical Values of Health Care Organizations

Health care organizations' ethics have three intertwined but distinct scopes. The first is the expression of the moral compass for the organization referred to its mission, vision, and values. The Chief Executive Officer should also play the role of Chief Ethics Officer. The second dimension relates to the critical ability in identifying ethical challenges and solving them in methodical means. The third element relates to the practical implication and integration of organizational ethics through the management process.32

On one hand, compliance relates to meeting regulatory and legal requirements and it aids the organizations in reducing the risk of severe punishments. Such programs are obligatory and are usually recognized by top management. On the other hand, ethics programs are optional and dedicated to important standards and values. Ethically admirable organizations must hold a deep set of values applicable to the promotion of health and care of the sick and must be skilled at dealing with conflicting values that arise in health care. Organizational ethics refers to an organization’s attempts in defining its core values and mission, seek the best possible resolution of struggles, and run its functions to confirm that it acts according to the defined set of values. The scarcity of resources in the health care sector drives organizations to set significance in a way that is both ethically justifiable and clinically sound.
Madison Powers and Ruth Faden in their book, Social Justice, set up ethical motives for why all human beings have a right to well-being. They define the six fundamental dimensions of well-being: health, personal security, reasoning, respect, attachment, and self-determination. It is proposed that governments, NGOs, and businesses have a synergistic responsibility to deliver these aspects. Pharmaceutical companies create medicines and therapies to help alleviate suffering while increasing profit. Yet, these companies, if they are to be morally ethical according to Powers and Faden, should play an active part to help access medicine for the impoverished people around the globe. This could be achieved in many ways including making new treatments for neglected tropical diseases (NTDs), offering free drugs to poor communities, providing donated goods to disadvantaged regions, offering low-priced price structures for critical medicines, grant transitory patents to external companies to make life-threatening drugs.

It is important to note that the health care sector cannot solve the underlying causes of poverty, however, the social circumstances for human health are more accountable to global economic organizations ranging from the World Bank and IMF to international governments who work within this international economic structure. Thus, a partnership of the pharmaceutical companies and hospitals with governments, international institutions, NGOs might achieve social and health equity.

**UNESCO Article 14: Social Responsibility and Health**

The Report of the International Bioethics Committee of UNESCO on Social Responsibility and Health has addressed this idea of social responsibility in the framework of health care delivery proposing a new standard in hospital governance. The scope of this responsible behavior necessitates hospitals and other healthcare organizations to accomplish their social and market goals, based on law and general ethical standards. The report proposes that social responsibility should be considered a moral obligation to create organizational value.
The originality and the significance of this article are that it openly broadens the concept of social responsibility, applying it not only to the private sector but also to the public sector and governments to fulfill the full recognition and deliverance of health care as a right to everyone based on universal ethical principles.\textsuperscript{38}

Julian Huxley, the first Director-General of UNESCO, stated that to make science play a part in creating peace, security, and human wellbeing, it was obligatory to correlate the uses of science to values.\textsuperscript{39} This highlights the principle of social responsibility and health, which aims at re-arranging bioethical decision-making in the direction of crucial concerns of several countries (such as access to quality health care and critical medicines).\textsuperscript{40} Governments aim to promote health and social development for their people. Progress in science and technology should also increase the access level to quality health care and essential drugs, nutrition, and water. Progress in science and research should also be associated with the progress of living conditions and the environment; and reduction of poverty and illiteracy rates\textsuperscript{41}. Despite the increase of new medicines and technologies, there are many global health concerns. Thus, social responsibility actions will contribute meaningfully to a decrease of inequities in health, promote human rights, and construct social capital. However, accountability and commitment and the consistent performance of professional responsibilities in the chase of social goods are always major concerns.\textsuperscript{42}

Some recent international efforts to meet the needs of the unfortunate include improved health, which also was included in the eight UN Millennium Development Goals (MDG). This includes halving poverty, halting the spread of HIV and AIDS, and offering worldwide primary education. The UN concrete action plan emphasized the fact that extreme poverty is indicative of a globe of insecurity because poverty, inequality, and disease are some of the main grounds for
violent struggle and civil war. The Millennium project assumes that the health care sector including hospitals and the pharmaceutical industry already has the technology and know-how to solve the majority of the problems faced in poor and developing countries. The goal was to achieve the following eight goals by the year 2015:

- Eradicate extreme poverty and hunger.
- Achieve universal primary education.
- Promote gender equality and empower women.
- Reduce child mortality.
- Improve maternal health.
- Combat HIV and AIDS, malaria, and other diseases.\(^4^3\)

Development organizations have confronted the pharmaceutical industry to increase its efforts to tackle the health disaster affecting developing countries. They reflect that a socially responsible company should design, plan, and implement policies on access to treatment for developing countries which include the five significances of pricing, patent, joint public-private initiatives, research and development, and the appropriate use of drugs. They state that critical challenges continue, chiefly the issue of pricing. Recently, new projects of pharmaceutical companies have a purely charitable characteristic that will not generate profits. Examples include the new Institute for Tropical Diseases in Singapore for the discovery of drugs for HIV and AIDS and other prevalent diseases. These companies should make alliances with public, private, NGOs, international organizations, and civil society to address the elements of health in a globalized world through health research and progress.\(^4^4\)

5. I.E. Ethical Principles

**Principle of Justice**

Thomas Pogge elaborates on the moral duty of western societies and companies to deliver system transformation to alleviate some of the world’s prevalent human grief. In his
book, World Poverty and Human Rights, the comments on Articles 25 and 28 found in the United Nations Declaration on Human Rights: Everyone has the right to a standard of living satisfactory for both the health and well-being of himself and his family, including food, clothing, housing, and medical care.\textsuperscript{45} Pogge then clarifies an intuitive notion examining the current globalization and interconnections that necessitate universal justice principles in which everyone should accept and share. Therefore, social justice includes the human right to health based on the idea that health is a universal human right; there must be worldwide access to medicines.\textsuperscript{46} Hence, pharmaceutical companies and healthcare organizations have a moral responsibility to provide access to medicine for those who cannot afford them while achieving sustainable business ends.\textsuperscript{47}

Justice explains how social burdens and benefits should be distributed. The egalitarian theories state that people should receive an equal distribution of health care.\textsuperscript{48} Based on John Rawl’s principle of Justice, fair opportunity is vital to justice in the health care field. This implies that each person, regardless of his/her social status, should have equal access to a sufficient level of health care. There should be a right to a decent minimum\textsuperscript{49} of health care: basic health care and other health-related resources.\textsuperscript{50}

\textbf{Principle of Beneficence}
In addition to the justice principle, pharmaceutical companies and HCOs have an obligation to follow the principle of beneficence. In their Principles of Biomedical Ethics, Beauchamp and Childress describe beneficence as not simply kindness or charity, but a real obligation to support others and further their genuine benefits. Beneficence states that one should prevent harm, remove harm, and promote wellness.\textsuperscript{51} It is important to note that there is an embedded beneficence assumption in all health care professions; health education and vaccination
programs. HCOs have a moral responsibility to research medicines that can help those in disadvantaged regions, not just profit-driving medicine for Western conditions or lifestyle medications.\textsuperscript{52} Active social responsibility requires hospitals and other healthcare organizations to do something beneficial (out of beneficence duties) and not only abiding by the law or too broad ethical principles. This implies that the interests and values of all stakeholders are taken into concern.\textsuperscript{53}

5. I.F. Common Good

**Pharmaceutical Corporations & Health Care Organizations**

Pharmaceutical corporations and HCOs contribute to the common good. With their goods and services, they make different types of value-added for society. For instance, current medicines and therapies, aid in reducing death rates and preventing/curing diseases. Therefore, it is argued that successful HCOs increase the quality of life of the sick, minimize costly hospitalization through researching, manufacture, and distribute drugs of high social benefits.\textsuperscript{54} HCOs should pursue their ends by contributing to their society. They own the know-how, vast resources, expertise, and management talent to solve social problems that they fully comprehend both in the developing world and in economically deprived communities.

Creating shared value in practice by following a strategic approach to CSR, Porter argues that such strategic CSR efforts are fundamental to a company’s profitability, success, and competitive position.\textsuperscript{55} Therefore, HCOs with their embedded ethical values combined with their knowledge and resources should focus their CSR activities on solving health-related issues in local and international communities.

Clear and comprehensible efforts by individual actors’ governments, donors, NGOs, and the private sector are required to act based on each party’s skills, techniques, knowledge, and
assets. Thus, social corporate responsibility is also articulated by the readiness of the health care organization to cooperate with other parties. The pharmaceutical companies and HCO have an end that is achieved through its normal business activities like research, development, manufacturing, and selling pharmaceutical compounds to avoid premature mortality, to treat or lessen diseases, to avoid or shorten hospitalization, and to contribute to the quality of life of sick people.\textsuperscript{56}

The pharmaceutical industry and hospitals are heavily regulated, on national as well as international levels.\textsuperscript{57} This triggers much exacerbation and financial stress.\textsuperscript{58} In the field of health care, the ethical and socially conscious behaviors are both the community and professions' anticipation. CSR in the health care sector is different from CSR in other businesses because medicine and medical care are vital for the good being of humanity.\textsuperscript{59} Poor individuals cannot afford expensive medications due to the market and patent requirements, the absence of generics, or affordable changes to patented medicines. This truth has become intolerable in society’s eyes. In numerous polls, U.S. consumers rate the pharmaceutical industry as one of the most unethical businesses.\textsuperscript{60}

The health care sector, in general, is a sector where the thoughts of corporate commitment, liability towards patients, ethical performance, and an overall responsibility towards society are universal. David R Brennan, CEO of Astra Zeneca says, accountability is integrated into the strategy of pharmaceutical companies because it is significant to sustained success.\textsuperscript{61} In illustrating pharmaceutical CSR, Heal suggests programs run by the health care sector to respond to issues related to making drugs accessible at reduced prices to impoverished populations.\textsuperscript{62} All the top 20 pharmaceutical companies have developed robust CSR initiatives and many have fundamental CSR teams in place. Most importantly, the pharmaceutical industry
and hospitals have the technical know-how in medicine development and health care services, they have the ethical commitments of beneficence and justice to provide better development and access to medicines for underprivileged societies. CSR meets stakeholders’ demands, objectives of health care institutions, and universal ethics requirements – help lessen human suffering and improve the lives of people.\textsuperscript{63}

In health care, CSR means that there is an ethical obligation that requires hospitals and other organizations to do something beneficial to health-related issues such as delivering quality health care to everyone who is titled to it. Integrating social responsibility strategic planning and daily activities require time and effort by the management professionals of HCOs.\textsuperscript{64} Pharmaceutical companies and hospitals should tackle and meet the needs of various stakeholders and strategically focus on some.

\textbf{CSR and Health Care}

In the health care setting, a set of values should be followed such as equity in access to health care, universal coverage, and efficient resource allocation. Therefore, the implementation of socially responsible behavior could be a vital step for a hospital to expand its competitiveness and to protect its external image. There should be a serious consideration for all stakeholders including the public and society at large: patients, patient associations, NGOs, the environment, healthcare professionals, healthcare payers and policymakers, the government, and regulatory groups.\textsuperscript{65} For example, a socially responsible pharmaceutical company or hospital should investigate and find which way to treat or to discard carefully a waste product that may pollute the environment.\textsuperscript{66}

Klaus Leisinger of Novartis states that the pharmaceutical company in an international economy must research, develop, and manufacture groundbreaking medicines that transform sick
people’s quality of life, and they have to do so in a profitable way. No other societal actor assumes this responsibility. Nevertheless, several pharmaceutical companies recognize a moral duty to do more, whenever probable, to aid in lessening the health problems of poor individuals all over the world. Small and Medium Enterprises (SMEs) in the health care sector usually adopt different CSR practices when compared with large corporations because they do not have the resources. However, SMEs should also pursue CSR activities to become and remain successful locally as well as in the international economy. Companies report their CSR practices to be accountable and transparent, in terms of corporate governance as well as environmental, social, and financial sustainability.

Having a vigorous CSR program can help HCOs attract and maintain key talent. Companies and hospitals will have better social perception and community engagement. Surveys indicate that people not only desire to work for socially responsible firms, but may essentially give up a proportion of salary to do so. For instance: A 2009 Kelly Services Survey questioned around 100,000 people in 34 countries around the world. They found 88% of respondents are more probable to want to work for a company that is considered ethically and socially responsible. 56% say that in deciding where to work, an organization’s ethical status for ethical conduct is very significant.

Michael Porter and Mark Kramer’s view recommend companies to wisely select the social subjects they aim to solve especially the ones that interconnect with their professional, proficiency, management talent, and know-how, arguing that corporations that choose social issues based on their expertise will have a greater impact on the social good. Williams and Aguilera (2008), in their comparative assessment of CSR, report verification in the literature regarding the impact that occupation or industry has on the type of CSR a firm implements.
5. I.G. Corporate Social Responsibility and Competitive Advantage

Examples of CSR

Nonprofit hospitals have some responsibility for contributing to the general welfare of the community, as required by the Internal Revenue Service (IRS). Services and resources of nonprofit hospitals that are utilized to the advantage of groups or individuals who are not members of the plan itself are called community benefits. It is argued that community benefits form a vital part of the ethical obligations of HCOs. Many hospitals were established based on a charitable objective to serve the poor and there is a long tradition of healthcare institutions offering benefits to the surrounding community. Moreover, American hospitals have frequently provided free care and immunizations for the uninsured. In some states, the community benefit system turned to be a codified effort rather than a voluntary one via state laws necessitating HCOs to have shown concrete plans for community benefits. Moreover, it is argued that generous contributions to the neighboring communities are a central obligation of all businesses. The pharmaceutical industry could reinterpret the notion of social responsibility by acknowledging the access of vulnerable populations to life-saving medicines. Developing and enriching the local communities are as essential as profit maximization. Eli Lilly is one of the largest charitable foundations in the United States.  

The pharmaceutical industry could reinterpret the notion of social responsibility by acknowledging the access of vulnerable populations to life-saving medicines. Examples of CSR activities include offering drugs to disadvantaged populations, providing preferential pricing in the world's poorest countries to aid in combating diseases such as AIDS and malaria, supplying vaccines to international NGOs or UN agencies at better prices. Moreover, corporations should address the health and safety of employees at work from possibly toxic processes and products. For instance, hospitals should offer increased health and safety protection for technicians while
working with radioactive substances in particular oncology treatment manufacturing procedures. Other examples include: building LEED standard Green buildings, adopting environmentally friendly practices such as energy-saving processes and packaging reduction, conserving water, protecting the supply of clean potable water to the surrounding communities.

Philanthropy-based CSR activities exemplify the pharmaceutical industry. The main philanthropic role that should be recognized by the pharmaceutical industry is its entitlement to improve human life and offer treatment for diseases. Moreover, pharmaceutical companies often set up foundations, to support, educate, and better tackle a disease for which they offer a cure. For example, a company providing anti-retroviral drugs would establish a foundation that focuses on AIDS education in Africa. Furthermore, they also deliver humanitarian action and support to various causes, often in association to a product they deliver, or to help a community they work with, or a nation where they carry out their production process or conduct clinical research. Additionally, pharmaceutical companies usually fund research grants to students, universities, and educational organizations because the pharmaceutical industry is very much reliant on research and the development of science through research.

The Link Between Competitive Advantage and Corporate Social Responsibility

Strategic CSR initiatives start with a strong strategic grounding to connect an organization’s values to investments in social issues that can reinforce the organization’s competitiveness. The CSR of HCOs and pharmaceutical companies should create a balance between their responsibilities to add value to society and the growth of the enterprises. Strategic CSR can be a source of opportunity and competitive advantage rather than a cost to the health organization and more than a moral obligation. Achieving both social and economic interest for the organization demands looking beyond community anticipations to opportunities.
Strategic CSR should integrate society, business, and ethical values. It necessitates the corporation to act differently from competitors and reap the benefits of shared value by capitalizing on social issues that reinforce the company’s competitiveness. Characteristically, the more closely tied the CSR to the company’s business, the greater the opportunity to leverage the firm’s resources and benefit society. The most strategic CSR occurs when the cooperation adds a social element to its value proposition, and this provides a new edge in competitive positioning. This is essentially important especially in an era where liability exposure, consumers’ awareness of social problems, and government regulations are all continually increasing. These attitudes must change if companies want to leverage the social dimension of corporate strategy. To choose the right options for CSR, managers of HCOs have to be selective and construct practical and focused social initiatives and integrate those within their core strategies.

5. I.H. Managers of Health Care Corporations

Virtue Ethics of Managers and Leaders at Health Care Organizations

Professional ethics, such as in healthcare, is an application of virtue ethics. This kind of ethics focuses on the moral agent and not on the results of actions taken by the moral agent. Virtue ethics lists good judgment as a fundamental characteristic of the moral agent. “Practical reasoning”, as Aristotle says, is a requirement for mental virtues, and this includes several virtues such as vision, experience, and other critical analysis skills. High moral standards of employees would provide the organization’s excellence and decent ethical climate. The good character of honesty, compassion, trustworthiness, and devotion of high-level managers is an essential requirement for excellent ethical practice. However, this is not sufficient.

Enterprises with enlightened leadership should do more than just the minimum obligation described by the must" dimension because of the global social problems of our times. The health care organization has to entirely realize the difficult social issues, then investigate methods to do
good. Enlightened leaders who own sufficient courage and imagination, will show the right signal through an organization and into the broader society. This will achieve the expectations of society and achieve the long-term interests of the organization. These leaders must integrate CSR into the cooperation’s strategy through the understanding of the competitive market environment, the connection with the corporation's goals and strengths. This is critical to achieving the long-term goals of the organization and achieving better financial performance. Thus, CSR should be linked strongly to the organization's strategic planning and monitoring process. This is more likely to happen if the institution has enlightened leadership combined with virtue ethics.

**Managers’ Role in Undergoing Corporate Social Responsibility Activities**

The healthcare industry is significantly regulated, but the continuing request for it to be socially responsible and ethically oriented is definite. It follows that a new organizational culture is considered crucial to overcoming the market failures that can appear in the health care sector. Public inquiry of business activities has boosted over the last years, causing more deliberation to be placed on social contribution, social responsibility, and the ethical performance of managers and directors. This necessitates health care managers to fully comprehend the conceptions around CSR.

HCOs face new encounters in recent societies. The deficiency of economic sustainability of most health care systems guided the introduction of innovative public management to certify the existence of the welfare state. Due to high levels of anxiety and poverty, the criticism against globalization, increasing acknowledgment of the failure of governments to resolve many social problems, and distrust of giant businesses, there is mounting pressure on business
managers and their companies to deliver broader social value. This necessitates successful management skills and the applicable use of stakeholder engagement.89

The health care industry is in a remarkable position because it supplies both the entrepreneurial power and the skill crucial in encouraging economic development. Nevertheless, it can often be publicly disregarded if profit maximization is noticed to be the leading target. When debatable settings happen in an organization, the moral character of management who take decisions can become the heart of speculation.90 Patrick Maclagan considers the debate on the ethical or non-ethical character of the organization challenges, as these features must apply to the behavior of the members working at the organization or company. Consequently, the emphasis should be on its members, their values, actions, and ethical choices.91 The formal implementation of CSR by corporations could be connected with the altering personal values of managers.92 This implies that key individuals will be involved in articulating and applying companies' CSR policies.93 Managers’ personal beliefs and values are important and should not be constrained by the values underlying the system in which they operate.94

In HCOs, inaccuracies in management plans and poor leadership judgments can influence all stakeholders and shareholders because actions could form life-threatening consequences. Health care managers, in essence, form the structure and managerial support that makes the day-to-day activities of health care attainable. They also tend to form the ethical norms for corporations. Thus, they must have a broad understanding of several business values and ethical principles. They also need to acknowledge their dual role of serving the patients and communities and making a profit, as this is a significant managerial capability.95 Therefore, health care managers need ethical training as a meaningful part of their professional position.96 Ethical counseling may become fundamental in achieving ethical capability and developing
capacities for success. The manager’s responsibility is considered a crucial one. The manager has the mission of bringing things together; making them work together, shaping opinions, and leading all action. However, several factors make leadership decisions and actions morally challenged including the increased presence of managed care, and an aging population predestined to demand higher levels of health care.

**Conclusion**

CSR in health care applied to hospitals and pharmaceutical companies should promote shared values and common ethical principles in new patterns of hospital governance. In the health care context, social responsibility has a broader field of involvement including issues related to human rights, gender equality, child labor, and the environment. The health care sector is rigorously anticipated to behave ethically and deliver treatments for all individuals. As such, it is under very tight pressures from policymakers, NGOs, media, and the public at large, especially that it has become very competitive. The importance of CSR is now well recognized in the health care sector. In conclusion, CSR and organizational ethics are essential to regain vanished confidence of the local and international communities and win back the admiration of skeptical patients and doubting communities. Therefore, HCOs have to have a renewed commitment to ethics.

It is important to note that benchmarking HCOs on their CSR performance forms inter-business rivalry, which in turn improves CSR and leads to actual access to medical practices.

**II. Governance Ethics**

The purpose of this essay is to examine the various ways in which the board of directors works to create good ethical governance in healthcare organizations. The issues challenging health care organizations are various and complex such as enhancing the quality of care and patient safety, decreasing revenues and growing expenses, mounting uninsured population, increasing regulatory inspection of issues such as tax-exemption and community benefit, an
aging population, and greater competition between healthcare organizations. The convergence and greatness of these subjects are generating greater worry and causing a loss of public and stakeholder trust in health care institutions.105

The modern public company failures that headed the Sarbanes-Oxley legislation and other directives for governance reform truly indicate that loss of public trust goes further than organizations and comprise the boards that govern them. Boards of health care organizations are called upon to achieve numerous responsibilities that span from the short term and tactical to the long-term, tactical, and mission-driven. However, all their tasks stem from a core and ethical duty which is to gain and preserve the public’s trust in and devotion to the health care organization.106

5.II.A. Organizational Ethics
Organizational Ethics: Background
Organizational ethics is the study and practice of the ethical conduct of healthcare organizations. It involves elucidating and assessing the values rooted in organizational policies and practices and seeking methods and procedures for founding ethically acceptable values-based practices. Variations to hospital accreditation standards in the United States in 1994 aided to commence the noteworthy new consideration to organizational ethics in healthcare.107 This includes clarifying and assessing healthcare organizations’ moral standards and forming a climate within them that mirrors and reinforces those values. According to Spencer, Mills, Rorty, and Werhanel, the objective of organizational ethics is to create a positive ethical climate where the organizational plans, activities, and self-evaluation means and methods incorporate patients, business, and professional viewpoints in positive value-creating activities that express, employ, and support the organization’s goal.
Organizational ethics is a form of applied ethics that regards an organization’s responsibility for the values and moral standings it conveys and applies. By definition, the organization endeavors to delineate and characterize its respective core standards and mission, categorize areas in which imperative standards come into conflict, pursue the best conceivable resolution, and manage its functioning to guarantee that it acts in harmony with espoused values. The shared moral choices of organizational members, including the board and administrates, healthcare professionals, technical and support staff, should be corresponding to the organization’s fundamental values and aimed at reaching its mission.\textsuperscript{108}

Organizational ethics is concerned chiefly with the ethical topics confronted by managers and board members of healthcare organizations, the ethical implications of organizational decisions and actions on several stakeholder interests (such as the patients, employees, and community), and the ethical hurdles of assessing the objective of quality patient care with other significant objectives such as financial sustainability, staff well-being, and public accountability. The rising significance of organizational ethics in Canada and the USA encompassed the accreditation standards for health care organizations.\textsuperscript{109}

Organizational ethics, as a discipline, necessitates the acknowledgment that organizations constitute a distinctive component of ethical study as organizations have some special features and organizations are, by description, complex composite objects. Both the level of most organizations and the tasks they do imply that they have a great influence on the lives of individuals. In healthcare, plans, practices, and allocation decisions of organizations have a direct impact on the life span and quality of people’s lives. Nowadays, most organizations have official ways to express the values that push them further. The majority of large corporations nowadays have codes of ethics, and many make candid promises about how they will perform and behave.
Likewise in healthcare, most professionals who work in hospitals, including healthcare managers, have professional codes of ethics that they are required to follow, and most hospitals have mission, vision, and values statements. This indicates that organizations can be reshaped in ways that allow principles-driven reform as mission statements and strategic plans can be revised and modified.  

More importantly, organizational ethics offers some ways to form and cultivate a culture that is encouraging to ethical performance. The mission, vision, and values of the organization must be utilized to lead organizational behavior; for instance, a clear conversation of mission, vision, and values should be part of all policy-making processes and activities. Transparency of values will aid individuals to utilize a shared set of values to influence and guide behavior within the organization. Moreover, organizational ethics delivers proper tools for the moral self-evaluation of healthcare organizations. For example, the stakeholder analysis tool from business ethics divulges the moral responsibilities that managers owe to many stakeholders. Ethics audit is the second tool from the business ethics field which is a process by which an organization endeavors to measure its performance on several ethically significant issues such as the number of women in upper management.

The Contribution of Organizational Ethics to Bioethics and Business Ethics

Organizational ethics intersect with business ethics, but it varies from both business ethics and bioethics since its emphasis is not the individual’s ethical choices that allow people to realize their own professional goals; instead, its emphasis is on the shared moral choices that allow the achievement of organizational objectives. The developing domain of organizational
ethics may offer means to cultivate the incorporation of bioethics (which has been chiefly driven by communications between individual healthcare professionals and individual patients), and business ethics (which has been primarily driven by the conduct of corporations themselves, via the conduct of senior corporate management).\textsuperscript{113} Organizational ethics has been portrayed as the subsequent step in the development of bioethics. Bioethics as a field has inclined to center on ethical subjects in the delivery of direct patient care, the behavior of healthcare research concerning human subjects, and the characterization of professional integrity. Lately, attention has twisted toward organizational ethics as a field of bioethics examination and practice.\textsuperscript{114}

Clinical ethicists often find themselves on the front line dealing with ethical matters in their organizations. Conventionally, the responsibility of the clinical ethicist has been outlined by ethics consultation, policy development, education, and research chiefly concerning direct patient care. In 1998, the American Society for Bioethics and Humanities Task Force on Standards for Bioethics Consultation recognized knowledge and proficiency in organizational ethics as a fundamental capability of an ethics consultation service but was only able to present conditional guidance for practice given inadequate knowledge about organizational ethics in health care, the needs of people requesting organizational ethics consultation, and the likely role of clinical ethicists in countering to these needs.\textsuperscript{115}

Business ethics can offer organizational ethics with pragmatic consideration to the business dimensions of healthcare as the financial aspect is essential in sustaining the functioning of the healthcare institution. Second, through its contribution of “stakeholder analysis,” business ethics can offer organizational ethics a wider perspective on the importance of taking into consideration the wide range of interested parties that can affect or are affected by the
organization’s decision or policy. Third, the importance of business ethics on corporate responsibility can be an example of organizational ethics similarly to develop plans to endorse shared accountability. Fourth, business ethics adds a clear emphasis on the roles and principles of organizations, and not on individual people. Similarly, the bioethics field can contribute to organizational ethics in healthcare, by highlighting the importance of responsibilities toward individual patients. Second, bioethics can offer a well-built range of tools with which ethical problems can be acknowledged, evaluated, and resolved such as the professional codes of ethical conduct. Third, bioethics contributes a knowledge with the broad and various values linked with healthcare and the interaction of these values. Therefore, the contributions of both business ethics and bioethics are essential. In this way, the field of organizational ethics will tend to tackle decision-making and problem-solving that include individuals, the organization, and the community it attends.116

5.II.B. Corporate Governance
Definition: Corporate Governance

As developed by the Organization for Economic Co-operation and Development (OECD Report) (2001), corporate governance (CG) is outlined as the processes and procedures by which organizations and companies are directed and managed. This operational standpoint which concentrates on the shareholders, the board, and the management has been the foundation for much work in corporate governance. The notion of best practices in the activities and connections between them is central to the corporate governance codes.117 Additionally, the
OECD report reinforced the operational standpoint by including the association among several participants. It specified that the corporate governance (CG) structure requires the allocation of rights and duties among the various members in the organization such as the board, managers, shareholders, and other several members in the association such as the board, managers, stakeholders, and lays down the directions and procedures for decision-making. This relationship viewpoint was strengthened by the California Public Employees Retirement System, a noteworthy institutional investor, which involved in its description the main members are shareholders company management (directed by the chief executive officer and the board of directors). Monks and Minow (1995), key contributors to corporate governance, agreed but included also the employees, who are considered significant in the direction and functioning of companies just like the chief executive officer, management, shareholders, and employees. In this essay, the outlook of the broader association perspective is taken into consideration. CG is about the actions of the board and its associations with various stakeholders, and those supervising the enterprise, as well as with the exterior auditors, regulators, and other legitimate stakeholders. Demb and Neubauer (1992) also took the stakeholder understanding: CG is the process by which corporations are made receptive to the rights and desires of stakeholders.

In 1995, Blair set CG in the societal framework defining CG as the entire set of legal, cultural, and institutional activities that regulate what public corporations can do, who controls them, how control is exercised, and how the risks and return for these actions they carry out are assigned. Sir Adrian Cadbury, speaking in the Global Governance Forum of the World Bank in 2000, took such a view when he said: CG is concerned with holding the balance between economic and social objectives and between personal and shared goals. The CG framework is there to inspire the effective use of resources and correspondingly to necessitate responsibility and liability for
the stewardship of those properties and capitals. The goal is to bring into line as nearly as conceivable the welfares of the individuals, corporations, and society. Such a viewpoint included all the stakeholders involved with the company, comprising the contractual stakeholders such as the shareholders, managers, other employees, suppliers, customers, consumers, bankers but also other stakeholders out of the company’s borders but whose interests could be influenced by corporate behavior, including the local, national, and other international; societal welfares. This viewpoint is echoed in the rising interest in stakeholder theory, which will be reflected later in this essay.

From the perspective of law, the corporation is an entity exclusively distinct from the individuals who own it and work for it. The personhood of the corporation, the corporation’s legal character, is an extremely valuable and beneficial concept for two main reasons:

- It eases and decreases the burden on the firm and government agencies that deal with the corporation (no need to list every owner in every country).
- It permits the partitioning of business assets from the individual and private assets of managers, shareholders, and other corporate constituents. This would remove the risk that the firm will be influenced by the financial problems of its consistencies, asset partitioning decreases the risk endured by creditors of the corporation and thus allows the firm to raise capital at a lower cost. Additionally, asset partitioning also safeguards the personal assets of the corporation’s consistencies from the variations of corporate life.

Corporate Governance Theories

Agency Theory:

Corporate governance is the control or monitoring system that aims to decrease agency costs. Agency costs arise when separation happens between the ownership of the company and its management where self-interested managers have the chance to take action that benefits themselves, while stakeholders and shareholders tolerating the costs of these actions. A theory created by academic economists in the 1970s asserts that shareholders are owners of the
cooperation and implies that corporate managers must maximize shareholder’s value; as shareholders are owners by their position, and thus they have decisive control over the business of cooperation.\textsuperscript{124} Over the last few years, the agency theory has offered the foundation for several changes in management and governance practices, wherein turn has caused mostly growth in the power and impact of certain sorts of shareholders. At the same time, this theory has not confirmed any equivalent duty or accountability on the part of shareholders who exercise that influence, and this just represents a flawed assumption. Consequently, managers are under growing pressure to achieve ever quicker and more expectable returns and to restrict riskier investments designed at meeting imminent requirements. Experts are worried that the agency-based model of governance is being applied in approaches that are failing companies and—if applied even more extensively, as experts forecast—could be destructive to the wider market and nation.\textsuperscript{125}

Much of the academic research on agency theory has focused on confirming that managers try to capitalize on shareholder returns—principally aligning their benefits with those of shareholders. These concepts have been more established into a theory of organization whereby managers can introduce apprehension and worry for shareholders’ interests through a company by appropriately allocating “decision rights” and generating proper motivations. This has also caused the introduction of the view that boards of directors act as an organizational mechanism for controlling shareholder’s costs that arise due to giving power to managers; known as agency costs. Therefore, the main role of the board must be monitoring management and designing managerial compensation to bring into line management’s welfares with those of shareholders.\textsuperscript{126}
The concepts promoting the agency-based model originate in Milton Friedman’s popular New York Times Magazine piece, 1970, condemning corporate “social responsibility” as a socialist principle. He confirms the primary duty of the manager in a corporation is performing business operations based on the wishes of the owner, where he also accepts shareholder’s ownership as a given assumption. 1976 Journal of Financial Economics article “Theory of the Firm,” by Michael Jensen and William Meckling. Jensen and Meckling agree with Friedman that corporations should not participate in acts of “social responsibility.” They further developed these concepts and established forward the theory’s crucial ideas:

• Shareholders possess the corporation and are “principals” with fundamental authority to run the corporation’s business
• Managers are assigned decision-making power by the corporation’s shareholders and are accordingly “agents” of the shareholders.
• As mediators of the shareholders, managers are necessitated to perform the corporation’s business in agreement with shareholders’ wishes.
• Shareholders aspire business to be accomplished in a way that capitalizes on their financial returns. 127

On one hand, Jensen and Meckling do not debate shareholders’ wishes concerning the ethical values that managers should follow in leading the business. On the other hand, Friedman proposes two opinions in his Times article. First, he sees that shareholders commonly require managers to maximize return while adhering to the fundamental rules of the society, those exemplified both in law and in ethical practice. Moreover, he mentions that shareholders ask managers to make use of resources and achieve profit by participating in open and free rivalry without dishonesty or fraud. 128

Stakeholder Theory

This theory takes into account the interests and rights of the comprehensive range of individuals and organizations who cooperate with and are affected by business decision-making. It emphasizes the role of various stakeholders in the long term and the success of the
organization. This theory is important to business ethics because it recognizes many values and moral agency on diverse levels. A stakeholder is any individual or group of people whose role is essential to the survival and well-being of the organization. Stakeholders are mostly affected by the cooperation or organization and its activities and guide it in defining objectives and mission. Management, employees, shareholders, customers, suppliers, society, and the community are examples of stakeholders.\textsuperscript{129}

This theory argues that the goal of any organization or company is to prosper the firm and all its stakeholders. It implies that profit maximization is not a problem in itself; it only becomes an issue if managers give profit-maximizing actions a preference over activities that promote the well-being of primary stakeholders, including society.\textsuperscript{130} The theory challenges the argument that a manager’s chief obligation is to maximize profits and encourages the firm to coordinate stakeholder interests. The father of stakeholder theory, R. Edward Freeman, believes that the corporations and stakeholders have reciprocal relationships in the sense they can affect each other in terms of benefits and harms and terms of duties and harms.\textsuperscript{131}

5.II.C. Board of Directors

**Board Responsibilities: Aspects of Governance**

Elected by shareholders, the board of directors supervises the managerial role and function. In theory, they are present to resolve the agency dilemmas linked with the separation of a company’s ownership from decision controls.\textsuperscript{132} The main responsibility of the board of directors is to guarantee that the company’s assets are secured and that the managerial decisions and actions are accomplished in a way of maximizing shareholder wealth while shielding the welfares of other stakeholders. In this framework, the board of directors must identify major stakeholders (investors, customers, creditors, suppliers, and others) who are affected by the company’s business, ensure proper stewardship of the company’s resources, establish an
effective monitoring system, and holds management accountable for performance, and ensure the company is conducting its business in the utmost ethical, legal, and professional manner.\textsuperscript{133} The Board of directors has the fiduciary duty of approval and monitoring of strategies (on behalf of shareholders), this is referred to as decision control. In carrying out their oversight role, they should not involve themselves in managerial and operational decisions through micromanaging because decision management (initiation and operation of strategies) is regarded as the management’s duty. Therefore, the board of directors is eventually accountable for the company’s business governance as stated in the governing documents, involving the articles of incorporation, the bylaws, and the shareholder agreements. They direct, supervise, and control a company’s business activities. The main oversight function of the board is the selection of the CEO and agreement with the CEO’s selection of other senior executives to govern the company. Moreover, the board, in supervising management, must be able to impact the company’s vision, mission, strategies, and objectives without micromanaging.\textsuperscript{134}

Boards differ in their participation in the strategy formulation process, in a board with the mainstream of executive directors in many small and family firms, the board is likely to be much involved in this process because several of the directors are doing dual responsibilities as the director and manager.\textsuperscript{135} By contrast, in a board with the mainstream of independent outside directors, as in most large US and UK companies these days, the strategy is certainly taken by top management- the CEO and the management team.\textsuperscript{136} One of the main responsibilities of every board is to confirm that its corporation is heading in the right direction. The board that lacks a common view of the company’s function and objective and future direction cannot develop an operative corporate strategy. Strategy formulation is the process of producing and
revising alternate longer-term guidelines for the firm that leads towards the achievement of its purpose.¹³⁷

There is also a requirement to incorporate law and ethics so that companies will be able to navigate gray zones; where the rule of law is vague.¹³⁸ In the words of Kenneth Andrews, 1989, a satisfactory adequate corporate strategy must comprise non-economic objectives. An economic strategy is refined by taking into account other essential elements such as the character the company is to have, the ethics and values it promotes, and its connections to its customers, employees, communities, and shareholders. Moreover, the personal values and ethical aspirations of the corporation leaders, though probably not precisely detailed, are inherent in all strategic decisions.¹³⁹

Board members are selected based on the skill and expertise they offer for this purpose, including previous experience in a relevant industry or function. The board is a governing body elected to stand for the interests of shareholders. Based on the OECD report on Principles of Corporate Governance, the board responsibilities include both advisory and oversight functions. Despite the interconnection of these two functions, these two functions are essentially different concentrations. In an advisory capacity, the board consults with management concerning the strategic and operation course of the corporation. Attention is given to decisions that balance risk and reward. In its oversight role, the board is anticipated to monitor management and ensure that is acting meticulously in the interests of shareholders. The board hires and fires the chief executive officer, measures corporate performance, assesses management contribution to performance, and awards compensation. Moreover, it supervises legal requirements for publicly traded companies and industry-specific regulations. In delivering these duties, the board
frequently depends on the advice of legal counsel and other paid professionals (such as compensation consultants and external auditors).140

Overall, the board has to direct the company. This activity can be seen to include four fundamentals: strategy formulation; policymaking; the direction of executive management; and responsibility to shareholders and others.141 In delivering their duties, directors have to think and respect the future of the company as its present location and current results. They also need to look inwards at the organization and its parts, and outwardly at the company in its competitive market position and its wider economic, political, and social setting.142 In articulating strategy, the board works with top management, looking into the future and seeing the firm in its strategic external setting. Strategies are then deciphered into policies to guide top management action and to deliver strategies for subsequent control. The board needs then to examine, oversee, and control the events of executive management, looking inwards at the present managerial state and current performance. Accountability includes looking outwards and disclosing corporate actions and performance to the shareholders and other stakeholders with genuine rights to accountability. It is worth mentioning that boards can choose the extent of their designation of functions to the management. In some cases, for example, boards play a chief part in the devising of the company’s strategy; in others, this is delegated to top management, with the board receiving, questioning, and lastly endorsing management’s strategic proposals.143

Framing corporate strategy recognizes the core objective of the organization, creates its core values, and sets its longer-term direction. Directors are so-called because they create and direct the company’s direction. Many companies attempt to capture this sense of purpose and direction in a mission statement and a statement of corporate vision, while some seek to merge the two. Such statements state what the company is trying to accomplish and how it aims to
accomplish it. They offer a device for steering and monitoring strategic choices.\textsuperscript{144} They also incline to reflect a company’s intrinsic culture: that collection of assumptions, attitudes, and principles that all organizations obtain over time.\textsuperscript{145}

The board of directors is the most crucial component of corporate governance in providing advisory and oversight functions. Consequently, the excellence of oversight and advising function of the board is contingent on its board characteristics.\textsuperscript{146} Public companies are obligated to have a board of directors that is controlled by the chairperson. Companies often merge the positions of the chairperson and the CEO. This dual status permits the company’s CEO to assume the two most significant functions of corporate governance, specifically, the managerial and oversight functions, authorizing the CEO to supervise the direction of the company as well as manage its processes and activities. Both the chairperson of the board and the CEO must be leaders with vision, strategy, business acumen, motivation, and problem-solving skills. In an ideal world, two qualified individuals should undertake these two distinct positions.\textsuperscript{147}

Best practices of corporate governance recommend that public companies’ boards, in general, be managed by independent, non-executive directors, and only under limited and exceptional conditions should the two distinct roles of the CEO and the chair be combined. The potential advantages of the separation of the CEO and the chair positions are: such separation bring into line U.S corporate governance with that of other countries and is helpful for these reasons:

1. CEO responsibility is enhanced
2. CEO potential conflicts of interests are condensed
3. Having two people in the corporate leadership role should advance corporate governance and processes
4. And the board's responsibility is to supervise management for shareholder’s benefit would be more effective when the chair of the board undertakes no executive role.\textsuperscript{148}
It has recently received significant attention as companies complemented cash compensation for their directors as outside directors have also benefited from backdated stock options. There is no perfect way of deciding how to pay directors and how much to pay them. Nevertheless, the general insight and best practices propose that any increases in stock ownership, the decrease in cash payments, and fluctuations in compensation should be associated with shareholders’ long-term interest determined by the board, accepted by shareholders, and entirely unveiled in public reporting.149

**Fiduciary Duties of the Board of Directors:**

Dean Jay Light of the Harvard /business School wrote in 2009 about leadership and stated that the need for leaders who know how to create a visible difference in the world has never been greater than it is nowadays. Qualities that are central to good leadership comprise decision that leads to sound- decision-making, the capability to attend and communicate efficiently, a profound sense of one’s values and ethics, and the courage to act, based on those standards and ethics.150

Fiduciary Duties mean that as shareholder’s protectors, directors must be truthful and honest, acting in the best interest of investors and shareholders, and turn have assurance in the director’s activities. These are the main duties:

- The duty of Due Care: this duty sketches how the directors should carry out their duties. They should work in the best interest of the company and its shareholders, act in good trust in a way that is believed to be in the best interest of the shareholders and company, use and apply the care that is expected of a “reasonable” person under the same conditions, be knowledgeable about the company’s business activities, exercise an attentive oversight
function, ensure a consistent information reporting procedures, supervise compliance with relevant rules, laws, and regulations.

- The duty of Loyalty: this duty necessitates directors to refrain from following their welfares over the interests of the company.

- Duty to Promote Success: Directors should act in good faith and foster the success of the business for both its shareholders and other stakeholders. They should support the creation of strategic goals and policies that promote stable shareholder value and other stakeholder value protection, through producing reviews and capitalizing on shareholder wealth. As well, directors have the accountability to protect stakeholder value by promoting the interests of employees, encouraging ethical business conduct, and taking into consideration the impressions of the business processes on the environment, community, and society.

- Duty to Exercise Diligence, Independent Judgment, and Skill: The ultimate decision-making tasks lie with the corporation’s board of directors. Therefore, directors must use due diligence, expertise, and independent ruling in making strategic choices. Therefore, directors should continually to update their understanding of the company’s businesses, activities, and performance, and use rational meticulousness and independent ruling in making decisions.

- Duty to Avoid Conflict of Interests: Directors must evade any condition that may trigger possible conflicts of interest that would endanger investor self-assurance in their oversight function or weaken their independence in making strategic decisions. For example, potential conflicts of interests may happen when a director accepts material gifts or benefits from a third party that is doing business with the corporation.\textsuperscript{151}

In 2005, a panel of hospital and health system CEOs and board members was organized and included governance researchers and others with board expertise to study the purpose and work
The Center for Healthcare Governance and HRET organized a Blue Ribbon Panel involving senior board leaders, CEOs, governance consultants, and university faculty members with knowledge and experience in governance research. The Blue Ribbon Panel on Healthcare Governance confirmed that healthcare is in crisis and that the intensity of the cost, quality, safety, and access matters confronting the U.S. healthcare system has been a factor in the loss of public and stakeholder trust in the nation's healthcare organizations. The panel affirmed that a healthcare board's fundamental duty is to gain and preserve the public's trust in and devotion to the healthcare organization. Panel members added that unless boards answer the call to advance their functioning and responsibility to crucial stakeholders, they will be regarded as part of the problematic aspect rather than the resolution.

The panel's report: “Twelve Principles of Governance That Power Exceptional Boards”, published in 2005, concluded that extraordinary boards add noteworthy worth to their organization, create an apparent difference, and are knowledgeable stewards. Moreover, they tend to create apparent transformations in their advance on a mission. In addition, responsible boards focus on fiduciary oversight to ensure that their organization comply with the law, act with financial integrity, and function successfully and ethically. Exceptional boards add dynamic engagement and autonomous decision-making to this oversight role. Moreover, they enthusiastically challenge and support efforts in search of the mission. Responsible boards are knowledgeable agents. Concentrating primarily on fiduciary oversight, they guarantee that their corporations comply with the law, act with financial truthfulness, and function successfully and ethically. Exceptional boards add dynamic engagement and self-governing decision-making to this supervision function. Their members are sincere and honest with each other and the chief executive. They avidly challenge and endorse efforts in quest of the task. The difference between
responsible and exceptional boards lies in contemplation and intentionality, act and engagement, intelligence and communication.\textsuperscript{159}

\textbf{5.II.D. Governance in the Health Care}

\textbf{Key Governance Factors in Achieving High Operating Performance}

Several issues impact the operating performance of complex healthcare organizations. These include internal factors (management and clinical staff competencies) and external factors (economic environment).\textsuperscript{160}

A recent study published by HRET validates that board culture in high-performing hospitals is noticeably more interactive and proactive as parallel to the boards of mid-performers.\textsuperscript{161}

- Right People, Right Size: In choosing board members, strive for diversity in age, gender, and ethnicity, to mirror the patients and the community served.
- Incorporate physicians, nurses, and other healthcare professionals on the board because their clinical capability and perspectives are appreciated by other board members and will assist the board in better recognize and appreciate the concerns of several stakeholders.\textsuperscript{162}

In these confidential meetings, several board members at ten high-performing health systems were questioned to indicate and classify the top main factors that contribute to their system’s strong functioning performance. Six major issues arose from the meetings

1. Robust, Values-Based CEO Leadership. effective CEO leadership is very important in accomplishing and preserving a high level of system operating performance. Among the characteristics stated regularly was devotion to the system’s mission and values, outstanding communications and relations with the board and medical staff, proficiency in financial management, passion for developing the system and its services, and strategic vision. Moreover, there was the broad-based acknowledgment that robust, effective teams with
proficiency in all management functions are vital to fruitful system operations in the modern healthcare environment. As well, the capability to invite talent and cultivate strong, actual management teams is extensively documented by these trustees as a crucial distinguishing feature of successful CEOs.  

2. **Well-Understood Mission, Vision, and Values**: They all stressed the significance of having a significant and expressive systemwide mission statement, a captivating vision for the system’s future, and a clearly stated set of fundamental values that are recognized, appreciated and supported by crucial stakeholder groups. It seemed to be a universal agreement that expressions of organizational mission, vision, and values can be influential in uniting the stakeholders toward recognized objectives and standards, especially if they are constantly strengthened by organizational leaders through the whole system. They also acknowledge that developing the understanding and support of crucial communities within the system and in the communities, it attends is a significant task and necessitates constant consideration by governance and management leadership.  

3. **Dedicated and Engaged Board of Directors**: The presence of a greatly committed, educated, and a proactive governing board that works collaboratively with the CEO and physician leadership was acknowledged by trustees as being extremely significant in reaching and sustaining organizational success. Moreover, the board should proactively act and be aware of the environmental, strategic, and operational matters that ultimately may lead to problems that impend the system’s future.  

4. **Strong Clinical Leadership and Capabilities**: Most trustees underscored the vital importance of committed, competent clinicians as a critical determinant of operational performance. They believe that without strong physician leadership, no hospital or health system can
achieve enduring success. Numerous also spoke about the importance of exceptional nursing leadership.166

5. Clearly-Defined Organizational Aims, Goals, and Metrics. Most of the community health systems emphasized the significance of having precise organizational “goals” and evidence-based metrics that allow board, executive, and clinical management to examine actual performance and compare it to recognized standards in main characteristics of system processes, such as financial performance, community benefit, and patient care quality. The trustees think that the development of well-defined targets, advanced standards, and improved metrics presented to system leadership consistently has been the main contributor to attaining and sustaining distinguished levels of performance — and in encouraging quicker corrective action when the well-known benchmarks are not being met.

6. Organizational Culture. this concept is acquiring noteworthy traction in the health area. The drive has been towards understanding the complex culture of healthcare organizations through research and to adopt new approaches to performance improvement that integrate cultural change.167

**Healthcare Boards: Great Responsibility**

The encounters confronting healthcare delivery organizations today are significantly greater than in the previous years. The continuous rise in healthcare costs, increasing market demands, public mindfulness, growing customer disappointment, the appearance of new diseases and treatments, technological developments, and media attention are all influencing dynamics. In an extremely competitive consumer market, the rivalry is driving healthcare providers to try to offer the best care possible, and yet persistent anxieties continue concerning the transparency and responsibility of these organizations.168
Hospitals are significant assets for many communities in the United States, working to offer access to quality care and to advance the health condition of their community. A hospital must function efficiently and successfully, to provide quality care, and sustain a good reputation in the community it attends. Since the governing board is eventually responsible for the performance of the hospital, apprehending the board's role is imperative. The disturbing changes in the healthcare field—the beginning of managed care, the emergence of novel technology, and a competitive business nature have shaped exceptional challenges for governing boards, demanding that they keep well-informed of new business approaches and complex developing problems.¹⁶⁹

Nearly all hospitals (by state articles of incorporation) are expected to establish and maintain a board of trustees. Starkweather proposes that hospital trustees conventionally have had eight functions to perform they have been charged to (1) found institutional goals and key policies; (2) certify that plans are established to meet corporate objectives; (3) provide for the long-range financial health of the organization; (4) found and sustain qualified and functioning medical staff; (5) appoint and assess the chief executive officer; (6) evaluate and support the complete organization of the hospital and the designation of authority therein; (7) guarantee that the community is well known regarding the organization's objectives and performance; and (8) found and sustain good processes for directing the matters of the board, including the assessment of its performance. Cast in these terms, the dominant governance function in hospitals might be understood as stewardship, with trustees functioning as caretakers to safeguard the resources of a hospital.¹⁷⁰

Understanding of governing boards has progressed over time, moving from a structural viewpoint (the reflection of such factors as board size, composition) to a behavioral perspective
(a focus on the working relationships among board members). Sonnenfeld (2002) argues that what differentiates exemplary boards are not structural factors but vigorous, effective social systems including forming a climate of trust, ensuring personal accountability, and assessing the board's performance.\textsuperscript{171}

According to Meyers (2008), responsibility commences with the chief executive officer (CEO) and boards of directors. Another imperative factor associated with board performance is the essential role of the chief executive officer (CEO). The CEO plays an exceptional role, as this person signifies both management and governance, as he both leads and reports to the board.\textsuperscript{172} Boards are accountable for establishing the tone within healthcare organizations and assuring that everything is going in the right direction, from the proper equipment and facilities to competent clinical staff, and access to hospital resources and services. Boards across profit and non-profit hospitals consequently face an immense responsibility. Examples include communicating mission and goals, integrating several quantitative and qualitative performance standards, restructuring different arrangements of care delivery and measurable establishing checks and balances, and at the same time endorsement transparency and accountability.\textsuperscript{173}

Based on the literature, there is an immense need for visionary and strategic thinking as an indispensable characteristic of healthcare boards. This relates to the increasing complexity of healthcare organizations, which necessitates an advanced level of leadership and broader visions. Moreover, it is important for healthcare boards to work together with management and to plan and put into practice organizational policy.\textsuperscript{174}
5.II.E. Role of Board of Directors in Creating Good Ethical Governance (Part 1)

Improve the systems and processes that ensure high-quality care and patient safety

The two main types of board authority for quality and safety consist of decision making, which has to do with medical staff credentialing, and an oversight role. However, most boards designated oversight of clinical issues to their medical personnel and managers. Boards characteristically centered their capacities and resources on financial matters.¹⁷⁵

This has changed shortly due to two main events. First, a sequence of corporate scandals in the for-profit world, capped by the collapse of Enron in 2001 and WorldCom in 2002, and nonprofit scandals such as the $1.3 billion bankruptcy of the Allegheny Health, Education, and Research Foundation in Pittsburgh led to a much better inspection of corporate boards and far advanced standards of accountability. Consequently, the 2002 Sarbanes Oxley legislation (SOX) presented key changes to the regulation of corporate governance.¹⁷⁶ Second, the US Institute of Medicine reports on medical errors (nearly 100,000 deaths per year from medical errors) published in 1999 and 2001, correspondingly, led to great force on healthcare organizations, mainly hospitals, to advance the quality of care provided to their patients.¹⁷⁷ These two influences changed the roles and tasks of hospital boards.¹⁷⁸

Boards have the legal duties of care, loyalty, and obedience. The duty of care denotes the responsibility of corporate directors to act as follows: (1) in good faith, (2) with the care a normally insightful individual would exercise in like conditions, and (3) in a way that they rationally believe to be in the best benefits of the healthcare organization.¹⁷⁹ A board applying its duty of care must be concerned about the quality and patient safety in all of its decisions. Board oversight activities for hospital quality and patient safety necessitate deliberating, examining, and monitoring performance and allotting satisfactory resources to guarantee high-quality safe care. Regulatory agencies (such as US Centers for Medicare and Medicaid Services) and
accreditation agencies (such as the Joint Commission) strengthen board responsibility through standards that specifically direct governance functions linked to the quality and patient safety.\textsuperscript{180} The increasing force to tackle quality and safety problems has amplified attention in physician board partnerships. The board must generate a quality and patient safety improvement system that is meaningful, measurable, and manageable. This necessitates business insight and clinical knowledge and includes recognizing and implementing best practices and solutions to performance problems to guarantee that patients consistently obtain evidence-based treatments. Physician contribution in these areas is indispensable. Boards can cooperate with physicians by assigning them to leadership positions or by encouraging them to participate in hospital committees and medical staff meetings. With increasing rates, governing boards engage physician members.\textsuperscript{181}

Boards should have a distinct quality and patient safety committee that gathers often and reports to the full board. Evidence proposes boards with such a committee tend to devote more time to improvement activities, and their hospitals may have improved results. If they do not have such a committee, there should be strong evidence that quality and patient safety is a dynamic program element at every board meeting.\textsuperscript{182} In union with the CEO and medical staff leaders, boards should recognize precise and measurable quality indicators coherent with strategic objectives and evaluate performance against the indicators quarterly. Such a review should include regular quantitative measurement against benchmarks, performance transparency, a survey of quality and safety culture.\textsuperscript{183}

Boards should guarantee the presence and annual evaluation of written quality improvement and patient safety strategy that indicates systems thinking covers valid empirical measures of performance and is coherent with national, regional, and institutional quality and
safety goals. Moreover, boards should regularly hear accounts and stories (such as case reviews) of harm that happened at the hospital, putting a face on the problem of quality and patient safety. Additionally, boards should ground compensation for the CEO on the achievement of measurable improvement objectives for critical responsibilities including quality of care and patient safety.

Quality governance is established on systems that support individuals’ capability to tackle poor quality services. These systems include incident reporting, acting on learning from incident inquiry, and offering a guarantee that teams are working to enhance quality.

In summary, vibrant and successful governance systems are those in which:

- Every individual in the organization comprehends his or her duty for carrying out high-quality care.
- The delegated tasks for refining the quality of care are clear to all employees, from the board to the wards, and guarantee that board advice and response on quality is acknowledged and recognized by front-line staff.
- Teams’ delivery of good care is meticulously studied and revised every month, and these reports should be communicated via the governance system to the board promptly. Improvement strategies are in place to tackle performance problems and these are monitored for timely effects on care delivery.
- Learning across a corporation is well recognized and shared.
- There are clear and operative clinical and internal audit processes concerning quality governance and evidence of action to resolve worries introduced by the audits.
- A whistleblower and the error-reporting process are well-defined and made known to all employees.
- There is a performance management system with guidelines and procedures that tackle underperformance and distinguish and incentivize good performance at all levels within the organization.
- There is active and successful engagement with the community, patients, staff, and broader stakeholders to receive criticism about the provided services.
- Finally, boards should receive continuous education on quality and patient safety standards. Physician leaders may deliver such education and may suggest joint medical staff/board training when emerging requirements are new for both groups.

Develop and Enforce Corporate Codes of Ethics

Due to the recent corporate scandals, the focus turned to the effective role played by boards of directors on the development and monitoring of corporate codes of ethics, forming
internal codes of conduct to sustain the reputation, ethical conduct, and integrity of companies. Kaptein and Schwartz defined a code of ethics as a separate and official document encompassing a set of instructions developed by and for a company to lead current and future conduct on several matters for at least its managers and employees toward each other, the corporation, external stakeholders, and/or society in general. In terms of the code’s objectives, codes help preserve a reputable public image and stakeholder trust and avoid public criticism. Moreover, codes prevent wrongdoing and encourage ethical behavior, including the ethical management of conflicts of interest in the personal and professional relationship, improvement in management and incorporate culture, better social responsibility, better compliance with related government laws, rules, and regulations. In short, it is a method to validate, inspire, and directly responsible behavior among employees and organizations. At any level, every culture integrates a value system, which mirrors the attitudes, principles, and expected behavior in that culture. Corporate values impact the way the healthcare professionals and executives in the association behave towards each other and towards those with whom they interact outside the organization. Corporate values are involved in each activity, from board-level decisions of strategic importance, such as transferring the production to a developing country, to everyday communications between managers and employees, staff, and clients. Corporate values reproduce the morals of corporate leaders. Increasingly, healthcare organizations are striving to make corporate values clear, conveying what the board seeks and needs to promote. Corporate values can be influenced from within an organization, but mainly corporate values arise from the top. A successful ethics policy mirrors a company’s central and
fundamental values and stems from its corporate mission. However, without a board and top management indolent and commitment, ethics policies are not likely to flourish and prosper. Some boards develop ethics policies that establish standards for employee behavior and necessitate employee compliance with these standards. The codes of ethics that flow from such policies establish benchmarks and models of predictable behavior, pursue to enforce discipline and are employee focused. Other healthcare organizations establish ethical policies to foster the commitment to good relations with all stakeholders. A successful ethical policy possibly embraces both viewpoints; describing the anticipated relationships between the organization and every stakeholder, while delineating the behavior anticipated from employees.

A sound ethics policy is expected to: Be focused on corporate values and principles, rather than organizational discipline; seek honest obligation rather than being a beautifying task; identify the cultural framework; avoid trustworthiness gaps between ethical codes and actual behavior; connect with corporate governance policies and practices; link ethics management systems, including data and control systems; systematic audit, policy review actions, and social accounting systems; demonstrate responsibility and accountability with regular reports. A corporate ethics policy is typically reinforced by a corporate code of ethics or code of conduct. This is a clear statement setting out the ethical standards, projected of everyone in that association. Characteristically, it will be accepted and issued by the board of directors. Healthcare has developed rapidly, resulting in noteworthy transformations in organizational environments. Economic forces and commercial welfares now direct the healthcare industry to center on clinical efficiency, performance metrics, and regulations, which ultimately caused healthcare professionals to see a greater number of patients with less time for each patient. Consequently, time spent in significant interactions with patients has shortened, compromising
the conventional patient-doctor relationship.¹⁹⁸ Medical educators’ attempts to challenge the decline in humanistic care have mainly centered on refining humanistic characteristics and codes in individual physicians.¹⁹⁹

A deep-rooted personal pledge to integrate human morals and codes and values like caring, compassion, and respect into every health care relationship characterizes medical humanism and is instilled within the framework of medical professionalism. Even though technological advances have greatly affected care and treatment, patients most want and anticipate from their doctors the humanistic dimension and this can be applied through a code of ethics and policies by the board and communicated through the healthcare organization.²⁰⁰

Information is central to effective ethics management. Information about ethical codes, policies, procedures should be broadcasted to all those affected. Morals, goals, and performance criteria need to be sent and acknowledged. Achievement of these criteria needs to be supervised and relevant, timely data reported so that managers can monitor states within their area of accountability and take appropriate action when necessitated. Some healthcare organizations create reporting channels for all employees, including ethics hotlines that can be employed to report ethical concerns, sometimes namelessly, occasionally providing feedback.²⁰¹

5.II.F. Role of Board of Directors in Creating Good Ethical Governance (Part 2)

Develop an Ethical Organizational Culture: Beyond Legal Compliance

Organizational culture is described as the collective morals, underlying assumptions, and beliefs, or perceptions held by workers within an organization, and it is the social tie keeping an organization joined. Mission, plan, structure, leadership and human resource practices are significant factors of organizational culture.²⁰² The structural analysis implies that a culture demonstrates itself at the level of artifacts and espoused values, yet its core lies in the fundamental basic assumptions.²⁰³
Essentially, cultures stem from three basic sources:

1. the beliefs, values, and assumptions of founders of organizations. Founders decide on the basic mission and the environmental context in which the new group will operate.
2. the learning knowledge and skills of group members as their organization develops
3. the new principles, morals, and assumptions brought in by new leaders and members.\(^{204}\)

Supportive leaders should effectively model change behavior and/or articulate a clear vision of necessary changes. Experts on organizational behavior recognize leadership as a critical factor in creating and maintaining or modifying (if needed) organizational culture.\(^{205}\)

The first step is constructive change is for health care professionals, leaders, and all stakeholders to reach an agreement on the organization’s mission, strategy, and goals since they all collectively form the culture to accomplish their vision, which must correspond with professional values and extremely advantageous to patients. In addition, they need to shape their relationships and work together to successfully create necessary structural changes that form and preserve humanism in organizations.\(^{206}\)

Organizational culture mirrors the character of an organization and its members, including its principles, values, opinions, traditions, traits, staff practices, all of which are intensely entrenched in the everyday life of the organization and its members.\(^{207}\) Kleining (1999) examines that despite particular intersections between legal and compliance mechanisms, there are some very noteworthy differences in the nature and content of ethical and legal requirements which can help us understand why ethics is accorded a normative primacy in practical affairs and legality is to be judged by reference to ethics (not vice versa). Precisely, a law is related principally with behavior and ethical requirements are mainly involved with reasons, motivations, intentions, and mostly with the character that conveys itself in conduct. Ethics consequently is related to what we are and not just what we do. Furthermore, the law is jurisdictionally restricted since what is legally mandatory in one state or country may vary from
another, however ethical values are more likely to be more universal.\textsuperscript{208} Longstaff (1986) claims that an overemphasis on legal obedience processes and systems could be at the cost of ethical deliberation because people may have a lower incentive to generate their views and take individual responsibility for their choices. Legalism is a method that focuses primarily on the strict and exact adherence to the law while inclining to disregard the aim behind the existence of laws.\textsuperscript{209}

The present healthcare business environment offers an outstanding opportunity to create an organizational culture that goes beyond simple legal compliance. Seidman remarks that in proposing an organization that endorses a culture dedicated to compliance with the law, it is significant to comprehend the nature of the culture and how it enlightens human decisions.\textsuperscript{210} Seidman concludes that the failures of corporate responsibility have been proved to be not only failures of legal compliance, but more essentially failures take right or ethical actions.\textsuperscript{211} Legal compliance mechanisms incline to endorse a rule-based approach that is consistent with the letter of the law- this may not essentially inspire or introduce excellence; nevertheless, ethical compliance mechanisms endorse a principle-based methodology that reflects the essence of the law. Differentiating between legal and ethical compliance can elucidate the insufficiency of the legal compliance mechanisms in addressing the central issues that encourage ethical behavior. Disregarding the ethical scope of decision-making runs the danger of institutionalizing unthinking behavior (imprudence) and loses foresight about the right thing to do.\textsuperscript{212}

The American College of Healthcare Executives supposes that all healthcare executives have a professional duty to employees to form an ethical culture. Therefore, healthcare boards should direct these efforts by:

- Representing and showing the significance of and commitment to ethics through decisions, practices, and behaviors; Circulating an organizational code of ethics
that involve guidelines for all employees' ethical standards of behavior and practices;
 o Revising the principles and ideas expressed in vision, mission and value statements, and other leaflets to ensure that there is a mutual perception of the organization's devotion to ethics;
 o Reinforcing viewpoints and behaviors that indicate that ethics is vital to accomplishing the organization's mission.\textsuperscript{213}

It is essential for management to move ahead of a compliance-directed organizational culture toward a culture grounded on integrity. This is considered part of ethical corporate governance which moves the organization toward moral creativity and excellence. Through informal governance processes, relationship-building systems are built that enhance the reputation of the organization and this will allow trust to evolve within an organizational culture built on integrity.\textsuperscript{214} Only value-based methods are deemed more efficient than a compliance-based approach because the former is established in self-governance and is more expected to inspire employees to act in agreement with shared organizational ethical standards.\textsuperscript{215}

**Assess societal and community health needs**

In today’s U.S. healthcare setting, well-qualified board members need an exceptional number of skills such as the capability to assess societal and community health needs, to be predominantly supportive of any offer that possibly advances the delivery of quality care, to be capable to exercise sound business reasoning and to be comparatively up-to-date with how the health field commonly functions.\textsuperscript{216} The board duty of loyalty states that not-for-profit board members must be the commitment in their discussions and decision-making to the hospital stakeholders (e.g., community).\textsuperscript{217} The duty of obedience necessitates devotion to the drive and mission of the healthcare organization. The duty of obedience necessitates the board to make certain that institutional policies and practices place significance on the quality of patient care.\textsuperscript{218} Although boards delegate much work, they are eventually accountable for everything that
emerges in the name of the organization.\textsuperscript{219} Boards must meet a fiduciary responsibility to guarantee the use of community assets for the benefits of the organization’s social work while they concurrently tackle complex and swiftly changing business problems.\textsuperscript{220}

**Conclusion**

And, as the healthcare environment has become ever more both competitive and regulated, an organization’s capacity to recognize its distinguishing, value-based patient care services has become harder to define.\textsuperscript{221} The boards, management, and clinical leadership must communicate a vibrant sense of perseverance for change, and to reinforce the association between healthcare organizations and their communities. While all health care leaders should notice the appeal, it is the board of each organization that must take the initiative and lead by example by engaging in practices that promote extraordinary governance.\textsuperscript{222} In conclusion, the board must recognize the essential and crucial values that drive choices and actions within the healthcare organization, and these values must be relevant to the specific mission of the organization. Once the organization is self-assured that it has recognized the right fundamental set of values, it must allow those values to form and support the life of the organization. Core values must be reflected in organizational policies and practices and in the organization’s relations with patients, staff, the community and the healthcare system as a whole. Larry Sanders, chairman, and chief executive officer, Columbus Regional Healthcare System, believes that no other field other than medicine in the society places a huge responsibility in the hands of others. In medicine, customers regularly uncover both their bodies and souls within the healthcare organization. This requires an exceptional ethical pledge of the boards and leaders of healthcare organizations, and this is only possible through instilling an assurance to ethics and integrity organization-wide.\textsuperscript{223} Achieving a high corporate reputation necessitates that financial performances are associated with high moral values and with societal anticipations of significant
stakeholders, better organizational value. Failure in corporate governance is a real hazard to the future of each corporation. With effective corporate governance founded on fundamental values of integrity and trust, healthcare organizations will possess a competitive advantage in attracting and retaining talent and promoting both customer loyalty but employee loyalty.

Effective corporate governance can be achieved by adopting a set of principles and best practices.  

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Chapter 6: Systems Approach in Professional Ethics

Virtue ethics is a framework that mainly highlights the nature of the moral person, rather than the rightness of a particular act. It acknowledges a significant element of human moral involvement, through recognizing the effects of emotional reactions on judgments and decisions. Therefore, virtue ethics studies the way moral agents can learn -via regular habits- how to acquire and foster good characteristics which would, in turn, help them act well.¹

6. I. Virtue Ethics

6. I.A. Background: on Virtues and Virtue Ethics

The Concept of Virtue

The notion of virtue originated in the Western world with the Greek philosophers. The Sophists thought that virtues are important for the exercise of power and that they could be taught to any individual. They also believed that virtues are the result of reason alone. The Sophists paved the way for the perceptions of Aristotle and Plato.²

- The Classical-Medieval Conception—Origins

In the Western culture, the most prevalent and persisting notion of virtue, the one most officially and fully advanced, is found in the philosophy of Plato and Aristotle, complemented by the Stoics and Epicureans, and shaped to full realization by Thomas Aquinas. The combination of those streams of thought turned out to be the Classical Medieval synthesis that has formed moral philosophy Classical-Medieval in the West for 2,500 years. Although it has gone through a variety of transforms and diminishing over the centuries, the Classical-Medieval concept of virtue is re-emerging today among dominant moral philosophers and is seeking its place among more modern normative ethical theories. This Classical-Medieval origin of virtue has also been the leading one in the ethics of the health professions as professions. For this purpose, it is the functioning notion in this argument of where to go "beyond virtue" in the wake of After Virtue.³
The elements of the Classical-Medieval synthesis that are most significant for a revival of virtue-based ethics in the health professions— the idea of virtue (1) a distinction in traits of character, (2) as a characteristic focused on to ends and objectives, (3) as a distinction of a reason, not emotion, (4) as focused on a practical decision, and (5) as learned by practice. According to Plato who first established the idea of virtue, through Socrates’ character, knowledge of the good sets one to a decent life and happiness. Vice is the consequence of ignorance of the good. Throughout his discourses, Plato established a list of the virtues: fortitude, temperance, justice, and wisdom, which with self-restraint, characterized the virtuous person. Plato recognized virtue as knowledge of the good for human beings. Ignorance of the good would lead to seeking evil and acting well. In his debate of virtue, Plato disregards passions and emotions. He did not see ethics as an applied science in the way Aristotle did where he viewed the purpose of ethics as practical; to be moral and to behave well. Aristotle defines virtue as a condition of character that leads to the excellence of human beings and causes excellence to be completed well.

Aristotle holds the perception of excellence and adds the idea that the orientation of virtues to the accomplishment of the end of human work. Aristotle associates being a good individual with doing well whatever one does. Aristotle believed that virtue lay in the mid of two opposing vices and illustrated it as “the mean by reference to two vices: the one of excess and the other of deficiency”. For instance, compassion lies between callousness and indulgence, and courage lies between foolhardiness and cowardice. On this understanding, virtue is a character attribute under balanced control. Virtue is a habitus, a foreseeable outlook to pick the good every time one is challenged with a choice. A virtuous person has information of the good and selects it for its own sake and from a stable character.
Socrates inquires, but never adequately answers Are the virtues one or many? How are they developed? Can they be taught?\textsuperscript{10} In contrast to Plato and Socrates, Aristotle takes the interpretation of emotion more evidently but describes the virtuous person as one whose emotions are organized by reason to the end of happiness. Aristotle's fundamental virtue is phronesis or practical wisdom. Consequently, phronesis is the virtue that allows one to reflect well in making moral decisions and to choose the means most fitted to the end of the activity. In keeping with his emphasis on the practical, Aristotle communicates that virtue is, itself, cultured by practice. He states that by constantly acting in conformity with the ends of human life, as the man of practical wisdom would act, a person becomes consistently inclined to act virtuously. One can then be contingent on the virtuous person to act well in all conditions.\textsuperscript{11} Moreover, Aristotle does not suggest any rule book of morality but emphasizes that moral agents should consider what is proper in every single case. Therefore, he highlights the importance of traits of character, and not on specific actions of the individual; but on the attitudes and viewpoints, an agent consistently brings to his acts. Virtues are traits and qualities that make an individual good and empower him to perform his work well.

The acts of the virtuous person proceed from three things:

1. Knowledge of the good in any act
2. A choosing of the good for its sake
3. A source for knowledge and choice in a good character.

Thus, for Aristotle, virtue is a habitual outlook to act well, not merely a sensation about what is good and not just a capacity to make a good choice. This implies that virtues can be instructed and explained by training and practice. Aristotle agrees with Plato and Socrates on several fundamental virtues like wisdom, justice, and temperance. Aristotle’s theory of virtue is
very significant as it connects the character of the moral agent with moral decisions, and it highlights the importance of the skills needed to be a good person, per say, and not the skills required to carry out professions.\textsuperscript{12}

According to Aristotle, there are three categories of human excellence (virtue): bodily excellence, excellence of character (moral virtue), and excellence of intelligence (intellectual virtue).\textsuperscript{13} In Greek ethics, moral virtues entail excellence relative to qualities such as courage and justice.\textsuperscript{14} Intellectual virtues are wisdom which is excellence in theoretical matters and practical wisdom (phronesis or prudence) which denotes excellence in practical issues and includes the ability to plan one’s life well.\textsuperscript{15} Humans cannot possess the intellectual virtue of practical wisdom (prudence) without moral virtue, or excellence of character: the excellence of character and excellence of intelligence are intertwined.\textsuperscript{16}

- The Stoics

The thinkers of the Early, Middle, and Late Stoa are correspondingly influential with Plato and Aristotle in medieval and classical comprehensions of virtue. During its 500-year history, Stoicism has exerted the main impact on the ethics of virtue and developed into the leading moral philosophy of educated Romans. Stoic medical writers primarily inserted features of compassion and humanism into Hippocratic medical ethos. Stoa ethics was associated with a theory of human nature and the good; human beings are a component of nature as they share in the divine creative force. In their view, virtue is the approach by which humans can reach the ends of the orderliness of nature and benevolence, as God is benevolent and free. Wisdom, temperance, justice, and courage are crucial virtues; the same virtues communicated by Aristotle and Plato. In their regard, compliance to duty looks almost to the description of virtue- very close to Kant’s definition of virtue. In addition, the wise man was pursued as a model and standard of
virtuous behavior by the Stoics. It was the Stoics, who presented the idea that it was the duty of humans to live virtuously, the virtues themselves being described in terms of resemblance with the absolute laws of nature.

- The Medieval Period

The traditional idea of virtue was upgraded by integrating it with the virtue ethic of the Christian Gospels, during the Middle Ages. Thomas Aquinas was the main figure in this formation; where he appropriated much of Aristotle’s philosophy of the natural virtues and combined it with the notion of theological virtue, where he augmented and expanded the concept by investigating the notions of moral psychology such as intentionality. Just like Aristotle, he thinks that the moral quality of human actions comes from their relationship to the final purpose of human life; and he offers reason a significant position in virtue. He also thinks that supernatural virtues (such as hope, charity, and faith) complement natural virtues- since the fundamental and greatest end of human existence is spiritual. Additionally, he gave a unique place to practical wisdom, or prudence, which closed the gap between intellectual and moral virtues. Prudence is a virtue that influences the reason to fit the good end of action; incorporating right intentions, right thoughts, and right actions.\(^{17}\)

In his study of Christian theology, Thomas Aquinas develops virtue-based ethics that starts with the same fundamentals as Aristotle's. He describes virtue very much as Aristotle does; nevertheless, drawing on Christian theology, Aquinas adds the theological virtues of faith, hope, and charity, which place humans to achieve their supernatural ends, union with God in the blissful vision.\(^{18}\)

Both for Aquinas and Aristotle, practical wisdom is a fundamental virtue. prudence associates the intellectual and the moral virtues, as it does in Aristotle, but it also relates those
virtues to the theological virtues. Prudence is the virtue that prioritizes other virtues when they might conflict and provides practical judgment in multifaceted conditions in the achievement of the objectives of human life.

- The Classical-Medieval Conception—Decline

Both the Classical and Medieval Christian conceptions of virtue were grounded on a vibrant moral epistemology and metaphysics. the post-Medieval and post-Enlightenment periods up to the present these metaphysical foundations for virtue ethics were extremely eroded by the union of an assortment of forces. The possibility of a metaphysical description of human nature or the good was subjected to cynicism and disowning. Virtues were substituted by many opposing notions: rights for Locke, duty for Kant, moral sentiment for Hume and Smith, and consequences and utility for Bentham and Mill.¹⁹

- Postmedieval Transformations

Some factors played a role in restructuring the meaning of virtue in ways that still exert influential effect today. The Aristotelian-Thomist synthesis was frequently confronted in the philosophies of the postmedieval period. The realistic anthropology of Hobbes’ and Locke’s recreated ethics in terms of rights and individualism. Hume and his British collaborators moved the debate of ethics into the scope of moral psychology as they explored the concept of an intrinsic moral feeling that led humans to approve some actions and not others. While Kant recreated the whole metaphysics of morals and reorganized the early Stoic concept of duty in terms of categorical imperative and moral maxims. Kant viewed duty as the way that defined the whole of morality, irrespective of the consequences. However, John Stuart Mill and Jeremy Bentham used consequences as the final determination of the moral excellence of actions.
The concepts of virtue were many, diverse, and often opposing especially during the time where moral philosophy was such variating. For instance, Hume defined virtue as a characteristic of the mind accepted by everyone who respects and considers it. While Kant defined virtue as a happenstance of the rational moral agent’s will with every duty tightly established in the character. He describes the virtuous person as one who does his duty.

• The Modern Renewal of Virtue

MacIntyre’s definition in After Virtue has given a novel interest to virtue ethics. He outlines the deterioration of the classical tradition of virtue and implies how the resulting loss of morale agreement has made moral discourse so disturbing and problematic. He suggests that virtue can be seen as acquired qualities distinguished by the subsequent features:

• They are essential for individuals to gain the goods internal to shared practices.
• They endure shared identities in which persons can pursue the good of their whole lives
• They tolerate traditions that provide customs and individual lives with the required historical background.  

• Virtue-Based Ethics—The Revival

Despite the convolutions in the concept of virtue shaped by a series of philosophical systems, the ideas of virtue and the virtuous individual were never wiped out. Ethicists resumed opposing the inquiry of character of the agent. Principles, rules, maxims, insights, language study, and technical talent in solving moral puzzles did not incorporate the full sophistication of the moral life. The fundamental nature of the character of the moral agent could not completely be overlooked. Consequently, several modern moral philosophers several years ago started to revitalize the knowledge of virtue and to find a place for it in ethical theory.
Maclntyre has most effectively built on the Aristotelian concept of virtue and reformulated it in more modern terms, taking into consideration the destruction of the tradition. Maclntyre (1984) shapes his description on three fundamentals; he regards virtues acquired qualities that are: (1) essential to attain the good internal to practices, (2) crucial to sustaining communities in which people can follow a higher good as the good of their own lives, and (3) essential to sustain traditions that provide vital historical backgrounds for individual lives. Virtue, consequently, is a character trait necessary to the accomplishment of a good—perfected excellence.

Maclntyre’s account of the virtues is context-dependent and relational. Although Maclntyre does not deliberate medicine as a practice, his interpretation of the virtues is extremely appropriate for the virtue-based approach to moral decision-making in medicine. Maclntyre’s interpretation of the virtues as established forth in After Virtue which is elucidated in the form of three propositions: (1) the role and significance of a narrative origin of the self in morality; (2) the value and nature of practices, goods, and the virtues; and (3) the role and significance of a tradition of examination in morality.

**Virtue Ethics-Origins**

Virtue ethics started with the ancient Greek philosophers Socrates, Plato, and Aristotle. They explored the essential components that made a person good through exploring the kind of character he had. They proposed that a good person who acts well must cultivate virtues, which, through constant use, develop part of that individual’s character.

Rachel defines virtue as a trait of character, demonstrated in habitual action, that it is suitable for an individual to possess. There is no complete list of virtues. The fundamental virtues developed by ancient Greek philosophers are courage, prudence, temperance, and justice. The theological virtues (faith, hope, and charity) are not extensively studied in secular moral
philosophy; while Toon has assessed them in a medical setting and illustrated them to be very beneficial. Beauchamp and Childress have studied and regarded five virtues relevant to the medical doctor: trustworthiness, integrity, discernment, compassion, and conscientiousness. Since the introduction into the modern debate by Anscombe, the ethics of virtue has come to be regarded as a “third alternative”, competing with both deontological and utilitarian perspectives. Deontological theories take rulings about the right action as vital, utilitarianism takes judgments about the attractiveness of states of affairs that actions yield as key, while ethics of virtue derives the desirability of the action from the appeal of the character.

Virtue ethics refers to a specific approach to ethics where the fundamental decisions in ethics are judgments about character. This crucial assumption about VE implies, as Trianosky notes, that the worth of character qualities are detached from judgments about the appropriateness of actions, and that the notion of virtue is clarifying before that of right behavior. These two main concepts mean that at least some judgments about virtue can be confirmed separately of any application to judgments about the appropriateness of actions and that the precursor decency of traits eventually makes any right act right and correct. VE calls for a great change in the pattern; where the emphasis is transferred from actions to virtues, where virtues are validated in terms of their significant role in the flourishing and welling of the individual. Virtue ethics is a normative ethical theory that determines rightness by the quality of an individual’s character rather than the nature of a person’s action or its outcomes. In virtue ethics, people are considered as moral agents, people who can logically assess right and wrong, who has the authority to take deliberate action, who has ethical responsibilities, duties; whose actions can be assessed; and who is accountable for his conduct. Virtue ethicists suggest different groups of virtues. One common set is Aristotle’s four cardinal virtues: prudence, fairness, courage, and
temperance. Aristotle wrote of these virtues as habits, clarifying that formerly the virtuous traits were inborn to people’s nature; however, they perfected them by habitually using them. This idea is very significant; for instance, managers in healthcare can reinforce their virtues character traits by constantly being truthful, compassionate, respectful, and so on.31

6. I.B. Virtues in the Medical Field

The link between Principles and Virtues

Virtue Ethics (VE) denies the basic and significant characteristics that are communicated by both utilitarianism and Kantianism: moral reasoning is a subject of utilizing principles, all human beings are obligated by universal duties, and the worth of the virtues originate from the concept of the right or of the good. It is worth noting that the idea of moral obligation is closely associated with a religious framework. Under the impact of Christianity, the presence of law is above all human institutions, where this law takes the form of an obligation compulsory on all human beings. In this regard, prohibitions (such as murder) are considered universally valid irrespective of the person’s ends or desires.32 The virtuous person is not virtuous because he admires the principle, but because he differentiates the vital and general nature of this principle, and views it not merely a duty in the Kantian sense, but as part of his character, into his identity and person. People deem others virtuous because they perceive and act habitually in a way that shows the habitual outlook to perfection- that, as humans, we perceive to be coherent with what it is to be a good individual.

Principles are general accounts of what leads to the actions of a good person. Therefore, a person is not virtuous as he abides by the principle or acts upon his duty, as Kant would have suggested. On the other hand, the principle draws its validity from the moral connection between rational beings proficient in choosing their ends, purposes, values, and life plans. Consequently, the virtuous person is someone who has the intellectual capacity to distinguish the good and the
right in any specific situation. These actions were established by the practice of practical wisdom, and they can be generalizable. This is called prudence, practical wisdom that aids people distinguish the good and the right. All humans incline to do good and avoid evil, and they also have a natural practice of the mind that enables knowledge of applied principles. Principles are essential as a benchmark but inadequate when making the moral choice- and this decision must be about the association of situations, intentions, and ends to a principle (it is not a decision about a principle). The virtue of prudence empowers individuals to reach the good and right prioritization of principles and facts in specific cases. This is so relevant and true particularly in the medical setting and medical choices and decisions.  

Obligation-based ethicists reason that the virtuous person won’t know how to behave in specific dilemmas as virtue ethics lack any rules for conduct. Hursthouse (1999) thinks this is not right because, in her opinion, individuals have access to a wide range of virtues and vices and there is substantial moral direction, within the structure of these virtues and vices. In addition, virtue phrases, such as ‘kind’ and the opposite vice terms, ‘unkind’ (or ‘cruel’) offer profound descriptive strength when compared with responsibilities and duty-based terms. Obligation-based moral theories have many well-established flaws. Furthermore, act, rule, and indirect forms of consequentialism fall short in taking sincerely some other morally significant characteristics. For example, they fail to deliver a rich interpretation of moral character; fail to offer a rigorous interpretation of the uniqueness of people and the importance of relations in human life, and fail to recognize the significant role played by feelings in the moral life of people. One of the well-known shortcomings of deontology is that it highlights the notion of ‘right action’ rather than on the interpretation of moral goodness, and it fails to tell how to resolve disagreements between
moral principles and duties; Because of these (and other) failings and omissions, obligation-based obligation based moral theories in overall ethics are inadequate and insufficient. 35

On one hand, Pellegrino and Thomasm a perceive a strong connection between moral principles and corresponding virtues, each complementing and enlightening the other. On the other hand, Rachels view virtue ethics as “an independent theory of ethics that is complete in itself”36. According to strong virtue ethics, one’s moral character, moral motivations, and the justification of acts are couched solely in the virtues. Strong virtue ethicists do not accept the application of deontic languages such as ‘right’ and ‘wrong’. Strong virtue ethicists would rationalize, for example, not lying to someone since ‘it is dishonest’; not because it is ‘unethical or “wrong”’. 37

**Advantages of the virtue-based approach in the Medical Practice**

A quarter of a century ago, the dominance of virtue in medical ethics started to weaken for three causes: First, was the establishment of principle-based ethics, which delighted health professionals as being more conclusive and decisive than virtue because of its applicability to clinical decisions. Second, socio-political change toward participatory democracy, greater public education, the uncertainty of authority, and the character flaws of some physicians directed the public attention on autonomy-based, contractual relations rather than trust-based relations. Third, the religious and philosophical agreement that reinforced professional ethics, mostly in the West, was confronted and diminished.38

Then the advancement of virtue-based ethics followed due to the dependence on principles in healthcare ethics. For instance, Edmund Pellegrino and David Thomasma have taken this methodology, stating that principle-based ethics fall short to take into satisfactory
account the character of the agent. Despite the efforts of trying to apply ethical principles to resolve applied dilemmas, the principles’ approach has failed in doing so because they are generally too abstract to present any actual help. When complex scenarios materialize in everyday ethics, principle-ethics either present no solution or voice higher-order principles of preference, when yet again are too vague or abstract to offer practical guidance. Therefore, if principles are inadequate and redundant as a practical guide for moral behaviors, then VE suggests that moral character is the factor that guides behavior in real-life decision-making. 39 However, the medical professions need more theoretical tools with which to elucidate and settle the many complex, multidimensional moral struggles.

There are four main central views of virtue ethics:

- It offers a thorough understanding and interpretation of moral character;
- It delivers a rich account of moral goodness;
- It offers a reasonable explanation of moral education.
- It offers a persuasive interpretation of moral inspiration.

There are numerous significant advantages of the virtue-based approach. First, this approach precisely mirrors the language of the virtues and vices, such as ‘care’ that healthcare professionals exercise regularly. Second, this approach places a strong prominence upon the critical role played by feelings and emotions in the moral lives of caregivers and care receivers. Third, this methodology makes fundamental the significance of using reasoning and moral insight to empower professionals in making ethically good choices and decisions with patients in diverse settings. Fourth, this method places strong importance upon moral education, for example, the importance of ethically (and clinically) good role models.
Despite the acknowledgment that healthcare professionals should exhibit moral virtues, these moral theories, predominantly the ‘four principles’ approach, continue to be prevalent in medicine and ethics literature. Their popularity endures regardless of continuous critiques because it offers professionals a structured context that can aid in the identification of ethical dilemmas.\textsuperscript{40} It is important to note that virtues cannot alternate moral principles as not all human beings are at the same stage of moral maturity and development. Thus, public moral policy, national guidelines, and moral rules are essential to creating minimum anticipation for everyone; particularly important in health care, where care involves strangers who do not know one another.\textsuperscript{41}

6. II. Virtues and the Professions

6.II.A. Professional Ethics

Professional Ethics & Virtuous Professional Role

Professional ethics denotes the overall moral rules that are acceptable in a particular occupational group to deal with morally vague circumstances and thus stop and prevent ethical harm. It is the application of formal ethics that constructs visibility and, consequently, self-confidence between professionals and, in specific, between professionals and the community. Professional ethics typically materialize informal codes, including orientations to corporate norms, duties, and insights of relationships between colleagues and with the public.

Professional ethics is founded on individual pledges and responsibility in the healthcare professional’s role. They involve self-respect and self-evaluation and help to form healthcare professionals’ relations with patients, managers, and other stakeholders. Professional ethics in healthcare embraces the description of professional accountabilities and duties that promote and preserve the societal drive and value of the profession. It demands that professionals deliver services and care proficiently, efficiently, and successfully and in a way that will not produce
preventable harm or injury to the patient. The association between professional ethics and clinical competence has been documented where professional ethics, in terms of responsibility, impact clinical competence and result in professionals adhering to rules, regulations, and patient rights. In addition, this relationship necessitates continual learning.  

Professionals are those who pledged services and other specific obligations recorded in codes of professional conduct. For instance, the medical codes were merely a written expression of the moral responsibilities take on by medical professionals. There is an ethical reality involved in the medical profession because health professionals hold themselves compelled to do a specific type of good for others, and this reality is reflected in the day-to-day medical practice. Though usually not discussed, all professional codes of ethics for physicians comprise fundamentals that are concentrated on the person (the character) and the aims of the agent rather than merely to the rules of conduct and the safety of the patient.

Professionalism is the knowledge, skills, competence, and conduct anticipated of practitioners of a profession. A professional role is well-defined as the assigned and anticipated functions, tasks, and working relationships of the person in a professional role. They should know many competencies such as:

- Recognizing and appreciating professional norms and roles: these professionals usually routinely and unconsciously conform to.
- Working with others: developing and sustaining working relationships with people in comparable or different roles and providing feedback.
- Self-management: such as upholding high ethical standards, career planning, and time management.
• Contributing or Giving back: this includes providing free or volunteer service to the community, the profession, and others.

In short, ethics is the foundation of professionalism as ethical morals help the most in choosing the best possible option. The first unique characteristic of professional relationships is the dependence, vulnerability of the person who seeks out the assistance of the physician. The person requests help to reestablish health by inquiring for help to be able to follow life’s other goals. The second distinguishing feature of professional relationships is intrinsic inequality. The professional holds the information that the patient needs, which places most of the power in the hands of the professional. The third characteristic of professional relationships is their distinct fiduciary character. In status of inequality or vulnerability, the patient is required to trust the doctor where the patient discloses his intimate self, personal life, soul to an outsider. Thus, invasion of privacy is a prerequisite for help. Physicians are anticipated to do what is best for the patient and this is made as a promise in a public oath at the time of graduation. This public declaration is the core that defines a real profession and separates it from other occupations.

Fourth, the knowledge of true professionals cannot be whole registered. Their knowledge is ordinated to an applied end, to meet selected central human needs. Professional knowledge does not happen for its own sake as society authorizes invasions of privacy that would otherwise be illegal so that physicians be qualified and skilled. These medical students, who are not entirely skilled, are allowed to dissect human bodies, join, and help at operations, and take part in the care of sick people. Teaching with patients includes interruptions, diffusion of accountability, anxiety, distress, and even physical risk for the patient. Society approves these attacks of privacy because society requires a continuous supply of doctors. Since medical knowledge is held in trust for those who need them, it can never be allotted only for the financial gain and benefit of
professionals. The fifth feature of a professional relationship is that the professional is the last shared pathway through which assistance and harm must pass. The final choices, actions, and advice must be completed by one person, the professional, with whom the patient has a conventional relationship of trust. Professionals are thus protectors of the patient’s welfares and accountable for any activity in which they partake.

The sixth feature is that the professional is a member of a moral community, united human associations whose members have the privileges of special knowledge and together pledge their dedication to use it to advance justice, health, or salvation. Together, the members of the moral community make the same promises and elicit the same trust they do as individuals. They are bound by the same fidelity to the promise they have collectively made and the trust they have collectively elicited. Collectively, they are responsible for fidelity to the trust they have solicited from society.46

Healthcare professionals confront further moral pressures beyond what is usually expected by the general ethical obligations of ordinary life. The very nature of professional ethical agency presents discrete role-related responsibilities and understandings professionals. Furthermore, patients often have high expectations of health professionals to act in ways truly reflect the nature and purpose of the healthcare professional’s specific field.

The concept that one’s professional role can be a source of guidance for the ethical agency has a long tradition that can be traced back to Aristotle. Aristotle debated for a eudaimonistic virtue ethics method that is coherent with the understanding that acting virtuously is perceived as a benefit for human beings and a crucial part toward appreciating a flourishing human life. For Aristotle, the concept of eudaimonia is associated with ‘the notion of living a ‘prosperous life. In his Nicomachean Ethics, he articulated the perspective that a virtuous agent will see for himself
what to do in a particular situation. Any excellence is impossible without the intellectual excellence that Aristotle called phronesis. Therefore, the virtuous ethical agent thus seeks to develop and possess virtues (such as compassion, courage, honesty, and benevolence). When these virtues are combined with phronesis, then the ethical agent can develop a virtuous character and excellence of character. Most importantly, the character traits that qualify as virtues are assumed by their associations with eudaimonia, the principal objective of a good human life.

Because of its teleological structure, Aristotelian virtue ethics, therefore, delivers a foundation for developing the distinct ethics of several professional roles. Such a virtue ethics context is valuable because the complex ethical characteristics of diverse professional roles can be apprehended in ways that traditional forms of duty-based ethics and consequentialist ethics cannot. Such ideas also have a natural affinity and resonance to the ethical dimensions of professional life. virtue ethics has been applied to diverse healthcare professional roles, including in psychiatry, nursing, psychotherapy, medicine, and generic mental healthcare.  

Professionalism does certainly go further than ethical principles, accounting for competency and pledge to excellence and indicating a virtue ethics description of medical practice.  

**Medical Virtues**  

Pellegrino and Thomasma have highlighted the significance of virtue ethics for the clinical self-understanding of physicians as well as for morally sound communication with patients. They have listed some virtues (e.g. fidelity to trust, justice, fortitude, temperance, phronesis, etc.), counting more emotional ones (also compassion), but they have mainly concentrated on the intellectual parts of decision-making.  

Virtue ethics is involved principally with two things: the realization by its physicians of several virtues vital to attaining the goods
directly related to practice and granting a community of practitioners within which those virtues can be preserved and nurtured.

Unless professionals lookout for their welfares, professionals will be suppressed by the influences of competition, commercialization, government control, malpractice, public and media anger, advertising, and other social-economic factors. These forces are collaborating to alter the learned professions into businesses and technologies. Pellegrino and Thomasma succinctly rationalize the need to integrate virtue ethics in medical education to cultivate those sides of human character to better empower the physician to apply his or her art, especially that virtue ethics has been underutilized in previous medical codes of conduct. These “indispensable traits” of the healthcare professional consist of fidelity to trust, self-effacement, and practical wisdom. In the words of Pellegrino & Thomasma, sick people should bear their vulnerabilities, compromise their dignity, and divulge privacies of body and mind. Patients depend on healthcare professionals to alleviate distressing symptoms, encourage independence, and expedite recovery, and endorse dignity.

On one hand, virtues develop part of one’s character; they are an internal part of one’s individuality. On the other hand, moral principles are external to the individual; these social standards are imposed upon individuals from the external sphere such as the professional obligations from the Nursing and Midwifery Council. Such responsibilities must be comprehended, understood, and utilized by people; therefore, they are not essentially compatible with the type of person one is. The moral virtues are ethically exceptional character individualities. There are many virtues related to the medical profession including:

- Fidelity to Trust:
Several main elements take on distinct significance in the framework of relationships with professionals. First, there is belief and anticipation of fidelity to what is entrusted to be accomplished. Second, there is the perception that the person trusted has openly or indirectly made a promise to act well concerning the interests of the person trusted. Third, there is the correspondence of comprehension between the two parties, and finally, there is an act of faith in the good character and the kindness of the one trusted.

In states of unusual dependence (such as in infancy, healing, justice, illness, or old age), trust is the most challenging aspect. In such instances, people are obliged to trust professionals so to obtain their skills and knowledge, and they are forced to depend on their fidelity to trust and their wish to shield rather than exploit the vulnerability of such individuals. Recently, the key place of trust in professional ethics has been extremely questioned as there has been a rising concern to ethics of distrust. Generally, trust is linked to a decrease in complexity, as noted by the sociologist Niklas Luhmann. He mainly denotes the complexity that happens because of the liberty of other individuals. Thus, the burden and impediment of complexity are reduced or removed. Annette Bair tried to provide a more formal definition of the nature of trust and defines it as dependence on others’ capability and readiness to look after. She highlights the vulnerability encompassed in trusting another individual.

There is a particular amount of trust in the system of medical education and credentialing; nevertheless, the intimacy and personal nature of relationships compel patients to be involved with the character and personal qualities of the professional as the system will fail to offer the needed reassurance. This can be achieved only by trusting the character and the person of the physician. It is essential to note that the physician is the one who records the orders, completes the procedure, and understands the recommendations of other health professionals. Depending
on his character, he may treat and care for the patient whether as the patient’s last shield against the system or treat the patient just as a statistical object.

Several factors have created an increasing mistrust of trust in modern society and medical practice, which is destructive to professionals and patients. Trust in the medical field has many interrelated features such as intimacy, randomness, urgency, and remarkable vulnerability within which trust must be offered. In ethics of trust, the physician is obligated to represent clinical data as free as possible of professional or individual bias. Fidelity to trust prevents manipulation, coercion, or dishonesty in acquiring consent. In such matters, the intersection of other virtues happens such as intellectual honesty and trust. Additionally, an ethic of trust does not disregard the adverse effects of fraud, incompetence, and insufficient self-regulation. Moreover, an ethic of trust must work beyond duty-based ethics to virtue ethics since virtue is best taught by practice in front of instructors and teachers who themselves are representations of virtuous conduct.

- Phronesis: Medicine’s Indispensable Virtue

Phronesis is the word that Aristotle utilized for the virtue of practical wisdom, a capacity for moral vision, and the ability to determine what path of action or moral choice is most beneficial for the good of the agent, in each set of settings. It suggests a picture of the end of the good; thus, it helps in choosing the best appropriate means to the good.

The concept was extended and developed in the thirteenth century by Thomas Aquinas, where he defined it as a capstone virtue connecting the intellectual moral (recognized by Aristotle) and the supernatural virtues of hope, charity, faith. In short, prudence is a guide to the correct way of acting while considering all virtues. It is a direction to moral truth and moral excellence of certain actions and their association to the ends of human nature. It is formed by the common and general moral guidelines where humans seek good and avoid evil. It is grounded on reason, but it
complements it with the concept of gratitude of the realities of faith commitment. However, prudence does not promise assurance and identifies the worry of choice in multifaceted settings.

In defining virtue, Aristotle focuses on two main things: the good for human beings and the good for the work humans do. Here, the focus would be on the distinction that makes an individual do his or her work well. Medicine as a certain kind of human activity has two key ends: the health of society and individuals (as an eventual end), and the good healing action for a particular patient (as a more proximate end). A good and right healing action is the objective of both the patient and the doctor, where the right action should be directed towards the interest of the patient – in terms of the patient’s aspirations, lifestyle, religious beliefs, and his medical good of course. Thus, the virtues of the physician should be focused on these major ends.

The virtue of prudence allows the physician to evaluate the relative weight of the methods at his disposal, the morals and life conditions of the patient and his preferences, the therapeutic potentials and results, and side effects. For instance, prudence aids physicians to balance between objectivity and compassion because too much compassion will make the doctor lose the objectivity essential for the healing course, and a lack of compassion will make the physician perceive the patient as a mere object.53

Bloomfield (2000) claims that the professional who has developed the virtue of practical wisdom knows how to make an accurate diagnosis and does well at problem-solving. When in a position to use any skill, the healthcare professional must first assess the situation.54 Moreover, the practitioner should request adequate involvement and knowledge to be able to pick up, for instance, ‘signs and symptoms.55 Later, experts can diagnose the condition by seeing the logical relations between the distinctive characteristics of the situation because they have practical wisdom (understand of how things relate and work), theoretical wisdom (comprehend the
principles functioning in certain conditions, and they have the experience (expertise in dealing with or observing such conditions in the past: (experience).\textsuperscript{56} For expertise, then, both theoretical wisdom and practical wisdom are needed. For practical wisdom, excellence of character, and this, in turn, entails experience and the example mentors are needed.\textsuperscript{57}

- Fortitude

Virtues regulate the natural inclinations of character and circumstances, toward goodness. For Aristotle, the virtues involve an individual’s reaction to his feelings. This means that moral excellence is developed from the person’s trained reaction to feelings of anger, fear, and other feelings. This specifically trained reaction becomes a character attribute when one can forecast an attitude to act in a particular way toward those emotions. Aristotle defines training in terms of an object that has been altered frequently in a specific way by guidance—which is not intrinsic or natural—until this object becomes ultimately qualified of acting in that way. For Aristotle, the person who is trained to be courageous for instance would also select to be virtuous in other dimensions because the core concept about the “excellence of character” is a subject of choice.

Drane argues that virtues do not only organize the internal moral life and influence one’s character as a professional; they also help individuals to discover the moral elements of reality. For example, a good physician is the one who notices the fears of the patient and attempts to ease them, whereas a poor clinician may not identify these fears at all. He thought that virtues do not signify overall ethics, but they contribute to good behavior, good people, and at the same time to good societies.

Fortitude, or moral courage, is a virtue that encourages confidence that physicians will fight the enticement to lessen the patient’s good through their uncertainties and fears or social
and bureaucratic pressure, and that they will use their time and education, and skills efficiently to achieve well in society.

- Temperance

As defined by Plato, temperance is a process of doing good in one’s business or affair. It is almost identical to virtue itself. It signifies a type of triumph over desire. For Aristotle, temperance also rules bodily pleasures. In keeping with Aristotle’s principle about virtue being a middle between two extremes. Aristotle reasons that the temperate person evades insensitivity. Temperate people dwell in a middle location, concerning things they want, things they should not wish for, and any kind of extravagance.

Medical temperance now can be defined as the constant disposition of physicians toward accountable use of power for the good of their patients evading both the underuse of technology and other interventions and the overuse of technology and interventions. The accountable use of power is present in a clinical ethical decision in every case about the best balance of results and interferences. Consequently, the virtue of temperance necessitates of physician's practically exquisite mindfulness of the physical state of the patient (to evaluate outcomes) and the ideals and principles of patients or their surrogates (to weigh the quality of those outcomes calculated against the patient’s standards). This knowledge is indispensable if an appropriate balance is to be made between over and undertreatment. “Therapeutic parsimony” is another way of articulating the important quality of temperance; using only those interventions that may result in a rational and practical ordering of efficiency, benefit, and burdens.

- Integrity: The Essene of Professional Ethics

Despite the power of autonomy thinking in current biomedical ethics, integrity is the more central notion. The moral entitlement to autonomy rests on the profound moral right of all
humans to the integrity of the person. Integrity as a virtue refers to the moral completeness and soundness developed by continuous practice through the interconnection and relationships among people. Healing involves re-establishing the entirety that establishes a healthy being curing the disintegration of the person enacted by diseases. This consists of the psychological well the physical domains. Restoration of the integrity of the person is the moral foundation of any holistic medicine. Similarly important is the responsibility to sustain the integrity of the self and values that categorize the person as a unique individual. To disregard, dominate, reject, or mock the patient’s values is to attack the patient’s very humanity. This further worsens the disintegration of the individual that previously occurs because of disease.  

Integrity is seen as “wholeness”, as steadiness and coherence of moral standards and values. For instance, Montefiore, after conducting a comprehensive literature review on integrity, deduced that the connection with wholeness is a central theme. Another characteristic of wholeness relates to the interaction with others; that is, integration into a greater system of relationships. Thus, Kaptein and Wempe highlighted the importance of a person being integrated into his or her setting and environment while being sensitive to social issues, and eager to be responsible for himself or herself. For a corporation, Brown (2005) precisely identified social integrity as civic cooperation and thus linked corporate integrity to corporate citizenship and social responsibility. When the natural environment is combined with those of the individual and the organization, then corporate or organizational integrity also comprises the sustainability topics vital to social responsibility. From this second viewpoint on integrity, integrity depends on the level of incorporation and integration into the system in which the actor functions.

A third outlook understands and recognizes integrity as professional wholeness or responsibility. This signifies that integrity happens when a professional exercises his task.
sufficiently, prudently, and responsibly, considering all applicable welfares. This clarification is very common in the literature and comprises a great assortment of professions (including the medical profession).  

Carter reasons that integrity necessitates three main stages:

1. Distinguishing what is right or wrong
2. Acting on what you have perceived, even at individual cost
3. And asserting openly that you are acting on your conception of right from wrong

In summary, integrity means realizing and understanding what you are doing and what values and norms are included and being eager to acting on them candidly.

Consequently, the dominant issue is conciseness and judgment.  

- Virtue of Truthfulness

It refers to a disposition to say the truth (what one understands to be the truth) not once, but repeatedly. It is the tradition of telling the truth even when it is not appropriate or does not act as personal suitability. Truthfulness offers profundity and fairness to the patient-physician relationship. Virtues shape character, and the distinct influence of truthfulness to the inner being of the physician in a particular firmness and internal strength. Speaking the truth should occur within the clinical setting and exceptional characteristics; attending to the patient’s specific and personal needs and accompanied with benevolence. In short, truthfulness plans the patients for full involvement in decisions concerning their own lives.

- The Virtue of Respect

It places a person to acknowledge and appreciate the importance of dignity, value, and freedom of the other person, and to keep sufficient distance to let the other be. It is an indispensable virtue for physicians as it is vital for human development and the existence of communities. Respect is
the virtue that helps physicians cope with the differences between the patient and the physician without manipulation or dishonesty. Respect is fundamental in real life and Kant’s moral theory because it is stemmed from the very formation of persons and relationships. If respect is inadequately established or missing, both relationships and individuals will fail.

- Respect for Autonomy in Medicine

The physician must respect the individual and personal preference of the patient first, and then act in the best medical interest of the patient. This virtue allows patients to make decisions that replicate their ideals and character and fulfill their vital needs. Moreover, it shows itself concretely in the physician’s devotion to all the legal and ethical foundations of truly informed consent.

- Medical Friendship

In the doctor/patient relationship, there are general remarks of an ordinary friendship where self-assurance is shared, trade of benefit, and gratification and desire in one another are company. The physician receives confidence and affection, and the patient helps the physician to gain more medical knowledge, which in turn the physician derives professional fulfillment. Like other virtues, friendship is an element of benevolence.63

- The Virtue of Compassion:

Compassion cannot be articulated precisely in a guideline, rule, principle, or duty. Compassion refers to co-suffering with the patient; trying to comprehend the feeling of the patient’s experience by taking upon oneself somewhat of another’s agony and pain and trying, to a degree possible, to make it one’s own. Compassion is surrounded in a personal dynamic relationship and can only be well-defined in terms of the communication of two individuals, not exclusively one or the other. Moreover, it is linked to an emotional state out of which it may
appear and with which it may be conveyed. Yet, the virtue of compassion is more than emotions. In addition, compassion as a virtue attempts for a mean because the physician must not lose the impartiality vital to the precise assessment of the clinical signs, lucidity, and precision of reasoning, and wisdom of judgment. This necessitates a good equilibrium between compassion as virtue and other virtues of medicine such as competence. The proper balance and monitoring of virtues can be attained by another imperative virtue called prudence.\textsuperscript{64}

Compassion is an element of professional competence and is possibly as significant as technical competence because both are necessitated to achieve profound healing.\textsuperscript{65}

\textbf{6.II.B. Professionalism and Compassion}

\textbf{Meaning of Compassion}

Compassion differs from sympathy and empathy. Empathy, in the clinical setting, can be seen as satisfactory comprehending by the physician of what occurs with the patient concerning his conditions, illnesses, and complaints. This involves emotions, sensations (as pain) as well as evaluative beliefs, optimism, and fears about the disease. Empathy can be supplemented by a positive, but also by a neutral or even unkind attitude. Sympathy is sharing the same feelings with the other while having an optimistic attitude towards him. Compassion, as an immediate, still non-processed effect, could be understood as a certain emotional response to the experienced suffering of another person. Compassion is no very zealous emotion, but a rather calm emotion that creates little feeling in the mind and is more acknowledged by its consequences rather than by the instant sensation. Characteristic for a compassionate reaction include recognition of suffering, benevolence, a feeling of being individually addressed, and an inclination to alleviate the suffering.\textsuperscript{66} Compassion, hence, involves not just affection for others but acting for others.\textsuperscript{57} Compassion incorporates valuable elements besides benevolence: the identification of a bad
condition, a more personal emotion of accountability, and a strong inclination to do something helpful for the needy person.\textsuperscript{68}

Healthcare decisions, then, were made within a framework of compassion and respect for the morals of the patient.\textsuperscript{69} Compassion is a horizontal sentiment because it comprehends the equality between the suffering individual and the person who shares the suffering and pain.\textsuperscript{70} Kant asserts that compassion cannot be a responsibility or a duty.\textsuperscript{71} Compassion is a virtue, an effort, a capability, and a distinction. The fact that it is both an emotion and a virtue, clarifies the advantaged view. Compassion permits people to pass from one realm to the other, from the emotional state to the ethical state, from feelings to commands.

**Compassion Within the Framework of the Physician-Patient Relationship**

Compassion should involve both identifying with another's involvement in suffering and the outlook to want to lessen the other's suffering. Therefore, compassion can be comprehended as a moral virtue and excellence of personality. Reich's considerate examination of the association of suffering to compassion is valuable for understanding how compassion is established within the framework of the physician-patient relationship. He asserts that several patients pass through three main phases of suffering and the doctor can decide the demands of compassion by reference to them.

- Mute Suffering: Often patients are so perplexed by what has occurred to them that they cannot precisely clarify the reason and nature of their suffering. In this phase, the compassionate physician should listen for hints that might aid the patient to express his inner misery. The physician also must assure the patient about the doctor’s presence and support throughout all the patient’s suffering and pain.
Expressive Suffering: Many times, patients do start to manage more dynamically with their suffering. They start to contemplate alternatives and regain the state of autonomy. In this phase, the compassionate physician should try to become the partner of the patient in choosing good alternative options to overcome the suffering.

New Identity in Suffering: In this final stage, the patient gives a new logic of significance to the experience. The compassionate physician who resumes to listen and deliver verbal support enables this alteration.

Reich's understanding of compassion seems more applicable to conditions of extended illness, profound impairment, or other extremely debilitating illnesses. This analysis divulges how the treatment goes beyond the application of technical and medical skills.⁷²

6.II.C. Compassion and Healing

Compassion: A Basic Virtue in Healthcare

Compassion has a significant place in the AMA Principles of Medical Ethics; Item 1, which states that the physician shall be devoted to delivering, experienced medical services with compassion and utmost respect for dignity. The Ethics Committee of the American “Society of Academic Emergency Medicine (SAEM) states that compassion is a part of professional competence and is imperative as technical proficiency because both are vital to result in meaningful healing.⁷³ Arthur Schopenhauer, a prominent philosopher, asserted that compassion is at the very center of the moral life, for everyone not merely to physicians. Compassion can be regarded as a moral virtue because it refers to both identifying with another's experience of suffering but also the disposition to want to alleviate the other's suffering. For this reason, compassion can be understood as a moral virtue. Compassion has two main components:

1) A capability and willingness to enter into another's state deeply enough to gain an understanding of the person's experience of suffering;
2) A virtue is characterized by the desire to lessen the individual's suffering.\textsuperscript{74}

Professional medical ethics stresses the prominence of the accountable and dependable personality of health care professionals besides specific medical duties. Though usually not well analyzed, all professional codes of ethics for physicians include components that are focused on the character of the physician and the intentions of the agent rather than only on the professional rules of conduct.

Based on the definition of Alasdair MacIntyre, virtue is defined as an established trait of character that supports the individual to fulfill the objectives of a particular practice with excellence. Therefore, emphasis should be on the individual to nurture the compassion virtue. Pellegrino and Thomasma have emphasized the prominence of virtue ethics for the clinical self-understanding of physicians and morally sound communication with patients. They have listed numerous virtues (for example commitment to trust, justice, determination) including more emotional ones (compassion), but they have concentrated more on the rational parts of decision-making.\textsuperscript{75}

**Healing and Compassionate Care**

Compassion also relates to the virtue of intending to diminish the patient's suffering, the patient’s chief interest. Because patients have diverse needs and health care practitioners have so many rapidly evolving standards, the precise duties of physicians differ by context. Compassion is not an additional value some physicians create within the context of physician-patient relationships: it is the responsibility of all physicians.\textsuperscript{76} Individuals can achieve healing if they become agents of understanding and compassion. Compassion involves an understanding of the suffering experienced by another. As De Unamuno declares that suffering is the element of life and the origin of character because suffering defines people. Therefore, compassion for the sorrow of others augments the understanding of human nature and makes humans better accept
suffering and appreciate their significance for our spiritual development.\textsuperscript{77} Compassionate care also implies that the patient who cannot be cured by medical sciences and technology — the chronically ill, the mentally retarded, the psychotic—may still be "healed."\textsuperscript{78} Aristotle’s comprehension of virtues attracts the attention of modern healthcare professionals for several reasons, notably because of the importance of exercise, experience, and the role of the mentor: critical importance is assigned to the role of the educator. The moral virtues or excellences of character can be cultured by habituation and the intellectual virtues by systematic teaching training.\textsuperscript{79}

Aristotle contrasts acquiring a good character with developing a skill. Before a person has developed the art or skill one acts in agreement with the directions of a teacher, who guides, and the person acts accordingly to the direction with determination and lots of work. Progressively, by exercise and repetition, it becomes effortless. In a similar mode, one is trained as a child (if lucky in one’s parents and teachers) to become honest, generous, just and the like by being communicated how to behave well and persuaded to do so. Parents supply the intelligence and experience that one has not yet established, and with practice and duplication, it becomes easier and easier to follow their guidance. Simultaneously, Aristotle thinks one’s practical intelligence will progress so that one will depend more on himself and need his teachers and parents less. If properly trained, one comes to appreciate and adore doing things the right way, and to be concerned about doing things wrongly. Similarly, mentors and teachers can facilitate the professional moral development of professionals.

The demonstration of ‘cases’ is one widespread method of teaching ethics, where the moral dilemmas are ‘formed’ and there is an obligation for settlement. This implies that the ‘focus is lessened to the person’s calculated capabilities. However, before the dilemma arises, students
need to see the person influenced by the situation, yet students almost always lack this sort of perception needed to observe. There is an immense range of literature in novels, poetry, which can be used with students to cultivate understanding and vision into real-life catastrophe and human suffering, and as Grayling has recommended, literature proposes the largest and richest store of reflections on the good life available. For instance, Tolstoy’s (1886) ‘Death of Ivan Illych’ focuses on how people, in this case, nurses and other healthcare professionals, may be so wrapped up in technology and pharmacology and the search for theoretical wisdom that they lose sight of the person suffering. It also offers a valuable understanding of the reactions of a family to terminal illness and death.

Literature, art, and film can be used to improve moral understanding and to present new circumstances to those with inadequate experience. In teaching how to be good, there is no need to discuss lists of virtues, but there is a requirement to nourish the mind and cultivate moral thoughts. This would help in developing the professional practices through educating the next group of exemplars.

One of the most appealing foundations of Aristotle’s approach to ethics is the practice stress. Teaching virtue is about persuading hearts as well as minds, and it necessitates a dynamic and thoughtful tactic that goes beyond that which is required for pure theoretical ethics. It is based on everyday training and cultivated by exemplary physicians and clinical teachers.

Ancient Ethics, principally in the Platonic dialogues, discusses the potential of teaching virtue. For instance, Annas (1995), propose that the answer is to be retrieved in skill analogy, and the view that virtue is a kind of knowledge that can be educated and instructed. Annas indicates the crucial fact that Socrates’ attention in the craft/skill analogy is focused on the intellectual character of the Techne. The person of moral excellence has the skill of virtue, and this skill
yields good actions: just as a good potter gives a high-standard creation, a good person will act well in all situations, and a good nurse will deliver a high standard of care. The intellectual component of the skill proposes that moral virtue and practical wisdom can be taught and that people can form moral proficiency.

Annas (1995) deliberates the ‘natural force’ of the ancient idea that virtue is a skill and marks significant issues which result from observing virtue as a skill. Features of a genuine skill that are most substantial for the interest in educating health care professionals are:

- That a skill/virtue is teachable, and teachers can influence moral development
- That is learning a skill there is a measurable development from beginner to expert level (building on experience)
- That the expert has dominated something, and the beginner can acquire from observing this (the exemplar and role model).

Socrates remained doubtful about this, and Pellegrino suggests that even nowadays practitioners and those involved in professional education can be skeptical about the likelihood of shaping students’ moral development as their characters are thought to be previously shaped. Despite some cynicism relating to shaping the moral development of students, Pellegrino (1989) asserts that it can and should be taught. According to Alasdair MacIntyre, virtue is a learned and developed trait of character which inclines to enable people to accomplish their goals of a specific practice with excellence. As Pellegrino suggests, a course in ethics does not make a person more moral. The important thing is not just learning about virtue, but becoming good and this is attainable if suitable strategies are selected. Just as professional educators teach moral theories and principles, they can also impact the moral development of future professionals.

**Chapter 6. Conclusion.**

This concluding chapter summarized the contribution of the Systems Approach in
clinical, organizational, and professional ethics in healthcare. The core characteristics of
the Systems Approach are these: collaboration that nurtures the inter-related identity of
professionals: continuous learning and problem-solving that nurtures the accountability
of professionals, and leadership that nurtures ethical conduct among professionals. The core
characteristics are aligned with each chapter

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12 Pellegrino ED, Thomasma DC. The Virtues in Medical Practice, 5- 6.
14 Begley AM. “Facilitating the development of moral insight in practice: Teaching ethics and
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Chapter 7: Conclusion

This research aimed to pinpoint the essential characteristics of a systems approach to analyze ethical issues in healthcare. This work applied a systems approach to clinical, organizational, and professional ethics in healthcare. This research hopes to inspire systems thinking as an approach to analyzing bioethical issues in healthcare as there has been little engagement between systems scientists and Clinical, Organizational, and Professional Ethics in Healthcare academic literature. The essential characteristics of systems thinking can assist in conceptualizing details of particular healthcare ethics challenges. These characteristics were applied to various issues in healthcare ethics. This research presented new ideas about the relationship between systems thinking and bioethics by reading the evolving systems thinking approaches and bioethics literature and identifying the underlying attributes of this approach and their use in ethical decision-making in healthcare.

Three main characteristics of a Systems Approach lead the analysis of the chapters. First, there is collaboration across disciplines, sectors, and organizations that engage holistically and coherently the complexities and interconnected relationships in healthcare. This characteristic nurtures the inter-related identity of professionals in healthcare. Second, there is continuous learning for practical problem-solving to address existing and emerging real-world challenges in healthcare. This characteristic nurtures the accountability of professionals in healthcare. Third, there is leadership that inspires ethical behavior among all stakeholders, being attuned to the contextual, operational reality of healthcare. These characteristics nurture ethical conduct among professionals in healthcare and offered a coherent conceptual base that sets the stage for this dissertation.
The conceptual strand of this argument focused on constructing systems thinking as an approach to tackle the complexities that encompass healthcare ethics today. It concluded that systems thinking is well equipped to attend to the interdependency and complexity of healthcare given that it encourages awareness of the relationships in healthcare. After researching and analyzing the key issues in clinical ethics (chapter 4), in organizational ethics (chapter 5), and in professional ethics (chapter 6), the primary attributes of a Systems Approach provide a framework to analyze ethical dilemmas in the healthcare sector given the complexity of ethical issues in healthcare. This dissertation presented the three characteristics of Systems Thinking as a methodology to understand and resolve health ethical challenges, tackle both clinical, organizational, and professional issues, identify instability, and respond adaptably to evolving opportunities.

Chapter 3 discusses the Systems Approach in ethical decision-making, highlighting the significance of vulnerability and consent. This chapter provides a holistic system thinking approach to identify vulnerabilities of research participants and highlights the interplay of social, political, and environmental factors that result in or exacerbate vulnerabilities and thus affect the consent of research subjects. It argues that informed consents are not adequate by themselves as means of protection and concludes that the systems approach respects the significant relationship between autonomy and freedom. Therefore, it emphasizes the need to view informed consent as a process, a discussion, and a continuous learning process. It underscores the need for collaboration across cultural, socioeconomic, and educational organizations to engage in a holistic approach to understand the complexities and length, and difficulty of informed consent. Collective effort is required to realize the motivations, preferences, and needs of research subjects. Without leadership from international institutions, no protection of research subjects can be achieved. A systematic
discussion of the universal normative framework and major ethical codes and institutions standardizing the norms of research in the clinical trial was highlighted.

In the second part of the analysis that deals with ethical decision-making, the section discusses the significance of healthcare ethics consultation in confronting ethical challenges while delivering healthcare services and in advocating the ethical existence of a healthcare organization. It argues that consultation services should be formally integrated into organizational policy because collaboration among several components and departments plays a significant role in creating quality-consultation services. Moreover, the collaboration would bring together a holistic approach and offer diverse critical thinking. The section highlights the importance of leadership support, accountability, staff time, continuous organizational learning, access, and proficiency.

Chapter 4 discusses the Systems Approach in ethical decision-making, highlighting the significance of patient safety and epigenetics. In the first part, the argument attempts to reflect on the way leadership in healthcare organizations can create a patient-centered and safe culture. The argument builds on the fact that the modern patient safety movement is more of a system thinking oriented. This emphasis ultimately promotes communication of mistakes and positively influences continuous learning within an environment that is supportive of open discussion to enable safe practices. Most importantly, this approach requires the collaboration of leaders and healthcare practitioners from different departments to promote a culture of safety. In addition, the argument highlights the significance of a close collaboration between the patient safety team and the ethics team. This would confront the issues in a systematized and proactive system-oriented approach.

In the second part, this section discusses the systems approach by underscoring the interconnecting relationship between health problems on one hand and the social and economic inequalities on the other hand. Molecular epigenetics emphasizes the significance of taking into
account the external factors affecting a system (the human body system in this case) in the resolution of a systemic dilemma, a health disease in this case. The close biochemical interaction between genes and environment, explained by recent scientific research in epigenetics, illustrates the ecosystemic connection that human beings are part of. The systems approach highlights the environmental and social dimensions of health and the nonpathological bases of poor health epigenetics. This approach implies that bioethicists need to broaden the scope of bioethics reflection about justice, a scope that is more articulate with the extremely complex and interconnected character of human health. The systems approach implies that bioethicists should try to pursue the link between the individualistic approach of bioethics and the social dimensions of health. Here, the importance of collaboration among diverse sectors to understand the root causes of bioethical issues is emphasized.

Chapter 5 discusses the Systems Approach in ethical decision-making, highlighting the significance of corporate social responsibility and governance ethics. In the first part, the systems approach stresses the importance of the role and collaboration of various stakeholders in the sustainability of the healthcare organization. The systems approach encourages organizations to think about its comprehensive and holistic effects on the whole society and to be receptive to the challenges and needs of internal and external stakeholders affecting the system. Through this approach, the healthcare organization will enhance the technical know-how and continuous learning. The argument continues to emphasize that the sustainability of the organization is not feasible without the enlightened leadership and the ethical performance of managers and directors.

In the second section, the argument explores the numerous systematic ways in which the board of directors works to create good ethical governance at healthcare organizations. It discusses
the value of integrating quality and patient safety in all its decisions and integrating ethics in
everyday practices. It highlights the importance of leadership and the significance of developing a
system thinking approach for the boards of directors, thinking internally about the organizations
and its parts, and outwardly at the company in its competitive market position and its wider
economic, political, and social setting. The systems approach divulges the importance of
continuous learning where boards of directors must continuously revise practices and ethical
principles expressed in vision, mission and value statements, and other leaflets to ensure that there
is a systematic and collective perception of the organization's devotion to ethics; and reinforcing
viewpoints and behaviors that indicate that ethics is vital to accomplishing the organization's
mission. Moreover, the argument continues to argue that board members need to think in a
systematic approach regarding any ethical challenge they confront to capture the holistic picture
including the capability to assess societal and community health needs, offer the delivery of quality
care, exercise sound business reasoning and to be comparatively up to date with how the health
field commonly functions through continuous learning and training.

Chapter 6 discusses the Systems Approach in ethical decision-making, highlighting the
significance of virtue ethics and virtues and the professions. This chapter highlights the
contribution of continuous learning to moral agents- via regular habits- how to develop and nurture
good characteristics. This chapter highlighted the significance of moral education especially to
healthcare workers through the presence of ethically (and clinically) good leaders and in various
settings and scenarios, again through the collaboration of practitioners and guidance from
healthcare leaders and physician leaders.

The established element of the argument focused on three main characteristics through the systems
approach to lead the analysis of various healthcare ethical challenges. The ethical vision of any
healthcare challenges can be better defined through adopting this approach in clinical, organizational, and professional ethics. This framework can be useful to process ethical challenges enough to adjust to the broad type of healthcare organization or the nature of the ethical challenge.

In conclusion, effectively managing ethical analysis in this shifting landscape suggests that the collaboration of diverse people with various roles and assorted organizational expertise and technological expertise is very significant to contribute to the debate of holistic moral expertise and the role of ethicists in healthcare organizations. Additionally, the fruits of this research will need to impact the academic philosophy of the institution as well as its approaches of thinking, training, communication, collaboration, and learning. Moreover, the emphasis of this paper highlighted the importance of the systems thinking approach as continuing learning whereby systems-level change involves an appreciation that the setting is regularly changing. This emphasis teaches the actors in healthcare organizations about the importance of continual learning and training to incessantly adapt, understand, and apply new understanding and information to existing challenges. This approach also underscored the influence of leadership in understanding ethical dilemmas on hand, and inspiring ethics of culture on the other hand.

The conclusion of this research set the path for further critical research endeavors. This section offers a view of potential investigations beyond the extent of this thesis and building on its findings. To better recognize the implications of these results, future studies could bring out the relationship between systems approach and ethical decision making in healthcare and applying this approach in various scenarios. As such, future work on the specific questions facing forms of healthcare organizations seems helpful. One important next step would therefore be attempting to recognize and understand how to build the systems thinking skills of current and future healthcare
leaders as an approach to think holistically and solve ethical challenges as a team with multiple stakeholders and to think about any given scenario in a continuous learning fashion. How concrete this needs to be valuable is an open question; nonetheless, the inquiry of founding a verification level of analysis may prove to be required to sufficiently deal with ethical inquires in the healthcare sector. Future work that helps healthcare organizations conceptualize this concept of systems thinking and operationalize it to cope with ethical challenges would be very useful to offer a holistic picture about ethical dilemmas and see the underlying connections of ethical challenges.
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