5-1991

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WMU ScholarWorks Citation

Pisaneschi, Janet, "Virtue and the Health Professions" (1991). *Center for the Study of Ethics in Society Papers.* Paper 17.
http://scholarworks.wmich.edu/ethics_papers/17

WESTERN MICHIGAN UNIVERSITY

Center for the Study of Ethics in Society

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Papers Presented to the Center
Vol. 4, No. 3
May, 1991

Center for the Study of Ethics in Society
Western Michigan University
Kalamazoo, MI 49008

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Founded 1985
Phone (616) 387-4380

Publication Editor: Paul Farber

This booklet printed on recycled paper.

VIRTUE AND THE HEALTH PROFESSIONS

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Presented to the WMU Center for the Study of Ethics in Society,
February 8, 1991

This paper is not what its published title promises. It is not an exploration of the place of virtue in the professional life of the health care provider. Rather, this is the preamble to such a paper. It is an attempt to sort through my own disquietude about current theory in biomedical ethics. I have tried to do this sorting by reviewing and pulling together the threads of a number of the more compelling, recent critiques of prevalent ethical theories. Basically, I am trying to answer three questions: What prompts me to think there is a problem? Who else thinks there is a problem? And, what are the general parameters of this problem?

But, I begin with a little history--
In the 1973 annual oration of the Society for Health and Human Values, Edmund Pellegrino advocated a new rapprochement between philosophy and medicine, between Minerva and Aesculapius. Pellegrino foresaw mutual benefit resulting from this rapprochement. Philosophy could reinfuse "critical intelligence into medical thought, practice, and education." It could enable the new medicine to develop a "'new' value system to match its potentialities." [1] And medicine, he hoped, could be

instrumental in philosophy's reclaiming its role as a "significant factor in culture."[2] High hopes!

Almost ten years later, in 1982, Stephen Toulmin concludes in his article, "How Medicine Saved the Life of Ethics," that the "interaction with medicine, law, and the other professions (in the 20 years prior) has had spectacular and irreversible effects on the methods and content of philosophical ethics." Toulmin continues,

> By re-introducing into ethical debate the vexed topics raised by particular cases, they have obliged philosophers to address once again the Aristotelian problems of practical reasoning, which had been on the sidelines too long. In this sense, we may indeed say that, during the last 20 years, medicine has 'saved the life of ethics', and that it has given back to ethics a seriousness and human relevanc which it had seemed--at least, in the writings of the interwar years--to have lost for good. [3]

Not everyone in philosophy has appreciated either this "new rapprochement" or this "resuscitation." Not everyone in philosophy has welcomed the preoccupation with practice or "clinical ethics", with the emergence of physicians or other health professional "upstarts" attempting to "do" ethics without philosophical portfolio.

Nor has everyone in medicine taken kindly to the intrusion of philosophy and philosopher/ethicists into the medical education curriculum, into the hospital committee structure, or onto the patient bedside.

Nonetheless, both philosophy and medicine have reaped some harvest from this cross fertilization. But is the harvest of the sort that Pellegrino and even Toulmin anticipated? Has philosophy given order and a viable value system to medicine? Has medicine truly humanized philosophy and returned it to cultural significance?

If we were to use bibliographies as an indicator of the extent to which the "critical intelligence" of philosophy has been infused into medical thought, practice, and education, we would declare the rapprochement a success. The literature of what has come to be known as "biomedical ethics" is voluminous. New special journals have been developed and innumerable books have been published. The sources of all of this scholarship include both philosophical ethicists and health professionals, some with formal education in philosophical ethics or bioethics, and some without.

The number of textbooks available provide evidence of the proliferation of academic courses or programs over the past twenty years. Ethics rounds have been established in clinical settings to enable students and practitioners alike to cultivate their sensitivities to the moral dimension of their practice and to sharpen their skills at addressing the moral problems that they face. However, even with all of this education and this published philosophical reflection on the practice of medicine and the delivery of health care, I believe that vexing, fundamental problems and doubts remain about this rapprochement. Now, perhaps, even more than at the time twenty years ago when Danner Clouser first made the observation, this "mixed marriage" of philosophical ethics and medicine is in need of counseling.[4]

The doubts about this relationship are of two related sorts and they go to the heart of Pellegrino's expected outcomes of the "new rapprochement". First, there are doubts about the applicability of philosophical theory to medical practice.

Second, there are related or consequent doubts about the adequacy of the present ethical theories that we are attempting to apply to medicine. These are not simply doubts that the deontologist might have about the utilitarian or vice versa. Rather, these are, for the most part, doubts about the adequacy of the sort of ethic that has evolved to address the complex ethical challenges of medicine.

For the most part, the first of these doubts, those about the applicability of theory to medical practice arise from observing the practice of philosophical ethics; and those doubts about the suitability of the prevailing medical ethic or value system arise from observing the practice of medicine or health care. Let us look now at how some of these doubts are being articulated in the current biomedical ethics literature.

I'll begin with the first of these misgivings. Albert Jonsen has long been skeptical about our ability to link specific practice or particular moral judgments to ethical theory. In a recent review of the 1989 edition of the Beauchamp and Childress textbook, Principles of Biomedical Ethics, Jonsen notes that he is not alone in his skepticism. Jonsen points out that in the three successive re-editions of the Beauchamp and

Childress text the authors express a diminishing confidence in our ability to find a higher-order ethical theory from which middle-level principles can be derived and to which we can appeal in making particular moral judgments.[5]

Jonsen and others, including, probably, any number of medical ethics instructors who use case method, describe a phenomenon that has prompted some of the doubts about the significance of theory for practice. They observe that when groups of people discuss and attempt to resolve particular moral dilemmas or cases studies, advocates of diverse, even opposing, ethical theories often come to the same conclusion or practical judgment. Jonsen uses the example of the deliberations of the President's Commission for the Study of Ethical Problems in Medicine to illustrate this phenomenon--this ability to achieve consensus around specific cases in spite of differences in theory.[6]

In his book, The Abuse of Casuistry: A History of Moral Reasoning, written with Stephen Toulmin, Jonsen proposes a return to the use of casuistry; that is, a return to arguing or deciding a particular case based on prior cases or precedence, as in the practice of common-law. Jonsen sees casuistry as a viable and defensible alternative to the often times fruitless traditional practice of deducing moral practice from ethical theory.

However, Jonsen and Toulmin's pragmatic solution presupposes some common moral intuition and a common cultural framework in order to successfully argue cases. But as George Annas and other critics of casuistry have pointed out, "Part of our current malaise is that we appear to lack such common ground."[7] Although Jonsen's solution is not a totally convincing one, his search does underscore our inability to cleanly link practice to some one higher order theory which we all affirm.

Leon Kass, in a recent article marking the twentieth anniversary of the Hastings Center, also presents a sweeping critique of the practice of biomedical ethics today and puzzles over its relationship to the everyday practice of medicine or health care.[8] In his critique, Kass voices doubts about both the applicability and the suitability of the ethic of medicine. For Kass our problems with application of theory are a consequence of the nature of the theory we are trying to apply. How, Kass wonders, can our current, highly rationalistic philosophical ethics--given to abstractions, to rules or sometimes guidelines-- facilitate moral decisionmaking in the often complex, sometimes critical and confusing, sometimes routine and frustrating, always contextual, daily practice of medicine and health care?

Philosophical ethics today, Kass contends, as do I, is not only rationalist but "hyper-rational." He states:

> The dominant mode of American philosophizing today remains analytic. It concerns itself with the analysis of concepts, the evaluation of arguments, and the criticism of justifications, always in search of clarity, consistency, coherence. It spends little time on what genuinely moves people to act--their motives and passions: that is, loves and hates, hopes and fears, pride and prejudice, matters that are sometimes dismissed as nonethical or as irrational because they are not simply reducible to logos.[9]

"Rationality at work," Kass notes further, "is above all a problem-solver." And rationalistic philosophical ethics, in its approach to medicine and health care, isolates and focuses on problems which it abstracts and analyzes. The problems most appealing for such analysis are the problems of extremes. So, the "morality of ordinary practice,Kass observes, "is largely ignored."[10] Further, in so far as the problem solving process is rigorously rational, the solutions are often "purely rational" rules to govern conduct, or ideals toward which we should strive. "The methodical rationality of procedure," Kass complains," is put in place of the discerning reasonableness of the prudent man-on-the-spot that all real choices demand."[11] In addition, our current theory too often leads us away from the confounding moral complexities of our medical practice, to search for simple, clean, minimalist principles--autonomy or benevolence, and the like.

Other participants in and observers of medical and health care practice echo, from a variety of perspectives, Kass's critique of a rationalistic approach that can deal only with abstractions or with ideals, or with clear cut rules logically applied. Clinicians are confronting increasing numbers of disconcerting medical or health care practice issues that are not readily or suitably resolved with such an approach. Let's look at some of these examples.

Some of them, I should note, have arisen as a consequence of our incredible achievements in medical and biological technology and research (once again validating the warning that ". . .today's achievement is only tomorrow's confusion"). In looking at these practice issues, I will focus on only one of the central ethical principles in biomedical ethics, i.e., autonomy. And the practice issues to which I will refer will be limited to: 1) the care of impaired elderly and the decisionally incompetent, 2) the cost of and access to health care, and 3) the treatment of persons with AIDS. My purpose is not to defend or deny the solutions provided by the authors presented but rather to point up the problems that they identify, most of which I also recognize as such.

Autonomy in biomedical ethics in the U.S. has been pivotal--even sacrosanct. The practical application of the traditional notion of autonomy to the everyday care of the impaired elderly or of persons in a persistent vegetative state has left clinicians and ethicists alike unsettled. Several recent authors have identified and attempted to address the limitations of the principle of autonomy as it has been articulated or interpreted to date.

James Childress, in the past a dedicated proponent of autonomy, has attempted in a recent article to re-articulate its meaning. Autonomy, Childress now informs us, is complex because real persons are complex; they are not idealizations or abstractions. There can be no simple or, as he puts it, "no mechanical application of a clear-cut moral principle" here. Sometimes when we make a supposedly autonomous choice, we don't know what we are choosing, sometimes we contradict ourselves, sometimes we change our minds, sometimes we choose one thing but really would choose another if we weren't being intimidated--and this applies to you and me and not only to the impaired elderly or others who are decisionally incompetent.[12] The patient's history, values, and context, Childress asserts, must be considered when trying to determine if an act is autonomous. The autonomous individual is not an abstraction.

George Agich, moves the discussion of autonomy even more emphatically from the realm of abstraction into the realm of daily reality. "Traditional treatments of autonomy," Agich observes, "simply abstract from actual examples of finite human autonomy and context of choice and focus instead on idealizations of autonomous action and choice."[13] Agich calls for, instead, a "refurbished, concrete concept of autonomy that systematically attends to the history and development of persons and takes account of the experiences of daily living."[14] "Actual" (in contrast to "ideal") autonomy, as Agich defines it, is complex and "clearly less neat" than the traditional view. For him, "Expressions of (actual) autonomy are. . .the playing out of who the individual is as well as who the individual is becoming; the field or state for such 'playing out' is the social world of everyday life." [15] In addition, Agich contends that to understand autonomy one must understand how individuals are interconnected. We must understand, also, the place of habit in daily life. We must understand that habitual actions, if consistent with one's self-identity are as autonomous as those actions that arise from "reflective, deliberative decisionmaking.[16] They cannot be denied or dismissed.

John Hardwig, in his article "What about the Family?," explores even further this notion of interconnectedness in autonomy, especially as it relates to the impaired elderly or the decisionally incompetent. In the traditional or idealized view of autonomy, individualism is central, relationships or interconnectedness are peripheral or less. Hardwig observes, however, that

> The way we analyze medical treatment decisions by or for patients is plainly anomalous to the way we think about other important decisions family members make. I am a husband, a father, and still a son, and no one would argue that I should or even responsibly could decide to take a sabbatical, another job, or even a weekend trip solely on the basis of what I want for myself. Why should decisions about my medical treatment be different? Why should we have even thought that medical treatment decisions might be different?[17]

Hardwig warns that to adhere to an individualistic, disconnected concept of autonomy in medical ethics will serve only to isolate the individual patient more and to diminish the role and importance of relationships and of community.[18]

Let us continue to look at autonomy but move now from concerns related to the care of the impaired elderly and the decisionally incompetent to the issues of health care cost and access. Concerns-- if not panic-- about the cost of medical and health care and the allocation of these resources are also leading theorists to try to re-articulate or revise the traditional view of autonomy. A number of critics are advocating, as I have noted, a return to the consideration of our interconnectedness or community. One example of such an attempt is presented by Danis and Churchill in their article, "Autonomy and the Common Weal."[19] The authors review the current critical state of access to health care and examine, as well, the debate about the role that the individual physician should play in addressing the cost issue. Should the physician be society's gatekeeper to health care resources, especially those that are costly? Some clinicians, like Pellegrino, declare that the physician must be the advocate of his/her patient solely and that the physician ought not be, simultaneously, an instrument of social justice. If one follows this line of thought, considerations of the cost of diagnostic or treatment modalities should not enter into the physician's deliberations when treating an individual patient. Others, however, consider this bracketing of cost issues as irresponsible and contributing to the growing cost and access crisis. Danis and Churchill suggest that perhaps both sides are somewhat correct. They recommend a "new integrated moral framework" to resolve this conflict. The authors propose a concept of citizenship to undergird this new framework--not an altogether original concept. Both the physician and the patient, the authors contend, must see themselves, and accept their role, as citizen. As citizens, both belong to "something larger than self, or (their) particular individual relationships." This larger than self perspective must balance the perspective of the autonomous individual.

Certainly, this proposed new framework is not the total answer to the crisis over health care access and cost, but its suggestion does, again, underscore the inadequacy of a principle of autonomy that isolates the individual.

Most of the examples that I have just reviewed deal with the growing realization that our ethical theory deals too much with abstractions or ideals. More specifically, in the cases reviewed, it deals with the "ideal autonomy" or with the individual as an abstraction rather than with the actual and the concrete. What has been suggested in varying ways by the authors reviewed, is a principle of autonomy that recognizes and respects the history, context, and interconnectedness of the person who is patient.

There is yet another important facet of the rationalism of our prevailing biomedical ethical theories that we must consider. It is the emphasis on principles and rules, rights and obligations, and the de-emphasis on the consideration of those factors that truly move people to act morally. Kass observes that the rationalistic approach,

> speaks little about motives and attitudes, and still less does it concern itself with figuring out how to get people to do what theory says is best. Universalist in conception, it cares little for the variety of human types, some move by the love of gain, others by the love of honor, some by reverence, others by fear, still others by pleasure. In short, it treats the rational content of speech and argument without regard to the engaged concerns that incite both speech and action. It by and large ignores mores and customs, sentiments and attitudes, and the "small morals" that are the bedrock of ordinary experience and the matrix of all interpersonal relations. It by and large ignores real moral agents and concrete moral situations,

> preferring the abstraction of the hypostatized "rational decisionmaker" confronting the idealized problem needing to be solved. . .Though originally intended to improve our deeds, the reigning practice of ethics, if truth be told, has, at best, improved our speech.[20]

If we do indeed want an ethics that enables us to make a practical moral difference, then we must be concerned about moving both the patient and the provider to action. Any number of other theorists, past and present, have troubled over this challenge, as well.

In current medical and health care practice, the conflicts that have arisen over the care of persons who are HIV positive or who have AIDS have forced this challenge to the forefront. Is an ethic of obligation and rights that also stresses autonomous individualism adequate to moving providers to act responsibly in the face of the AIDS epidemic.

In a 1987 article, Abigail Zuger, a physician who did her residency training in the wards of Bellevue Hospital in New York City, aptly addresses these "physician-oriented" ethical issues. "Is a physician ethically obliged to care for a patient with AIDS? What does the care of these patients do to the physician's training, practice, and quality of life?" Zuger asks.[21]

It is the case that a number of physicians, dentists, residents, nurses, respiratory therapists, and others, have explicitly refused to treat or to care for persons with AIDS or with HIV infection. Zuger points out, however, that there are many more subtle forms of refusal to treat. She describes the AIDS patient who is never visited on morning rounds for any number of specious reasons-- "there's nothing new to say; all the students upset him; the intern will come back and talk to him later." Or there is the person with AIDS in the emergency room whom caregivers delay in seeing--procrastinating because they know the difficulties to be faced. And, the author observes, "Probably most common of all. . .are the refusals that never take place," because interns, residents, physicians, and other health professionals simply avoid training or practicing in facilities in which they may have to provide care for persons with AIDS. As the epidemic spreads, however, this form of avoidance will be more and more difficult to accomplish. I would add the personnel shortage crisis we are experiencing in the field of medical technology--some of which has been attributed to AIDS--as another example of refusal to care.

The reluctance of physicians and of other health professionals to care for patients with AIDS, Zuger reports, can be ascribed to a number of difficulties that must be faced in delivering that care. Fear of infection, although the most frequently cited, is perhaps the least important, she notes. Some of the other difficulties in delivering care relate to the nature of the various diseases called AIDS. For example, these diseases can be palliated but seldom cured; they are debilitating, depressing, and often times ugly--causing, in varying cases, unrelenting diarrhea, skin lesions, physical wasting, neurological impairment, blindness, and unremitting pain; their treatment requires esoteric knowledge that is rapidly changing; and the care required is time consuming, requires inconvenient precautions and is technically sophisticated. Other causes of the reluctance to care relate to the AIDS patient. As Zuger notes, "These needy, time-consuming patients are all too frequently persons whom many physicians (and other care providers) have inherent difficulty in accepting."22 They may be gay, IV drug users, or prostitutes--ready targets, even precluding the disease, for misunderstanding at best, as well as acrimony and blame. It is within this context that the question of the responsibility of and the motivation for the health care professional to provide care is raised.

Zuger does not give a definitive response to her original question about the ethical obligation to treat. Rather she describes the full spectrum of responses that have been made by individual physicians and those that have been counseled or mandated by various physicians groups. Interestingly, she entitles this section of her article "A Spectrum of Self-Sacrifice." Zuger includes both the joint statement of the American College of Physicians and the Infectious Disease Society of America, issued in early 1986 and the AMA statement issued in late 1986. The former is brief and clear: "denying appropriate care to sick and dying patients for any reason in unethical." The latter hedges: it allows that "not everyone is emotionally able to care for patients with AIDS."

To my mind, given all of "the parameters (the difficulties and constraints) that define the medical care of patients with AIDS," as Zuger and others have experienced and articulated them, an ethics of rights and obligations, of autonomous individualism, cannot alone make a practical moral difference or move the health professional to act responsibly. I believe that looking at the delivery of care for the elderly in long-term care facilities prompts the same sort of conclusion. Some of the same parameters exist in the context of the care for this population as in the care of persons with AIDS.

From my own observation of clinical practice, both with AIDS patients and the impaired elderly, I know that the health care provider needs more than a sense of duty or obligation just to sustain him or her. I know, too, that to treat or to provide care for the AIDS patient or impaired elderly resident, the health care provider will need patience, endurance, courage, loyalty, prudence, considerateness, to mention just a few virtues or moral habits.

With some few exceptions - such as Pellegrino, Drane, Kass - these characteristics or virtues are seldom, if ever, brought up in our discussions of rights and obligations. We shy away from speaking of virtue and character, even in our educational process. We fear it will sound like moralizing. We fear the accusations of not being "rational" or of abandoning philosophical rigor as we search for some standard of the "good" against which to measure our virtue and our character. Yet, in terms of making a moral difference, these virtues may well be essential.

They make a difference to both the health care provider and to the patient. I can recall observing the manner in which various LPNs cared for my father during his stay in a long term care facility before his death. He was fragile; I worried that they would not be attentive or caring. I wanted them to be considerate and patient and loyal to him. I wanted my father to be more than an "obligation" for them. I wanted them to realize that he was more than a "bearer of rights", as Cohen has put it, that he "should receive gestures that confer respect." [23]

From my own observations of clinical practice, I know that in addition to a realization of one's obligations and the need for virtue, health professionals must learn to live with ambiguity and uncertainty. Our current rationalistic theory (I would agree with Kass) abhors messiness, inexactitude, ambiguity. However, medicine and even more so, biomedical research, especially as it grows and evolves and even succeeds as a science, often leaves us confused, ethically and politically, and even clinically. I was surprised and delighted with a particularly disarming response to a recent Hastings Center Report case study. The case study questions the morality of the laboratory creation of transgenic animals or transspecies chimera. Freedman and Goulet, in their commentary, readily concede that such transspecies manipulation is not, as they put it, "business as usual." To address this challenge, they counsel that, "We will need to canvas our traditions, religious and cultural as well as ethical, for clues. . . we will need to entertain and explore new principles of reasoning, too." They conclude their commentary with the thought that, "We are not suggesting that transpecies manipulation be banned, nor are we prepared to say how it should be controlled. We are simply wondering how we should think about it. All that we are certain of is how this inquiry should start: with somber awe." 24

Freedman and Goulet's counsel is a fitting conclusion to this paper. Pellegrino's hoped-for rapprochement between philosophical ethics and medicine is not yet complete. Current philosophical ethics has proposed to medicine a framework of values or theories that does not fit medicine's complex needs. To make the fit, in addition to abstract theories and principles of rights and obligation, there is need to make accommodations for the concrete, even the non-rational, for uncertainty, for interconnectedness, for virtue and character. I don't see the resolution of our dilemma to be an either/or choice--rationalism versus non-rationalism. And certainly dealing with dualisms is not new to philosophy. But like Freedman and Goulet, I think that to further this rapprochement, we must "canvas our traditions, religious and cultural, as well as ethical;" we must "entertain and explore new principles of reasoning, too."[25]

And in the meantime, I believe that I must re-examine and broaden what it is I am teaching health professionals. I cannot portray current theories as the whole and only truth. I cannot present the four prevailing principles (the "mantra" of bioethics as Jonsen calls them) of bioethics--autonomy, nonmaleficence, beneficence, and justice, as the full and adequate armamentarium that health professionals will need in daily practice. The next paper will be much more difficult than this first.

NOTES

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22. Ibid., p. 18.

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BIOGRAPHY

Dr. Pisaneschi received her degree in philosophy from St. Louis University in 1972. In 1976, as a visiting professor in the Human Values and Ethics Program at the University of Tennesse in Memphis, she helped to implement a medical ethics clinical internship for graduate students in ethics. In 1983 at the University of Kentucky, she was the project director for an NEH funded six-week institute on health care ethics for allied health faculty, and in 1984 she served as project director and moderator for a national videoconference on ethics for health professionals. Currently she is Dean of the College of Health and Human Services, Western Michigan University.

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Jan 28	**Christine Korsgaard** Philosophy, University of Chicago **Creating the Kingdom of Ends: Responsibility and Reciprocity in Personal Relationships** *Monday, 8pm, Olmsted Room* *Mandelle Hall, Kalamazoo College*
Feb 8	**Janet Pisaneschi**, Dean, College of Health and Human Services, WMU **Virtue in the Health Professions** *Friday, 3:00pm, 205 Bernhard Center*
Feb 22	**Rudolph Siebert** Department of Religion, WMU **Habermas's Communicative Ethics** *Friday, 3:00pm, 205 Bernhard Center*
Mar 18	**Lisa Newton**, Director Program in Applied Ethics Fairfield University **How Valuable is the Environment?** *Monday, 7:30pm, 3750 Knauss*
Mar 28	**Patrick Jenlink** Department of Educational Leadership, WMU **Ethical Leadership in Educational Settings:** **A Panel Discussion** *Thursday 3:00pm, 205 Bernhard Center*

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