Stud. Hastings Cent 1973 1:53-62

Making and escaping moral decisions

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To conceive of a physician practicing his profession without constant ethical decision-making is to conceive of a physician operating in a cultural vacuum and caring for a collection of static facts wrapped in human form.

Medicine is inherently moral. That is to say, that the practice of medicine is a "doing" function. The practice of medicine—caring for the sick—takes what are presumed to be facts about bodies and disease, and on their basis does something to a person. In the practice of medicine, we might say, the doctor keeps before him a body "ought" and a body "is." Presumably, in health, the "ought" and "is" are the same while in sickness they are different. It might be argued that speaking of "ought" and "is" in the context of the facts about the body and disease is a misuse of the term morality, a confusion of facts and values. The doctor is dealing with facts (at least as he sees it). The body "ought" is not an ethic, it too is a fact. One might say, to point up that confusion, that a plumber works the same way in repairing a leak or installing a sink, that the plumber has an "ought" and an "is" for pipes, and that therefore his behavior in relation to the pipes can be examined in moral terms. While plumbers certainly can be immoral, commonly we would say that they can only be immoral in relation to people, not pipes. To the pipes, which are inanimate, unfeeling, replaceable and fixable six different ways, the plumber cannot be immoral. He can just do a good or a bad job. There is nothing inherent in a pipe to make a plumber feel guilty if he errs. He can generate feelings depending on how he fixes the pipes, but the feelings are in him (or others), about himself. In fact, if something does go wrong and he carries on about the pipe, we say, "Why are you so upset, it's only a pipe." Thus the analogy of the plumber would show us that the body "ought" and "is" are in the realm of fact, not value—*if we could compare bodies to pipes*. We cannot, and we are offended when we see doctors treating bodies like pipes, rather than persons. It is, actually, quite possible to conceive of a body like a piece of cast iron pipe, even necessary to do so for understanding the body, but as we shall

see such a conception is only partially useful to medical care. It is caring that we are speaking about when we discuss the right of doctors to make ethical decisions for their patients.

For a physician to do a good job he must treat the patient as a person. This is a truism. The meaning of patient as person, however, requires some examination. But unfortunately, no reflection, however deep, will suffice to resolve satisfactorily the nature of the relationship of person to body. We know this question has been the subject of examination over the centuries.

Yet the relationship of person to body *is* the true question before us. It is at the center of the distinctions between pain and suffering so common to Catholic ethics, and the essence of criticism of radical vitalism (keeping the patient alive at all costs). It is, perhaps, the heart of medical ethics. Avoiding the ultimate resolution of the relationship of person to body, one might say, simply, that *a person is a body with values added.*

Perhaps medicine is called an art, not a science, because a necessarily inherent part of it is decision-making linked to human values. Ethical and technical decision-making are both a part of doctoring; both are rooted in human experience. Alfred Cohn, a renowned medical researcher, examined the difference between art and science. Surpised to have found so many similarities, he concluded by writing "Art is not science, nor is thought emotion, but they share in that which is lent to them by their common origin in the experience of man."[1]

Doctor as Arbiter

Previously we noted that the doctor treating the sick is confronted with a body "ought" and a body "is"; and he applies his skills and values in an attempt to make the two conform. In actuality, however, it is clear that he is confronted with the "ought" and "is" of a *person.* The "ought" of a person can be seen in ethical terms because it is a mixture of fact and value. What "ought" a man be or what "ought" a man do are determined by both the body and the values of the man.

We have discussed elsewhere the dramatic conflict of self and body in the dying person,[2] but the conflict is often present in the most simple illness. A twenty-eight year old actor has just gotten his first important movie role when he develops a non-specific illness resembling a bad cold. He continues working, and develops severe chest pain which on examination is seen to be a kind of "viral" pleurisy. With rest, the illness usually quickly clears; if he continues working the problem will continue and may severely worsen, even possibly (but rarely) become life-threatening. What is the doctor's job? In *body terms,* the answer is clear. He informs the actor of all the possible consequences and insists that he go to bed to insure that the illness is cured (and coincidentally, that the actor lose his job). In *person terms,* however, he helps assess the relative risks, agrees to continue to act as arbiter between the actor's desires and the needs of his body—and in so doing takes on responsibilty for risks incurred. Or more simply: a child has a cold—should it go to school? Every parent knows that the question is often hard to resolve in terms of symptoms alone. In *body terms* the answer often is clear, in *person terms* complex.

It is true that there are situations where *body terms* alone are the determinant: hemorrhage, heart attack, shock, etc. But most often the patient's values enter

[1]Alfred E. Cohn, *Medicine, Science and Art* (Chicago: University of Chicago Press, 1931), p. 73.

[2]Eric J. Cassell, "Being and Becoming Dead," *Social Research* 39 (Autumn, 1972), pp. 528-542.

in the decisions, whether so stated or not. The physician's phone rings all day with questions varying from "Can I have a drink when I'm taking the pills?" to "I have a pain in my chest, you know what a hypochondriac I am, but still. . . ." Certainly most of the moral decision-making is at a low level—not concerned with allowing to die or to live—but real and value-oriented just the same.

The doctor is the arbiter between the person and his body. Actually, as has been made clear by the sociologists of medicine, the situation is more complicated. The physician is not only the arbiter between person and body, he is also a representative of society and its values.

In the complex equation created in illness by the needs of person, body and society, the physician plays a vital role. As the only one who knows the body (and it does not matter if his body knowledge is correct, only that it is culturally consonant), he is the one who can legitimate body demands. The sociologists often act as if the only important aspect of the triad is the person-society matrix; as if disease did not really exist. Indeed, seeing illness in wholly cultural terms is another way of attempting to deny fate. There *is* a fate and fate can find expression in disease.

Are the moral decisions a physician makes about the sick an unjustified extension of his technical expertise? Or, are they not inherent in professional responsibility? Is it the level of ethical decision that is at issue, or just the fact of it? If it is the level of ethical decision, rather than its presence or absence, the question before us changes. A seventy-seven year old woman is admitted to the hospital with pneumonia. In the course of investigation some test results raise the possibility of widespread cancer. No other signs of cancer are found. The same test results may also be found in unimportant conditions, or may even be error. *Is the physician obligated to tell the patient all of the possibilities?* In the face of the uncertainty, it would seem unnecessary for the doctor to tell the patient, even self-indulgent to do so. Later, perhaps, when the diagnosis is made with certainty, the question of telling-or-not-telling is entirely different. It is not my intention to enter into a discussion of "telling-the-patient," but to point out that starting with the most routine moral actions on the part of the physician, we are gradually led to the deepest ethical issues. It is these profound questions, and our unease about how physicians handle them, that

Medical care is a *process*. . . . In the process of care, especially in cases that lead to difficult moral decisions, a number of minor ethical matters have been handled along the way . . . in which both patient and physician interact in making decisions. In that process both patient and physician have informed each other of how each feels, and the interaction helps form the basis for the next decision.