



Clinical Bioethics in the Twenty First Century: An Integral Perspective

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Abstract

My hypothesis is that the dominant theory and practice of clinical bioethics ignores one or more fundamental perspectives or methodologies, and is therefore often incomplete and ineffective. Offered as a corrective are the integral theories of philosopher Ken Wilber, also known as the AQAL (All Quadrants All Levels) approach. Current debates within the field of clinical bioethics will be discussed and a system based on AQAL will be introduced which will provide a more inclusive, integral process for case consultations, policy development, and community education.

Introduction

“The word integral means comprehensive, inclusive, nonmarginalizing, embracing. Integral approaches to any field attempt to be exactly that—to include as many perspectives, styles, and methodologies as possible within a coherent view of the topic. In a certain sense, integral approaches are “meta-paradigms,” or ways to draw together an already existing number of separate paradigms into an interrelated network of approaches that are mutually enriching.” —Ken Wilber

“The moral quality of a clinical decision is dependent on the process of that decision and not only on the outcome. We are accountable and responsible for the way in which our decisions are reached.” ---David Kuhl & Patricia Wilensky

In 1992, the Joint Commission on the Accreditation of Healthcare Organizations (now known simply as The Joint Commission) drafted a new regulation: all its approved hospitals must put in place a means for addressing the ethical concerns of patients, families, and health care personnel. The seed that led to this regulation had actually been planted much earlier and in a number of different venues. In the 1960s, US Catholic hospitals had begun to develop committees to discuss **“morals in medicine”**, and kidney dialysis selection committees were beginning to appear to help make decisions about the rationing of this new, limited resource. In 1976, a reference to the use of committees to help make treatment decisions was made by the New Jersey State Supreme Court, in the

famous Quinlan case. (Fletcher and Hoffmann 1994) Driven by an increasing ability to keep people at least clinically alive through improved technology, as well as a need for whole organ donors, the concept of “Brain Death” was being debated, and hospitals needed to develop new policies to keep up. Many saw the concept of brain death as a mere social construct. (Franklin and Lock 2003) By the time The Joint Commission issued its new regulation in 1992, many hospitals had already formed committees and academic training programs for would-be ethicists were popping up throughout the country. Today, virtually every acute-care hospital in the United States has an organized bioethics committee or individual bioethics consultants. Their most common functions are staff education, policy development, and case consultations. (McGee et al. 2001)

The history of health care ethics is considerably more detailed, and is as old as the Hippocratic Oath. For an excellent review I refer the reader to Albert Jonsen’s book entitled “A Short History of Medical Ethics”. Professor Jonsen begins his book by poignantly describing the prevailing attitude of physicians regarding medical ethics when he entered the field, some 30 years ago: “they believed in simple rules, such as firm dedication and courtesy to one’s patients, confidentiality, and the duty to provide free care for the poor”. (Jonsen 2000)

Much has changed over those 30 years, and the field of bioethics has grown and matured. But even as it has become a more mainstream academic and clinical field, clinical bioethics is not without its critics, who continue to worry about the theories and practices in daily use, the lack of national standards or accountability, and very little research-based evidence of practical efficacy. (Shalit 1997)

In this paper, I hope to illustrate that my quarrel with clinical bioethics is not just its narrow approach to complex problems, but that it is disconnected from the values and views of patients, families, and community. The field is now dominated by professionalized bioethicists and a single dominant theory, rather than its original vision of multi-disciplinary committees involving members with different backgrounds and perspectives. (Belkin 2004) I will introduce the integral theories of philosopher Ken Wilber, also known as the AQAL (All Quadrants All Levels) approach. Current debates within the field of clinical bioethics will be

discussed and an approach based on AQAL will be introduced which will provide a more inclusive, integral process for case consultations, policy development, and community education.

The challenges that I describe in this paper are not merely academic interests to me. I have been a bioethics consultant, chaired hospital-wide bioethics committees, and taught classes and seminars about bioethics for over 15 years. I have used the tools and made the decisions in exactly the ways that I am critical of in this paper. That experience has led me to seek a more inclusive, integral approach. The method that I will propose is both a way of looking at bioethical issues and a practical way of doing bioethics at the bedside.

Whats Wrong With Clinical Bioethics

With increasingly complex treatment decisions that can involve moral and legal questions, patients and families (as well as health care providers) often look to ethics consultants and hospital bioethics committees for assistance. However, there is very little data available about the effectiveness of these committees or their makeup and training. Intended as a solution to clinical dilemmas, and now required by organizations for hospital accreditation, there are no recognized standards for training the members of a hospital bioethics committee. (McGee et al. 2001) There are now many degree programs and conferences available for training, as well as two long-standing summer intensives which have attracted bioethics committee members for years; one is at Georgetown University, and the other is sponsored by the University of Washington. They promote ethical analysis in essentially the same way, although with some subtle differences. The theory they espouse is a variant of applied ethics known as principlism, and hundreds of health care professionals across the country can name "The Georgetown Mantra" as a result of these popular, week-long conferences.

Principlism seeks to apply four principals when working through a bioethical dilemma or decision. (Beauchamp and Childress 2001) Those principles are

- 1) Respect for Autonomy (respecting people's decisions);
- 2) Beneficence (the duty to help others);
- 3) Nonmaleficence (do no harm); and
- 4) Justice (equal distribution of benefits and burdens).

Principlism as taught by the bioethicists at Georgetown University tends to apply these four

principles over any given case. The difference between Georgetown and the program at the University of Washington is that UW endorses a variant of principlism called casuistry, or considering the specifics of each case before considering rigid principles. (Jonsen, Siegler, and Winslade 2006) In truth and practice, both methods are quite similar. (Kuczewski 1998) In cases of values conflict, both schools encourage practitioners to avoid a rigid application of principles and work toward a dialectic that does not value one principle over another. Settled law sometimes makes that impossible and tends to favor autonomy. Attorneys and Risk Management professionals who are employed by hospitals also tend to favor patient and/or family autonomy, in order to avoid costly lawsuits. (Tauber 2003)

How did principlism become the dominant theory? As academia was giving birth to the field of bioethics, an authoritative text emerged, which became "the core of the canon". Principles of Biomedical Ethics, by Tom L. Beauchamp and James F. Childress was first published in 1979 and outlined the application of academic ethics to medicine in what eventually became known as "principlism". It is a very well nuanced utilitarianism, although some bioethicists disagree. (Jonsen 2001) The approach became very influential. It was simple to apply, could be taught to a wide variety of health care professionals, and seemed to define complicated bioethical situations in a way that could easily be understood. Although many other ethical theories have been discussed and debated in health care, even by Beauchamp and Childress in subsequent editions of their book, the process they originally developed is still the standard by which clinical bioethics is applied and practiced.

In order to avoid a narrow application of principles and give voice to many perspectives, the hope was that bioethics committees would have an inter-disciplinary membership and would review cases as a group. However, a 2001 national study of hospital bioethics committees found that many hospitals assign one or perhaps two bioethics committees members to do any given case consultation, and that only 18% of case consultants report back to the entire hospital bioethics committee before a recommendation is made or action is taken. (McGee et al. 2001) Such a practice can create a serious conflict of interest if the consultant is a practice partner of the requesting physician, is employed by the same hospital, or if he or she is providing the imprimatur of the Bioethics Committee to decisions that have already been made by the primary physician. (McGee et al. 2001) An analysis from the University of Pennsylvania suggests that this practice exposes a hospital to potential liability as well. (Sontag

2002)

Another common area of concern in actual practice is the autonomy vs. futile care debate. On the one hand, patient autonomy is often considered the “gold standard” of ethical decision making. The advent of patient’s rights and the litigious nature of health care, as well as the uniquely American attitude of entitlement, have many patients and their families believing that they should be given every available treatment regardless of efficacy or cost. Hospitals and physicians counter that they should be the ones to decide if certain treatments should be provided, and this has led to a plethora of committees, policies, and even laws designed to define “futile treatments” and place limits upon them. (Helft, Siegler, and Lantos 2000) Other objections to the current practice of clinical bioethics have included the exclusion of feminist and narrative approaches and the tendency to devalue culturally-specific issues.

While I have mentioned some of the more common criticisms of the dominant model, there are many more. Be they political, religious, or academic critics, the fact remains that there is still disagreement in the field of clinical bioethics in terms of actual practice, with one notable exception: the way bioethicists themselves continue to narrowly evaluate actual bioethical dilemmas at the bedside.

While I believe that the prevailing methods being used to analyze bioethical dilemmas are narrow and possibly inadequate in many circumstances, there is nothing wrong with using the principles of autonomy, beneficence, nonmaleficence, and justice as a starting point. The problem I have with principlism, and the schools that teach it in five-day seminars, is that far too many health care providers come home from these seminars and feel that they are qualified to make life and death decisions based solely on these four principles, or on subjective determinations of what quality of life means to a patient and their family. (Murphy) To be fair, much of the bioethics community gives voice to these very warnings, and there are some hospitals and hospital bioethics committees that have gone to great lengths to tailor a more humanistic approach to bedside ethics consultation, with measurable results. (Gilmer et al. 2005)

Health care needs a way to help patients, families, and providers develop policies, resolve conflicts, and provide care that reflects individual, cultural, and societal needs and values. In that one sentence lays a Herculean task. Is there a practical, useful model that can include all of the voices and values that cry out to be heard in a comprehensive and coherent way?

All Quadrants All Levels: Ken Wilber

The All Quadrants All Levels model (AQAL), developed by American Philosopher Ken Wilber, may be such a way. Conceived as a framework from which to organize all dimensions of human experience, the model is derived from Wilber’s lifelong effort to integrate knowledge and experience from the fields of eastern and western spirituality, sociology, psychology, philosophy, anthropology, and science. Researchers in health care, most notably nurses, have pointed out that the AQAL approach, also known simply as “Integral”, can be a comprehensive and holistic framework for the discipline of medicine. (Fiandt et al.) Can it also be such a model for the practice of clinical bioethics?

For sure, the specifics of AQAL require a longer treatment than is possible here. Wilber’s own writings come across as complex and difficult. For a clear and colorful description that is quite easy to understand, I refer the reader to “The Integral Vision” (Wilber, 2007). Put simply, he developed AQAL by looking at all the known systems and models of human growth and behavior, and developed an approach that suggests that every situation or sentient being has, at a minimum, four fundamental, simultaneous perspectives that must all be taken into account for a deeper and more integral understanding. He calls these four perspectives “quadrants” and they form the core of his integral model which also includes levels, lines, states, and types.

When discussing bioethics, the quadrants are very appealing because they look so much like the Jonsen Grid, developed at the University of Washington and used widely by Bioethics Committees across the country as a tool to gather information about a case and apply the four principles of autonomy, beneficence, nonmaleficence, and justice. (Jonsen, Siegler, and Winslade 2006) But as we shall see, the Jonsen Grid (and principlism) brings just a small piece of the overall puzzle to the table. For my own purposes, I would like to concentrate on the four quadrants as they relate to bioethical inquiry, and then I will lay over the top of that discussion the “template” of levels, lines, states, and types.

So where does this quadrant model come from? According to Wilber (1997), “These four quadrants are a summary of a data search across various developmental and evolutionary fields. I examined over two hundred developmental sequences recognized by various branches of human knowledge.

Ranging from stellar physics to molecular biology, from anthropology to linguistics, from developmental psychology to ethical orientations, from cultural hermeneutics to contemplative endeavors; all taken from both Eastern and Western disciplines, and including pre-modern, modern, and post-modern sources." Wilber sees these four perspectives of reality or experience as subjective (the interior of an individual), inter-subjective (the interior of a group or collective), objective (the exterior of an individual), and inter-objective (the exterior of a group or collective). Another way to describe the quadrants might be experiences, behaviors, cultures, and systems. Table one illustrates the I, IT, WE, and ITS nature of the four quadrants. Although it is a bit of a simplification, table two illustrates what an integral health care model might look like. (Wilber 2007)

The AQAL Model is not based solely on these four quadrants. For the model to be complete, one has to remember that individuals, groups, or collectives may be at different places in their own evolutionary growth within each quadrant, and may also be different types. By type, I mean valid distinctions like masculine/feminine (Gilligan), the nine Enneagram categories, Jung's archetypes (Myers-Briggs) among others. Many useful models also exist to describe levels/stages/states/lines, such as Maslow's Hierarchy of Needs, Spiral Dynamics (Beck and Cowan), or multiple intelligences. Essentially, they describe "progressive and permanent milestones along the evolutionary path of one's own unfolding." In the setting of a bioethics consultation or committee meeting that uses the AQAL approach as a guide, the mostly likely place for these differences to show themselves is within the group dynamic of the committee itself.

Continuing my theme of oversimplification, here is an example of a practical application of AQAL theory. (Table One will be helpful during this example). Suppose I want to buy a new television. First I might gather factual information about televisions which are currently on the market, including their size, specifications, and cost. I might find out what stores carry the particular products that I am interested in, and I might read some consumer reviews of their reliability. All of these things would be upper right quadrant, objective facts. They ask the question, what is it? Moving to the upper left, individual and subjective quadrant, I might go to the stores, look at the televisions, and decide which ones are most aesthetically pleasing to me, or which ones would match the colors in my den, or which one seems the easiest on my eyes. In other words, how do I feel about this television? Do I just love the way one looks

over another?

Dropping down to the lower left quadrant, I would think about what this purchase might mean to the communities, or collectives, that I am a part of. Will my significant other like this television? How about my kids? Will my football buddies enjoy watching the Super Bowl on this television? Have I actually discussed all this with them? Put differently, we do we think about this purchase?

Lastly, I come to the lower right hand quadrant, where I ask the question "how does it connect?" This quadrant represents the exterior collective or community. For example, I might want to know if the company that makes the television treats its employees fairly, or how much energy it will use. I may want to know what cable and/or broadcast systems are available to me. Perhaps it is important to me that the television be manufactured from recycled materials, or that its parts can be recycled after its useful life comes to an end. I may or may not care about these things, but if I do not address each of the four quadrants, then I am making a decision based on valid, but only partial, information. "When we ignore one or more fundamental perspectives or methodologies, any conclusion or solution will be incomplete and eventually ineffective." (Formless Mountain, 2009)

Building an Integral Bioethics

My hypothesis is that the dominant theory and practice of clinical bioethics ignores one or more fundamental perspectives or methodologies, and is therefore often incomplete and ineffective. Others have identified these issues, but have described them differently. (Churchill & Schenck, 2005) Steeped in traditional medicine and philosophy, clinical bioethics always remains in the upper right quadrant of objectivity and rarely if ever ventures out into the other three quadrants. In Table Three, I introduce the AQAL Integral Bioethics Grid. I believe that it can not only help us to think more clearly about bioethical issues in general, but can also provide a practical tool for bioethics consultations at the bedside.

Let me describe what I think a bioethics consultation is and is not. From my own clinical experience as a bioethics consultant, I can safely say that the vast majority of consultation requests that I responded to were situations defined by a lack of communication on someone's part or were situations that called for straight-forward conflict resolution skills. Were I to informally poll a group of bioethics committee members around the United States, I am pretty sure they would all say the same thing. (McGEE et al. 2002)

These are issues that call for a skilled patient advocate, chaplain, social worker, or other clinician to help resolve and do not typically require a formal bioethics consultation. It is the big issues....end-of-life, medical futility, organ transplantation, honoring Advance Directives, making decisions for patients who lack surrogates....these kinds of issues warrant a full and thoughtful process that includes diverse perspectives.

Ideally, a bioethics consultation using the AQAL integral approach would blend the original vision of a diverse committee and good group process with the tool in Table Three used as a common road map. With the committee gathered and all interested parties present (including the patient if practical, family members, physicians, and primary caregivers) a skilled moderator could first introduce some simple rules of group process (see Table Four) and then guide the group through each of the quadrants, beginning with the upper right quadrant (where basic facts are gathered, using the Jonsen Grid if desired) and moving counter-clockwise. It is important that the moderator be carefully chosen. The chair of the hospital bioethics committee is often a person of deep commitment and passion, and may not be the best choice for moderator. The person who is chosen as moderator should be familiar with the AQAL Bioethics Grid, understand how groups work, and have no personal investment in showing competency or dominance in the group process (David R. Kuhl and Patricia Wilensky 2005).[1]

As the group moves through the grid, the moderator or other designated person can write down the significant points on a white board or newsprint, so they can be visible at all times to all of the participants. The moderator should allow sufficient time for the group to discuss each quadrant before moving to the next, and should summarize what has been discussed. A plan of care can then be developed as the group reaches consensus, which should always be the goal. Such a plan of care might itself use the AQAL quadrants as a planning framework. Finally, if any educational goals or broader initiatives have been identified, the committee can then develop a plan of action to address these.

[1] Regardless of what system or theory is used to conduct a bioethics consult, this is perhaps the best paper I have read on how to properly manage the group process during the actual committee meeting.

Case Study

This is a completely fictional case study, which I use to

illustrate one possible way of using the AQAL process to conduct a bioethics consultation. John, a 32 year-old lawyer, had worried for several years about developing Huntington's chorea, a neurological disorder that appears in a person's 30s or 40s, bringing rapid uncontrollable twitching and contractions and progressive, irreversible dementia. It leads to death in about 10 years.

John's mother died from this disease. Huntington's disease afflicts 50% of an affected parent's offspring. John had indicated to many people that he would prefer to die rather than to live and die as his mother had. He was anxious, drank heavily, and had intermittent depression, for which he saw a psychiatrist. Nevertheless, he was a productive lawyer.

John first noticed facial twitching 3 months ago, and 2 neurologists independently confirmed a diagnosis of Huntington's. He explained his situation to his psychiatrist and requested help committing suicide. When the psychiatrist refused, John reassured him that he did not plan to attempt suicide any time soon. But when he went home, he ingested an entire bottle of Tylenol and several Valium after pinning a note to his shirt to explain his actions and to refuse any medical assistance that might be offered. His wife, who did not yet know about his diagnosis, found him unconscious, called 911, and had him rushed to the emergency room without removing the note. He was stabilized and transferred to the Intensive Care Unit, where he developed acute liver failure secondary to acetaminophen poisoning. His wife was told that he required an urgent liver transplant to survive, and that he would be placed on the waiting list immediately.

By this time she had discussed his recent diagnosis with their primary physician and with the rest of John's family. It was their decision to not seek a transplant. Feeling that this was not a moral or correct decision, the intensivist and transplant surgeon on the case requested an urgent ethics committee consultation. They both agreed that not treating John would be the moral equivalent of abandonment and/or physician-assisted suicide. Because John was intubated and sedated, he was unable to speak for himself. His wife was his surrogate decision maker and legal next of kin.

The Bioethics Committee was gathered and in addition to eight committee members, John's wife, brother, and a maternal uncle were present. Also attending the meeting were the physicians who requested the consult. After discussing the expectations of group process (see table four) and asking the participants to introduce themselves, the moderator gave a brief overview of what the process would look like. She appointed a timekeeper and recorder, and began to

discuss the case using the AQAL Integral Bioethics Grid (see table three) as a guide. Beginning with the upper right quadrant (what is it?), the objective facts about the case were shared. The family discussed how he was found at home, and the physicians discussed his diagnosis and prognosis with and without a transplant. The Jonsen Grid was also used to review the medical indications for treatment as well as the issue of John's competency to refuse all medical care, as he had indicated on the note pinned to his shirt.

It was pointed out that the underlying chronic disease of Huntington's has no available treatment and a bleak long term prognosis. However, there are effective treatments available for the acute diagnosis of acetaminophen overdose including transplant. Further, significant disability due to Huntington's may not appear for years. Many committee members also pointed out the relevant settled law, namely the U.S. Supreme Court ruling allowing for the right to refuse medical treatment, even if it was lifesaving (*Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 1990).

Moving to the upper left quadrant (how do I feel?), family members told the story of John's long personal struggle with watching his own mother succumb to Huntington's, and the depression and drinking that resulted. They talked about their own relationship with John, how they knew him to be a logical and thoughtful person. They shared their anger with him at the prospect of his suicide, something they considered selfish. But they also supported his choice unequivocally, citing the many times that he had made his wishes clear on the subject.

Many committee members shared their own feelings and stories about similar situations they had encountered in their personal lives or professional practices. The intensivist physician spoke about his belief that the Hippocratic Oath insisted that he always "err on the side of life". In this situation, he was not convinced that the patient was of sound mind when he attempted suicide, and therefore should be treated until he could make his own informed decision. Still, to most present it was clear that John had a very good understanding of what his "quality of life" meant to him, and what he wanted that to look like.

Moving to the lower left quadrant (what do we think?); John's Uncle discussed how his mother's family dealt with her illness, and the cultural and religious heritage of the family. The experience had changed and challenged many of the family's cherished values. It has also helped them discover that clinical depression was a disorder that seemed to run in their family. The stigma attached to that was particularly difficult for

John's mother. Suicide as "cultural taboo" was discussed, as well as the religious and political debates that have ensued in the recent past on the subject.

Finally, the group moved to the lower right quadrant (how does it connect?), and discussed at length what an extremely scarce resource a donated liver is. UNOS regulations were reviewed and John was clearly a candidate[1]. Would he comply with complicated aftercare instructions? Should he even be placed on the waiting list, given his grave prognosis and/or his chronic Huntington's diagnosis? The conversation was clearly difficult for John's wife, who felt as though she would be depriving a chance at a long and happy life to another person on the waiting list if her husband underwent a transplant.

Some committee members felt as though they were being asked to make a decision using utilitarian criteria, which the UNOS allocation algorithm is largely based upon. Others were grateful for the process of hearing each other's stories. They identified features of narrative, feminist, and utilitarian ethics as the discussion progressed. They also discussed the financial and legal ramifications of various scenarios to the family, hospital and community.

Throughout the process, the moderator emphasized that the committee was being asked to help the parties involved reach consensus, and make recommendations to that end. There are many possible outcomes to this case study, so I shall not provide a fictional "final answer". I encourage the reader to come to their own conclusions, and perhaps experiment with this model in bioethics committee settings.

[1] That John would be a candidate is in and of itself an issue for debate. At the time of this writing, most transplant surgeons I have spoken with would indeed place John on the transplant waiting list based on the clinical and psychosocial circumstances I have described.

Conclusion

If the moral quality of a clinical decision is dependent on the process involved in reaching that decision, then I believe the AQAL Integral Bioethics Grid that I have introduced can be an effective tool for improving that process. Virtually no single part of the grid is new, per se, but that is its beauty: it brings together diverse perspectives in a different way and allows us to think more clearly about complex bioethical issues even as it provides a practical tool for performing bioethics consultations.

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Illustrations

Illustration 1

Illustration One

<p><u>I</u></p> <p><u>Self + Consciousness (Interior)</u> The Interior, individual perspective Subjective analysis Personal awareness, feelings Personal experience, spirituality <i>What do I feel?</i></p>	<p><u>IT</u></p> <p><u>Brain + Organism (Exterior)</u> What are the facts? Objective analysis <i>What is it?</i></p>
<p><u>WE</u></p> <p><u>Culture + Worldview (Interior)</u> What are our shared morals and beliefs? What does our cultural worldview say? Family history? <i>What do we think?</i></p>	<p><u>ITS</u></p> <p><u>Social System and Environment (Exterior)</u> What is the impact on groups or systems outside of ourselves? Politics? Public Policy? Different ethical theories? Economic systems? <i>How does it connect?</i></p>

Table One: AQAL

Illustration 2

Illustration Two

<p><u>I</u></p> <p><u>ALTERNATIVE CARE</u></p> <p>Emotions Attitudes Imagery Visualization</p>	<p><u>IT</u></p> <p><u>ORTHODOX MEDICINE</u></p> <p>Surgery Drugs/Medication Behavioral Modification Disease Management</p>
<p><u>WE</u></p> <p><u>CULTURAL VIEWS</u></p> <p>Group/Family values Cultural judgments Meaning of an illness Support groups</p>	<p><u>ITS</u></p> <p><u>SOCIAL SYSTEM</u></p> <p>Economic factors Insurance Healthcare policies Delivery systems</p>

Table Two: Integral Medicine

Illustration 3

Illustration Three

<p><u>I</u></p> <p><u>Self + Consciousness (Interior)</u> Subjective Feelings, Empathy Psychology/Spirituality Purpose, values, calling Quality of life <i>What do I feel?</i></p>	<p><u>IT</u></p> <p><u>Brain + Organism (Exterior)</u> Objective information (Jonsen Grid) Objective science Autonomy vs. Futility Relevant settled law <i>What is it?</i></p>
<p><u>WE</u></p> <p><u>Culture + Worldview (Interior)</u> Cultural/community values Bioethics in Art & Media Familial Worldview Political Values Corporate Culture <i>What do we think?</i></p>	<p><u>ITS</u></p> <p><u>Social Systems (Exterior)</u> “Health Care in U.S.” Economics & Environment Ethical Theories (value, feminist, narrative, utilitarian, etc) Systems + Chaos Theories <i>How does it connect?</i></p>

AQAL Integral Bioethics Grid

Illustration 4

Illustration Four

<p><u>I</u></p> <ol style="list-style-type: none"> 1. The patient is the most vulnerable of all present even when they are not in the room. This deserves some deference. 2. Physicians and other caregiver staff deserve to have their opinions, beliefs, and feelings considered. <p><i><u>What do I feel?</u></i></p>	<p><u>IT</u></p> <ol style="list-style-type: none"> 1. Describe the process. 2. Start and stop on time. 3. Introduce the participants. 4. Discuss the importance of confidentiality. 5. Appoint a timekeeper and notetaker. <p><i><u>What is it?</u></i></p>
<p><u>WE</u></p> <ol style="list-style-type: none"> 1. Make a commitment to reach consensus. 2. Family and significant others deserve to be heard. 3. We will treat each other with respect. 4. We will give each other equal time. 5. We will not evaluate or judge what others say. <p><i><u>What do we think?</u></i></p>	<p><u>ITS</u></p> <ol style="list-style-type: none"> 1. We will not pretend that legal and economic issues do not exist. 2. Administrator’s concerns should be heard. 3. Ethical theories in use will be explained. 4. Society has a claim that hospitals will be run ethically and efficiently. <p><i><u>How does it connect?</u></i></p>

Table Four: AQAL Group Process Grid

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