

Making Ethical Decisions Together

by John Hofer

Here in Oregon, there is no wanting for ethical and political splintering: pro-life vs. pro-choice; pro-assisted suicide vs. anti-assisted suicide; free range vs. restricted range; rights of salmon and other endangered species vs. rights of business and sports persons; urban interests vs. rural interests. The list grows by the minute. Everyone seems to be operating from a different set of ethical principles. It is for this reason that many otherwise reasonable people shy away from ethical discussion, believing that it can lead nowhere but to interminable conflict. In spite of this great cacophony of differing views, I remain hopeful about Oregon's future, convinced by my experience on a hospital ethics committee that what we most lack in this culture is not moral knowledge, but, rather, the moral courage to undertake the practical commitment to work together on common projects. Conflict over ethics is a crisis of will, not information.

When people think about ethics, they usually assume that for ethical reasoning to

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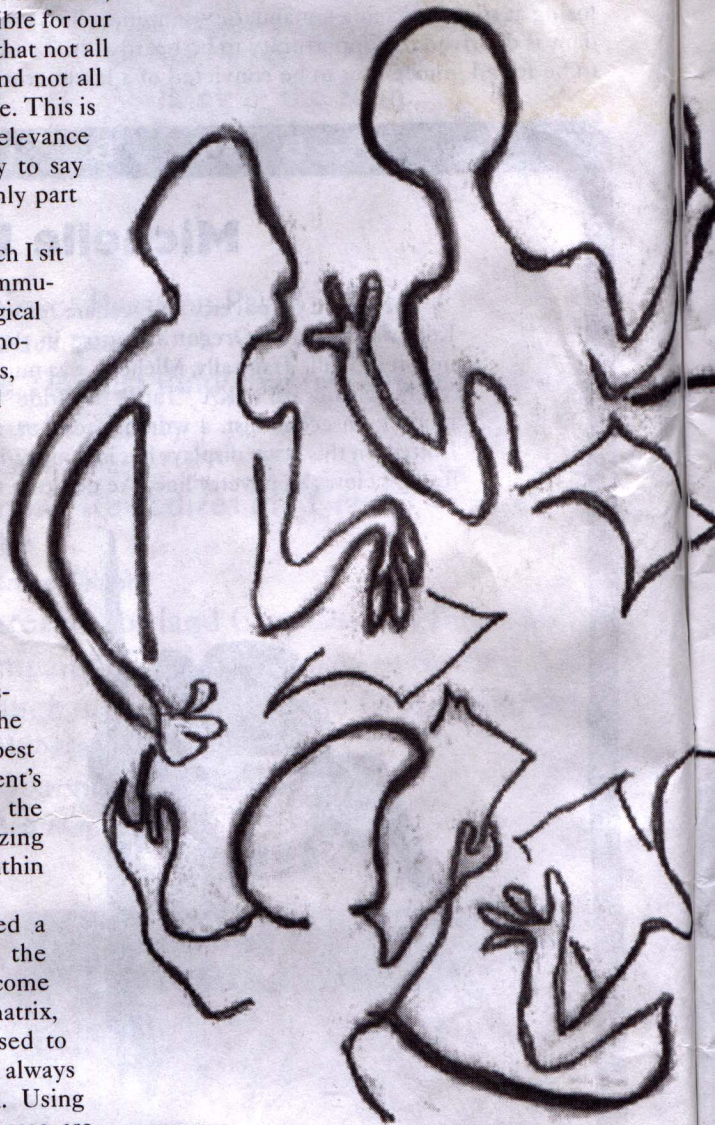
make sense, everyone must subscribe to exactly the same ethics. This, they reason, makes meaningful debate possible, because the people involved already have a common understanding. At a meeting of a medical ethics network a few years back, a member of the clergy expressed the opinion that the ethical dilemmas facing us in medicine, as well as other areas of human activity, could all be solved if everyone believed in God, and took the Bible at face value, using it as the primary text for developing a moral point of view.

Failing this condition, he seemed to believe that an argument on morals becomes an equivocation where the speakers, no matter how earnest, are doomed to talk past one another, their arguments only stirring emotions. This happens between two persons for whom the moral term “good” has very different meanings. For one, the term could mean “what God wills.” For the other, “good” could mean “what is consistent with Immanuel Kant’s Categorical Imperative.” Although belief in God is not a condition of ethical behavior, many philosophers lament the loss of a single moral tradition, believing that its loss is responsible for our moral dilemmas. The reality is that not all good people believe in God, and not all believers in God are good people. This is not to say that religion has no relevance to ethical discussion. It is only to say that religion can properly be only part of the discussion.

The ethics committee on which I sit is a microcosm of the larger community, being composed of theological moralists, secular moralists, emotivists, intuitionists, rationalists, the indefatigably dogmatic, and the plainly confused. Yet, out of an imperfect human mix, good work emerges. Why? Because the members of the committee are committed to one moral principle: to do no harm to one another, the patient, or the clinical staff in the process. This common goal of the hospital ethics committee helps the caregiver team provide the best care to the patient. It is the patient’s moral autonomy that provides the guiding principle for analyzing moral dilemmas that occur within the hospital setting.

Our committee has adopted a practical tool for discussing the clinical ethical dilemmas that come to it. It is called the Jonsen matrix, and it is a conceptual tool used to disentangle the values that always collide in a clinical situation. Using the matrix, the facts of each case are arranged by medical benefit, benefi-

cence; issues of patient preference, autonomy; issues of significant patient life goals, utility; and issues of law, family relation, and economics, to name a few. The approach is fundamentally an analysis of specific types of cases. “Refusal of treatment” could be a type of case: as one gathers a collection of cases dealing with this type, “refusal of treatment,” would be ordered along a spectrum, from the non-problematic to the most problematic case. This growing collection of cases of a par-



ticular type is the historical method by which one's ethical judgment evolves, previous cases serving as an analytical guide to current cases of a type, not unlike the way court decisions serve as guides for judgment in future cases.

In the nine years I have served on the committee, there has never been an active case discussion that broke down because of different points of moral view. This does not mean that everyone agrees with everyone else on every point. Far from it. It does mean, however, that the committee is not there to foist its own peculiar moral point of view on the patient or the care-giver team, especially at a moment when both are least able to protect them-

selves from meddlesome interference. The Jonsen matrix allows everyone to participate in the discussion, to offer insights which complement one another, and to help evaluate the event. A person whose tradition is theistic may emphasize an element of duty, another whose tradition is decidedly philosophical and secular may emphasize certain elements of autonomy. The discussion, however, does not break down because the Jonsen matrix mediates between the differing points of view, placing them within a methodological context where they complement rather than contradict each other.

In one case, it was thought that a person with a chronic condition, who was on life support, would very likely arrest, that is have a sudden heart failure. The issue before the committee was whether or not to resuscitate the patient when the arrest occurred.

For some on the committee, life is an absolute value, to be protected, continued, and fought for in any form. For others, life can become a burden, an indignity, an intolerable ordeal, and in such cases, can morally be allowed to end. Yet, in its discussion of the case, these differences among members did not impede reasonable and effective discussion. The committee's task was to understand the condition from the patient's moral point of view, to place the facts within the context of the patient's significant life goals. With a common, practical goal and a methodological tool to achieve that goal, the committee achieved a result which helped the patient and the patient's family decide how to respond to the inevitable arrest. This was done without making dogmatic demands on the family, without rebukes to the healthcare givers, and without attacks on individual members for moral weakness or stupidity. The

overriding goal of keeping the care-giver team functional and protecting the moral integrity of the patient was achieved.

What I have learned from my experience on the committee is that very different persons can work on very difficult moral issues and achieve successful practical results without universal ethical agreement. In his wonderfully informa-

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tive book, *Before the Shooting Begins: Searching for Democracy in America's Culture War*, University of Virginia sociologist James Davison Hunter gives a hopeful example of how persons from very different moral positions can find common ground from which to achieve healthy practical results. He presents an example from St. Louis, Missouri, where the director of the local Reproductive Health Services invited the attorney of the local pro-life group to enter into discussion in the hope of finding common ground. Very quickly, both sides realized that they were concerned about the welfare of women and children, drug addiction, better pre-natal care, and the need to reduce unwanted pregnancies. The two sides were able to pool their limited resources to work for improvement in these areas, rather than to expend precious resources sniping at one another.

What other members of the ethics committee taught me is that a degree in ethics is not necessary for solving ethical issues. They have also shown me that all the ethical knowledge in the world is useless without the practical commitment to work on common goals.

John Hofer grew up in Walla Walla, Washington. He received his doctorate in philosophy from Tulane University in 1977. He has taught high school English and college philosophy and worked as a civil rights investigator for the Oregon Bureau of Labor and Industries and as a paralegal in the legal department of SAIF Corporation. He is one of the early members of the Coalition of Oregon Ethics Resources.



Laura Nobel