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Peter J. Cataldo

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by

Peter J. Cataldo, Ph.D.

The author is Director of Research at the Pope John XXIII Medical Moral Research and Education Center, Braintree, MA. *This article originally appeared in the March, 1992 issue of* "Ethics and Medics" *and is used with permission of Editor the Rev. Russell E. Smith, S.T.D.*

Since 1983, beginning with the state of Oregon, there has been a rapidly growing grass roots movement across the country concerned with health care issues. The movement is known as the Community Health Decisions movement. The movement may be generally described as the creation of public forums for ordinary citizens to learn about the ethical issues of health care in the United States and to voice their preferences on the issues. To date there are Health Decisions Organizations in 18 states. Funding for these organizations and their projects has been largely private. In 1988 the various state Health Decisions groups formed a national consortium called *American Health Decisions.*

The aim of this article is to examine the goals, objectives, and accomplishments of the Community Health Decisions movement in the light of Catholic teaching. This movement attempts to re-educate the populace towards a majoritarian view of health care in the United States based upon a purely pragmatic calculus.

Goals and Objectives

The stated goals of the Health Decisions groups are to educate the public about the various ethical issues (both individual and social) in American health care, and to build and shape a "community consensus" about those issues. These goals are realized by means of community meetings. Each state organization plans a network of meetings, usually as a part of meetings of other local civic organizations. Many of these meetings begin with a slide-show or video on the topic as a basis for discussion. Specially trained discussion leaders then guide discussion and distribute participant questionnaires on the health care issues of concern. Some of the surveys are statistically valid and others are not. Results of the questionnaires are calculated, summarized, and then often used for drafting resolutions at an end-of-the year parliament. Using this basic meeting procedure, the state Health Decisions groups have held hundreds of meetings across the

country since the inception of the Community Health Decisions movement in 1983.

The educational goal of the Health Decisions groups is reached through two objectives. One objective is to identify and inform people about the critical problems facing the American health care system today. Public awareness about the problems such as the right and extent of access to health care, the allocation of scarce medical resources, the rationing of health care, the cost of health care, the use of life-sustaining treatment, and the authority for health decisions is encouraged.

Another objective is to clarify the individual and social values which are at work in the various health care issues. This clarification process is said to remain neutral and impartial with respect to the various ethical views which are either expressed by the participants or present within the issues. The examination of values is an attempt to help the participants recognize the different moral values with which they interpret and judge health care issues, either as those issues affect the participants personally or in their social context. The clarification of values usually takes the form of exercises that direct the participant to compare and prioritize various health care services with a view to also identifying the values upon which the ranking is based. Typically, the dominant moral values which emerge from the clarification process are absolute personal autonomy, avoidance of a burdensome life, preventive medicine, cost-effective medicine, and equity.

Establishing a common ground or a community consensus about the moral values and the priority ranking which ought to govern health care is the other goal of the Community Health Decisions movement. To this end, the operating rule of the Health Decisions projects is "to avoid polarizing the issues with which they deal" ("A Grassroots Movement in Bioethics,' by Bruce Jennings, *Hastings Center Report, Special Supplement,* June/July, 1988, p.9). It is the intent of the movement to shape and fashion a majority opinion which will guide health care legislation and public policy throughout the United States. The approach of the projects is to be open, inclusive, and tolerant so that common objectives may be identified and agreed upon among diverse views. Moreover, the majority opinions reported by the Health Decisions groups on issues such as health care rationing, Durable Power of Attorney for Health Care, and nutrition and hydration are having a direct influence on state legislatures, as for instance, in the cases of Oregon, Vermont, and Colorado.

Critique

The attempt to educate the public about the ethical issues of health care and to clarify the moral values of individuals and society with respect to health care in a value-neutral manner is an impossibility. This is evident both on a general basis and in the method of the Community Health Decisions projects. Generally, the educational goal of the Community Health Decisions movement rests on the failed assumption that education can be a value-neutral process which is part of a larger zone of moral neutrality in human endeavors. Each Health Decisions meeting and each project proceeds on the premise of openness, inclusivity, and tolerance. This premise is as much a specific moral value as any; it is a definite moral preference, a

statement of what is better and more suitable for people. Not only is the Community Health Decisions movement in this way inescapably value-laden, but it rests on a self-contradictory foundation since value-neutrality is itself considered a good to be achieved over others.

The moral neutrality in the educational method used by the Community Health Decisions movement is disproved in three ways. First, by the requirement that, in the name of consensus, participants ignore and be tolerant of views which they would otherwise find morally intolerable under any circumstances. Thus, the Catholic would need to tolerate values supporting actions such as direct sterilization, abortion, euthanasia, and physician-assisted suicide in order to be a discussant in the dialogue and a participant in the consensus.

Second, clarifying moral values through exercises of ranking health care services is a method already heavily laden with utilitarian values. The very idea of ranking as used by the Health Decisions groups is itself based on the moral assumption that social goods are to be determined by the weighing of benefits against costs for the greater number. The method of the educational component of the Community Health Decisions movement is incompatible with the Catholic moral doctrine that there is an objective order of morality, which includes exceptionless norms that will not succumb to a relativistic calculus of the greatest benefit for the greatest number.

Third, consensus is not a morally neutral goal, nor does it spontaneously emerge from the pages of participant questionnaires independent of the cumulative effect of many morally relevant factors such as the training of the discussion leaders, the presentations, the wording of the ranking surveys, and the fundamental moral assumptions underlying the goals and objectives of the movement.

The other major flaw of the Community Health Decisions movement is that it confuses "consensus" with "majority opinion." The two are related but not the same. Consensus is not mere public agreement. According to John Courtney Murray, S.J., consensus is "...not simply the least-common-denominator residue of a collation of opinions...it is something more than a mere registry of experience, and its contents are not simply facts. They are ideas and principles—or better, judgments and imperatives" *(We Hold These Truths: Catholic Reflections on the American Proposition.* NY: Sheed and Ward, 1960, p. 105). The constant search for the majority view and common ground, the fervent survey activity, and the casting of themselves as "a centrist Majority" is evidence that the leaders of the Community Health Decisions movement regard "consensus" in terms of the residue and registry of experience of which Murray writes.

What the "consensus" of the Community Health Decisions actually represents is a majoritarian push towards a utilitarian calculus of health care. This is reflected in statements such as the following made by T. Patrick Hill, representing the view of the New Jersey organization: "The majority of citizens whose voices have been heard through the Citizens' Committee are not ideologues but pragmatists, gravitating toward centrist positions and avoiding the polar extremes" ("Giving Voice to the Pragmatic Majority in New Jersey," *Hastings Center Report,* September/October 1990, p. 20). Moreover, to the extent that public officials are adopting the findings of the Health Decisions projects, the movement becomes

majoritarian rule. Many of the moral positions of the Catholic Church are not part of the Health Decisions' majority and therefore are not given equal consideration if the results of the Health Decisions projects are adopted by legislative bodies. This effect of majoritarianism has been recently witnessed in the case of Oregon's attempt at health care rationing.

Historically, the original American consensus consisted in the inheritance of a universal moral law, the applications of which public opinion was concerned. This should be the political process by which health care reform is achieved. However, in the Community Health Decisions movement, public opinion is granted the foundational status of that original consensus while dismissing its moral law as the minority view.
