How many of us have been in a training session on ethics where the instructor’s first action is having attendees define the term “ethics”? The author has served in compliance roles in both the public and private sectors, and has received ethics training in secular and faith-based organizations. In each case, attendees try to define ethics or what being ethical means. They grapple with definitions, usually settling on something that involves conducting business in a manner that is legal and doing what is right. But what does that mean?

Legality is at least codified, but what standards do you use to determine what is “right”? Our society is amazingly diverse, and with this diversity comes differing philosophies, each with its own understanding of what is right in different circumstances. How do we define what is right without a single basic philosophy? Can we have ethics without a shared belief system? How can we have an ethical system based on a belief system that not everyone holds as valid?

Finding a Basis for Ethics

As a response, some theorists have chosen to seek a value-neutral unifying principle on which to base the determination of what is right that rises above belief systems. This author and others like Rev. Benedict Ashley, OP, Sr. Jean deBlois, CSJ, and Rev. Kevin O’Rourke, OP, fail to see how one can construct an ethical system without first having an agreed-upon values system.

Ashley et al. note that “bioethics thus must be more than a set of general principles, but must be grounded in a sound anthropology and virtue theory.” They further note that “ethics concerns the needs and values of human persons.” How are we to determine the character of an act within a society that believes many different things? Henk ten Have asks a similar question, “How can bioethical views be justified, and how can bioethical dilemmas be resolved in a pluralistic and multicultural modern society?”

The answer that many have offered focuses on ethical foundationalism. Kimberly Hutchings defines ethical foundationalism, in a broad, non-religious sense, as what “encompasses any ethical theory that argues that there is a fundamental ground for moral judgments, for instance, in truths about human nature or human reason.” Ethical foundationalism, ten Have notes, is “the view that bioethics can identify and produce valid principles because it has a clear theoretical rock bottom.”

Kevin Wildes considers foundationalism a flawed approach to bioethics as it does not address pluralism within society. Instead, he suggests “proceduralism,” with the aim of removing the complicating factor of a belief-based morality system that guides most ethics and finding traction instead in more diffuse and shallow conception of common rules about basic needs. This seems very close to the “common morality” proposed by Thomas Beauchamp and James Childress, which ten Have defines as “the morality shared in common by all persons in all places.” Interestingly, anthropologists cast off the search for universals decades ago as they recognized the unique nature of cultures.

Wildes’ view, therefore, seems rather absurd. His reductionism passes over human identity where most would think the nature of ethics would logically reside. If we look instead to base needs, as Wildes does, taking food, forcibly or otherwise, might be ethically permissible because it is in our human biological nature to need sustenance. But we have risen above this and have a sense of right and wrong, which must be melded into our understanding of human nature.

According to ten Have, if theories of applied ethics are “not integrated into some broader theoretical framework they tend to lead to conflicting judgments about which actions and social policies one ought to carry out.” Without a unifying virtue theory, there is conflict, especially where different systems meet, whether they are secular philosophies or belief systems. When multiple moralities are in play, you get what ten Have rightly calls a “chaos of conflicting moral judgments,” leaving all confused on what to do in an ethical dilemma.

Ashley et al. “agree with Wildes that foundationalism, as he describes it, is a faulty methodology, but we
are convinced that the Catholic ethical tradition is truly foundational in its understanding of human nature in the light not only of faith but also of reason.” 11 They also accept elements of proceduralism in certain contexts. Foundationalism and pluralism are not mutually exclusive when grounded in an understanding of the human condition. Other religious traditions may have a similar approach, which could create some common ground in the sense of an informed, morally grounded proceduralism. Foundationalism is imperfect, but it may nonetheless be the best approach when contrasted with the lack of ethical uniformity in pluralistic society.

Engaging Pluralism

Foundationalism need not be hamstring in its approach to pluralism. Ashley et al. highlight Wildes’ four tasks for a bioethicist: (1) professor, (2) translator, (3) geographer, and (4) behaviorist.12 Each of these efforts requires virtue. One aspect that many scholars fail to address is that virtue is imperative in executing the above tasks because each of us needs an anchor when subjected to the good and bad influences of the world. Virtue enables us to avoid the erosion of our ethical identity, and thus safeguard against bad influences of the world. Regardless of whether the foundation is faith-based or based on some other construct, virtue is necessary for the work of the self-aware and prepared ethicist.

Furthermore, operating from a perspective of faith does not limit an ethicist’s ability to relate and assist others in our pluralistic society. Regardless of the difference of beliefs, each group does share a common ground. Recently, Pope Francis said:

The Lord created us in His image and likeness, and we are the image of the Lord, and He does good and all of us have this commandment at heart: Do good and do not do evil. All of us. “But, Father, he is not Catholic! He cannot do good.” Yes, he can. He must. Not can: must! Because he has this commandment within him. Instead, this “closing off” that imagines that those outside . . . cannot do good is a wall . . .

And this commandment for everyone to do good, I think, is a beautiful path towards peace. If we, each doing our own part, if we do good to others, if we meet there, doing good, and we go slowly, gently, little by little, we will make that culture of encounter: we need that so much. We must meet one another doing good. “But I don’t believe, Father. I am an atheist!” But do good! We will meet one another there.13

Clearly, the possibility of doing what is good shows that it is possible to operate a foundational ethical system in a pluralistic world. With a moral tradition like that of the Catholic faith (or any other faith) as a guide, health care practitioners, administrators, and bioethicists can meet other groups, as they always should, at “good deeds.” There is no need to forsake foundationalism for an overly flawed approach like proceduralism.14

The Path Forward

The need for virtue in any theory of foundationalism is evident when we face what are often complex and

sometimes rather nebulous issues. Take, for example, the issue of chimeras, a fascinating development of modern science that has been addressed by several bioethicists. On its face, when you hear “chimera,” there is some revulsion, thinking of the piecing together of two different animals, one of which could even be a human being. Experiments conducted by some of the worst political regimes of the twentieth century come to mind. But what about someone whose heart valve has been replaced with that of a pig? Clearly, that is not the same. But what degree of chimera is acceptable? What is unacceptable and why? Without a virtue theory, how could we answer these questions?

From the perspective of a Catholic ethicist, we know that chimeraism is wrong when it is a violation of human dignity. We also gain an understanding of how to treat the unfortunate creature that is created if such a violation of dignity should ever happen. Other approaches would be left with mere revulsion—at least we hope—but not an understanding why it was revolting or how to address the injustice. Much like defining what ethics and ethical means, one needs a foundation in virtue theory to create a dictionary with which the ethicist can interpret the complicated language of ethics in the realm of modern healthcare.

Don Arp Jr.

Don Arp, Jr., has a master’s degree in anthropology from the University of Nebraska-Lincoln and spent four years in health care compliance and contracting at a large Catholic health care system, including serving on a health care ministry ethics committee. While working for this system, Arp also completed its year-long certificate program in Catholic health care ethics.

2 Ibid., 31.
3 Ibid.
9 Ibid., 23.
10 Ibid.
11 Ashley et al., Healthcare Ethics, 19.
12 Ibid.
When Doctors Overrule Patients

Where does a patient’s decision to live his life end, and the doctor’s decision to end it begin? This circular question has become more difficult to answer as technology enables hospitals to keep medically fragile patients alive while our aging population is caught in the competition for expensive medical resources. Compassion for endless suffering that will inevitably lead to death is often cited as the reason to terminate a patient’s life support. Hope for recovery is given as the reason to use all medical means to ensure a patient survives.

As human beings, we hope that the patient’s personal values, attitudes, and beliefs will drive the process of end-of-life medical care and access to the machines that are life sustaining. But the end of life is often as tangled and complex as the wires that hold death at bay for so many of our loved ones. When those we care about enter this technical world, they are plugged into a system that keeps their hearts beating, their lungs breathing, and their bodies receiving nourishment. We look at friends or relatives in this situation, and they are all but unrecognizable to us. Only our past association with them allows us to see the smiles on their faces, hear them say they love us, and feel the strength and warmth of their hugs.

It is easy to see why physicians and hospital employees cannot see through the paraphernalia that surround their sickest patients to imagine them as vital members of a family or a group of friends or colleagues or participants in the life God has given us. End-of-life decisions never affect just the patient. For those who are closest to the deceased, the end of a loved one’s life is like a stone dropped into a pool, generating waves of emotion that extend well beyond the loss of the one who has died.

Purpose of Advance Directives

Advance care directives attempt to articulate a person’s wishes when making the most important health care decision in his lifetime. They are made in the context of that person’s belief system and the people his death affects. The American Medical Association says, “Advance care planning affords patients the opportunity to exercise their right to make determinations regarding their medical care in advance in the event they become incapable of active participation in health care decisions. The process provides individuals with the opportunity to determine their goals regarding health and medical treatment based on personal values, attitudes, and beliefs surrounding health care, illness, and death. It also enables individuals to communicate their wishes to their primary care physician, their proxy, and loved ones.”

It never occurred to my husband Joe or me as we wrote and talked about our advance care directives that we would be faced with a terrible dilemma in the final chapter of his life.

This document is supposed to avoid the anguish for our loved ones and to respect our last important decision as human beings. Most of us do not like to think about invoking a directive that closes the book on our earthly existence. Because my husband had some health concerns, we discussed the end-of-life issue in depth in accordance with his Catholic faith. His faith guided the important decisions he made and governed the way he treated fellow travelers in his journey through life. As my legal proxy, Joe also learned what was acceptable to me in terms of my end-of-life care.

Sadly, I recently used Joe’s advance care directive to disconnect him from life support on March 1, 2014 when he was a patient at a hospital in Atlanta, Georgia. My decision as his legal proxy was based on the diagnosis and prognosis of suffering and certain death within twenty-four hours. Months later, I learned that Joe’s diagnosis of sepsis from a perforated bowel and prognosis of no chance to survive was incorrect. In fact, when the formal radiology and blood culture results came back within a few days after Joe died, it was revealed that Joe had sepsis from a skin infection and did indeed have a small chance to survive, a chance that carried with it probable dialysis, possible tracheotomy, and a long and difficult recovery.

A lifelong and devout Catholic, Joe would never have made the decision to end his life if there was a chance he could survive. In addition, his Catholic faith determined the quality of life he would accept. Making sure I understood and carried out his wishes was of the utmost importance to me, but I learned that this was not a priority to many personnel in the medical field.

Quality-of-Life Judgment

Joe worked in the medical field for close to four decades. He was an internationally renowned pox virologist with the Centers for Disease Control and Prevention in Atlanta, Georgia, for thirty-seven years. He published over one hundred scientific research papers in journals such as Science and Nature. He loved science and the pursuit of knowledge. He was as moral and ethical in his scientific research as he was in his personal life. As a biologist, he was in awe of life, and as a Christian, he was committed to the Catholic teachings he learned as a boy and practiced as a man. He lived his Catholic faith even as he followed his quest to add to the body of scientific knowledge.

Suffering from Crohn’s Disease, Joe faced almost certain death in 1967 with peritonitis and again in 2001 with a cardiac tamponade. He fought his way back to health against incredible odds and was so thankful to God for every day he remained on this earth. No one wanted to live or appreciated life more than my husband. No one understood the odds of survival and recovery within a medical setting better than Joe. Joe had survived and even thrived after two life-threatening illnesses.

It took eight months and much research and perseverance on my part to come to the point where the medical personnel sat down with me to disclose why they gave me...
information they knew was not definitive the night Joe died. Their explanation was that they were operating on information that was preliminary, and the next day when the radiology report was formally read, the diagnosis changed. Perhaps the most disturbing part of this is that the physicians defended their actions with the idea that Joe had less than a 10 percent chance of living with the revised diagnosis—so the point was moot.

For Joe, a small chance of living was worlds apart from no chance of living. For the physicians attending Joe, there was no difference. Explaining that Joe was a Catholic and that we had discussed at length the circumstances that would lead to disconnecting life support for him, I asked if they understood how important this mistake was from a moral and ethical standpoint. One physician replied that if Joe had survived, the process would most likely have destined him to have had a quality of life that in his opinion was unacceptable. This experience led me to wonder how many other physicians in effect make the end-of-life decision for a patient by framing information in this way.

How many doctors use their own “attitudes, values, and beliefs” about quality of life when making end-of-life decisions for patients? How many physicians make a de facto end-of-life decision that is not in accordance with the patient’s own wishes or his religious beliefs?

Although I am an Episcopalian, Joe and I married in a Catholic ceremony. I attended Catholic mass most of the time with Joe, and our daughter was raised as a Catholic. My beliefs concerning end-of-life decisions for myself, as well as the quality of life that would be acceptable to me, weigh on the liberal side of the scale. However, Joe’s advance care directive was not about me or my beliefs. It was about carrying out the wishes of my husband, who was guided by his religious faith and his attitude toward what was acceptable criteria for disconnecting him from life support.

A Strictly Technical Decision

During a lengthy meeting with the doctors, I also learned that not all of the physicians were in agreement with the original diagnosis; however, professional courtesy built a wall of silence that concealed conflicting opinions. Joe’s past experience of surviving twice against overwhelming odds was one of the main reasons he would have opted to continue life support. He felt God brought him through those life-threatening situations for a reason, so he believed that treatment should be given if he had a chance to live.

None of the physicians who were attending Joe knew or cared about his past triumphs over similar medical odds or that his religious beliefs would be guiding him regarding his end-of-life decision. It was a strictly technical decision for them, and one that is probably quite acceptable within hospital walls.

It should be disturbing to Catholics and non-Catholics, liberals and conservatives, that advance care directives weigh so little when a person’s life is in the balance. When physicians can tip the scales so easily, we lose the right to live or die with dignity and in accordance with our “values, attitudes, and beliefs.”

Gayle Esposito

Gayle Esposito was Joe’s wife for thirty-one years. She volunteers for the Juvenile Diabetes Research Foundation as well as the Crohn’s and Colitis Foundation.