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Comparative Religion

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Bio-Ethics, Schmio-Ethics:

A Foundation of Morality Spawns a Practice of Religion

Death. It is the one feature of life that affects every single individual, regardless of race, ethnicity, geographical location, or even species. Death will always be the same. It will embrace everyone in the same fashion and will have the same result for every individual. However, the process of dying is where things become complicated. Not only will the process of dying be different for various religions but it will be different for every single individual when they experience it. This complexity is embedded within the process of dying and many religions even acknowledge the differences of an individual’s process of dying and thus allow for a level of individualism within their own practices. In a world of ever changing technology and other advancement the complexity of the process of dying has created a problem for the medical field in how to properly handle the various life and death situations their patients will ultimately force them to confront. In an attempt to vet this problem and acquire some sense of direction those involved in the medical profession have crafted the idea of bio-ethics[[1]](#footnote-1).

The purpose of bio-ethics is to provide, at minimum, a general set of guidelines for medical professionals to have to work within when confronted with the complexities of the process of dying and the ultimate reality of death[[2]](#footnote-2). The beauty of bio-ethics is simply that they are capable of being accepted into any sect of religion that elects to embrace them[[3]](#footnote-3). Now more than ever we are seeing various religions of highly diverse origins embracing the concept of bio-ethics and structuring them within the framework or their own religious beliefs and practices. Interestingly enough the creation of bio-ethics has reached far beyond the “newer” religions and delved even into older and non-theistic religions. Given the context of how diverse bio-ethics have seemingly become, via their indoctrination into a wide variety of religions, one would likely end up raising the question: which set of bio-ethics should we elect to follow? The easy answer is to follow the set that your particular religion has produced, but what if you do not subscribe to a particular religious sect that has produced them? Should you then follow the purely secular approach to bio-ethics? What if you are admitted to a hospital that is of a specific denomination or faith that has its own set of bio-ethics, should you be concerned with the practices that they will be led to follow based upon their set of bio-ethics? It is the desire of this essay to put these questions aside and ease the mind of any individual who may be facing them. This desire is reachable in that this author believes that when we look beyond the topical descriptions and names of each set of bio-ethics we will suddenly discover that they are nearly identical in their guidelines. Thus it will not matter where or what religious (or non-religious) sect an individual’s doctor or health care provider belongs to at any given moment because the bio-ethical guidelines for which all follow will end up in the same results. In order to explore this claim and show it to be true, this essay will explore two sets of bio-ethical codes from two incredibly different religions: Catholicism and Buddhism. However, before one can draw this comparison there must be established a base understanding of the two religions themselves and how they each view bio-ethics within their own framework. In order to proceed with the discussion the essay will now shift into a brief summarized introduction to both religions, their beliefs and practices, and their descriptions of bio-ethics, before comparing and contrasting the two sets of bio-ethical codes then ultimately explaining how the two are virtually the same. Let us begin.

**Catholicism and Catholic Bio-Ethics**

Catholicism is one of, if not the, most well-known sects of the Christian religion. The Catholic beliefs and practices have been a crucial part of world history and led to some of the most important changes in the religious world. Being a part of the over-arching Christian religion Catholicism is a mono-theistic religion which believes in the concept of an eternal afterlife in either Heaven or Hell. This belief has, and will continue to, always have an effect of the Catholic practices surrounding the process of dying and death. If there is more to come after “death” one of would think that there should be a difference of in those practices from a religion that does not support the idea of a literal afterlife, but is this really the case?

As the world continued to progress and both technological and medical advancements were made Catholicism, like so many other religions, found itself in desperate need of an updated set of guidelines for approaching the new situations[[4]](#footnote-4) regarding the process of death and dying. Thus in the 1960’s “a new development occurred in a long standing area of inquiry. What had been the largely intrareligious study of morality or ethics of medical practice became ‘bioethics’” (Kelly et al 3). Suddenly it was no longer acceptable to merely have discussion about the proper etiquette of the medical professionals as a means of “enhancing the prestige of physicians”, but it was necessary to have conversation of “actual moral analysis of health care procedures and structures” (Kelly et al 3). Thus, for the first time, the endeavor to create a set of, at minimum, guidelines for medical professionals that engaged in religious practices[[5]](#footnote-5) to understand how to properly make moral decisions about the harsh new problems surrounding the process of death and dying for their patients. For the Catholic medical practitioner the bioethical code comes down to a three basic pillars: Ordinary vs. Extraordinary, Killing vs. Allowing to die, and Autonomy, Privacy, and the liberty to decide.

**Ordinary vs. Extraordinary**

The Catholic bioethical code references situations which are either moral, or not moral, based upon the issue of ordinary treatment and burden versus extraordinary treatment and burden. Whereas many laymen may incorrectly assume that the goal of bioethics, particularly those of the Catholic tradition is to preserve life at all cost, in reality the Papal allocution of 2004, the Vatican responses of 2007 and the Catholic directives of 2009 make it clear that it is morally acceptable for a patient to forgo medical treatments when they involve morally extraordinary burdens. This seems all well and good but one must then ask the question: “what constitutes a morally extraordinary burden?” This issue is that this particular component is not laid out in black and white. There are indicators in place to assist individuals in assessing the question and making that judgement call, however it undoubtedly comes down to a case by case basis (an idea which resonates throughout both Catholic bioethics and Buddhist bioethics). One primary example of a morally extraordinary burden includes extreme financial burden on yourself or your closest relatives (i.e. are they risking losing the house to pay for the treatment?)[[6]](#footnote-6)

**Killing vs. Allowing to Die**

First, it should be obvious that it is never morally acceptable to kill. It is however sometimes morally acceptable to allow someone to die. While these two ideas may sound similar, and may be easily confused, there is a key distinction that separates them and allows one to be considered moral (sometimes) and the other never to be considered moral. The Catholic Church has gone on record to take a stance against such things as a physician assisted suicide which is always viewed as killing, but does not have such a hard lined stance against the withholding of, or withdrawal of pain relief which may hasten death, as this is seen as allowing one to die. Perhaps the best example I can provide of allowing someone to die is one of an Alzheimer’s patient. If the patient ceases to be able to feed themselves, it would be considered acceptable to not feed them and allow them to die. However, if a patient ceases to be able to feed themselves and one performed a physician assisted suicide, it would not be considered morally acceptable as this is viewed as killing the patient. The key distinction here is that in one instance, the patient is dying from a natural course of events, in the other, their life is being ended by another human being as means of speeding up the dying process.

The issue within this pillar however is one of intention. It is important to factor in the intention of the individual making the decision as to allowing someone to die or not. It is established in the Catholic Principle of Double Effect (PDE) that one cannot have intended something bad with their decision[[7]](#footnote-7). This becomes an issue in that often time’s families will feel guilty about having to make a decision as to whether or not to allow a loved one to die. In the book *Contemporary Catholic Health Care Ethics* author Kelly et al. offers a type of litmus test for this situation in which the medical professional simply ask the family “if there was a cure for your loved one would you take it?” If the answer is yes than the intention is good, because they are not intending death rather they are intending to cease the pain. However, if the family/family member states otherwise the intention is likely bad as they may have literally been intending death as a means to achieve their own desires.

**Autonomy, Privacy and Liberty to Decide**

The final pillar at hand in the Catholic bioethical code rest squarely on the shoulders of the patient themselves. This raises the question of the level of autonomy that a patient has over the decisions of their own death and dying and at what point the decision making authority is shifted away from them. It is understood that the decision making authority for a competent patient rest with them unless they willingly issue it to another authority[[8]](#footnote-8). In the event that the patient ceases to be considered competent the decision making authority is then shifted to a surrogate. This surrogate however does not have final trumping authority as they will always be overruled by a decision made by the competent patient, via advanced directives, prior to becoming incompetent.

**The PDE**

Finally, another key principle of Catholic Bioethics is the idea of the aforementioned Principle of Double Effect. The Principle of Double Effect is reliant upon four basic conditions that are in order as follows: “(1) The act in itself must not be morally wrong. (2) The bad effect must not cause the good effect. (3) The agent must not intend the bad effect (as an end to be sought). (4) The bad effect must not outweigh the good effect.” (Kelly et al 105). This is the most useful and universal order for which the components are listed, however as Kelly et al. points out sometimes component two and component three are switched in terms of order. Further it should be understood via the PDE that performing any action where there are two or more effects there will always be some of which are good effects and intended to be good, but also there are some of which are bad and are intended to be bad. The PDE is employed as means of better drawing a distinction between the act of allowing someone to die compared to the act of killing someone. It tries to break that decision down into the four aforementioned components as a way of guiding oneself to the best moral decision.

**Buddhism and Buddhist Bio-Ethics**

The concept of Catholic bioethics may appear to be a logical evolution of ideology given the Christian notion of relatively strict shared ideology across its various denominations. This is not necessarily the case for Buddhism however which is known for having incredibly varied denominations which attempt to rest upon a few core beliefs but ultimately have crucial differences between them. Given this it must be understand that this essay is not seeking to provide a comprehensive guide or understanding of Buddhism as a religion as that could feasibly fill an entire book and still not fully encapsulate the intricacies of the religion. What this is essay is seeking to do is to provide an introduction and moderate understanding of the Buddhist bioethical code based upon this author’s understanding of it from studies of Karma Lekshe Tsomo’s book *Into the Jaws of Yama, Lord of Death*. Overall it is important to note that Buddhism does not support a claim of afterlife in the same manner as Catholicism (or Christianity overall) but it also does not perceive death to be the end. Unlike in the Christian/Catholic faith where one lives on after death via the form of a celestial body or soul, in Buddhism one is reincarnated as part the process of Samsara while seeking out Nirvana. There is not material “you” that is passed on and there is no memory of the individual’s past life, they simply begin a new as a new lifeform which is determined by their good and bad karma.

To begin Buddhist bioethics are reliant upon the long and rich history which the religion harbors. The bioethics are careful not to deviate too far from this history as it understands it to be the foundational core for the bioethical code which was formed. It should also be noted that this bioethical code was created due to the vast change that occurred in the way in which we as a society deal with death. Whereas previously death was a long and drawn out process, where one simply passed on in due time based upon the nature of things, today we seek to make death as quick as possible. No longer do we allow for a body to lie for days on end to ensure that the person has moved on, rather we attempt to save them in the here and now, or declare them gone and move to the next individual.

Given Buddhism’s heavy reliance on the principle of preservation of life, even down to the subtle consciousness which may linger, the bioethics must carefully approach end of life situations[[9]](#footnote-9) and diseases which a patient may face. However, it is important to realize that this emphasis on preserving life does not indicate any obligation to prolong life. The bioethical code of Buddhism has an emphasis upon simply letting these end of life situations run their natural course. It is not saying that one cannot accept pain relief but one should not do anything to accelerate death, i.e. one should not kill. The Buddhist would view these end of life situations as valuable as they are still a part of the circle of rebirth and any interference with them would almost definitely have karmic effects for the rebirth of both the patient and the medical professional.

Another interesting component of the Buddhist religion is the insistence that suffering is a good thing. Suffering is viewed as a “concomitant with the human condition and therefore accepted as an integral part of the human experience.” (Tsomo 174) This could become problematic as one must then determine the difference between pain which is not meant to be “borne nobly” (Tsomo 174) and suffering which is part of the circle of rebirth. This ultimately comes down to an individual understanding of which is which and relies on the individual to take self-responsibility for it. If one is in such pain that it is hastening the dying process or unnecessarily incapacitating them[[10]](#footnote-10) they should then accept pain medications as a means of balancing themselves.

Another of the core principles of Buddhism that the Buddhist bioethics rest upon is that of the Eight Fold Path. The Eight Fold Path is essentially the road map for how a Buddhist is expected to live and is broken down in the following way: “1.) Right View: Understanding the first three noble truths[[11]](#footnote-11), 2.) Right Intention: commitment to ethical and mental self-improvement, 3.)Right Speech: avoidance of lies, exaggeration, idle chatter, malicious speech, gossip and backbiting, 4.) Right Action: Avoidance of stealing, hurting, and destroying life…, 5.) right Livelihood: To avoid certain professions, weapons, alcohol, poisons, etc., 6.) Right Effort: Develop good states of mind and prevent evil states of mind, 7.)Right Mindfulness: Awareness of, control over, and perfections of one’s body, feelings, perceptions and thoughts, and 8.) Right Meditation/Concentration (Knepper).

This Eight Fold Path has enormous implications for the formation of the Buddhist bioethics in that they will not contradict the Path. A key component that becomes very prevalent in the Buddhist bioethics that is essentially taken verbatim from the Eight Fold Path is the concept of Right Intention. Given that all actions have a karmic effect one must have the right intention when preforming said actions. For example if one chooses to take and advanced direction of a DNR (do not resuscitate) they must do so with the right intention of not prolonging life, not with the wrong intention of killing themselves. Further the individual must willing to accept complete self-responsibility for the karmic effects of that action.

Also Buddhist Bioethics have a principle of understanding that there will always be good and bad karmic effects for every action. If a medical professional elects to remove a feeding tube from a patient in a PVS they must recognize that even if the intention is to be compassionate there will be both positive karmic effects, the patient is allowed the opportunity to move forward in Samsara and possibly attain the ultimate liberation of nirvana, as well as negative karmic effects, in that the medical professional has elected to end the individuals life while there was still subtle consciousness thus they have killed the individual. However, had the medical professional never placed the feeding tubes in the patient to begin with they would not be considered to be killing the individual but would be allowing them today. This is not a “get out of jail free card” though as it will still have both positive and negative karmic effects just as every other action.

In the end Buddhist bioethics intentionally do not provide hard and fast “rules” for dealing with situations as it puts an emphasis on individualism. Further the bioethical code, at least in the manner which Tsomo describes them, appear to hint at the idea of erring on the side of caution when confronted with difficult situations. There is no blanket statement that can be applied from Buddhist bioethics because there is no blanket statement that can be provided for Buddhism overall.

**How They Are the Same**

Now that we have an understanding, albeit a rough understanding, of the two forms of bioethics we can begin to craft a comparison between them. Yes it is obvious that one is electing to act upon the principles Buddhism while the other is acting upon the principles of Christianity. However, while astatically it may appear that this would cause the two codes to be incredibly different due to the stark contrast between the two religions[[12]](#footnote-12), a closer examination of the codes reveals that they are not so different. They do in fact have incredibly similar core values and principles.

First both share a principle of intentionality. The Buddhist bioethical code, and the Catholic bioethical code insist that there must be right intention when preforming any action. I acknowledge that for the Buddhist this stems from the Eight Fold Path, whereas it appears to first appear in the formation of a bioethical code for the Catholic tradition, but this does not undercut the reality that they both rest upon it as a principle. If one does something with the wrong intention then there will be consequences which they must face at a later time, perhaps even at death. For the Buddhist this is the consequence of bad karma which may affect rebirth, for the Catholic this is the consequence of sin which will affect the location of their eternal afterlife.

Second, both rest upon a core belief if a double effect. While the Catholic bioethical code makes blatant this principle by literally naming it as the Principle of Double Effect, the Buddhist practices this principle in the form of karma. The Buddhist bioethical code will insist that all actions be performed with caution in that there is ALWAYS going to be BOTH good and bad karma. This is precisely the same thing that the PDE indicates, in that no matter what one does, regardless of intention there will be both good and bad effects. Both bioethical codes then place an insistence on self-responsibility. They make clear that the individual must not only be aware the dualism of effects that will occur from their actions but that they alone are responsible for those effects and must be prepared to face the consequences of them.

Third, both bioethical codes put an emphasis on preservation of life, not necessarily prolongation of it. While the Catholic bioethical code appears to allow for some more leeway on this, it does not desire to unnecessarily prolong life and create extraordinary burden. The Buddhist bioethical code too insist on not unnecessarily prolonging life and speaks repeatedly to the issue of burden. This goes back to the effects principles in which one must recognize the burden that is being put on not just the individual but any other person involved, and if it is deemed that there is an extraordinary burden occurring then there must be a different route taken.

Both sets of codes have room for an allowance to die, but do not create room for killing. They both draw distinctions between these two options and are insistent that killing is never going to be acceptable regardless of intention, while allowing one to die is sometimes acceptable, taking special care to be concerned with intention. They both make room for this idea of “allowing to die” via things running their natural course. They both view life and death as a process which must be respected and is completely natural. If it is happens according to the natural course of things then it is important not to interfere with that death as you would be robbing them of their reward (for Buddhism would be interfering with their progression through the process of Samsara, for Catholicism be pulling them away from their eternal life in either Heaven or Hell). This is important because neither of them view death as the final end to existence. They both view death as the beginning of something, either life eternal, or rebirth/ultimate liberation.

Finally both sets of bioethical codes rest upon an idea of individualism. They are both careful not to create hard and fast rules which are to be stringently followed in every case. They make room for special circumstances and realize that an individual’s death is unique to them. These bioethical codes are both structured in such a way as to not make overarching blanket statements, but as to create and overarching theme. A theme which forces one to slow down and truly think about the decisions which they are making when confronted with death. This is the key to both of these sets of bioethical codes. They both function as a “breaking” method to prevent rash decisions with everlasting or irreversibly damaging effects. So yes while astatically they may appear to be vastly different, at their core they are one in the same. They both share the same core values and principles and they both seek to achieve the same purpose of recognizing the individualism of death and ensuring one is making well thought out and rational decisions.

**Conclusion**

There is no doubt that the two forms of religious bioethics have their differences. However there should also be no doubt that the two have numerous, deep seated similarities that ultimately tie them together in a manner that should one strip away the “religious” context, it is nearly impossible to tell them apart. At their core, these two forms of bio-ethics are the same, and this is because, as Pascal Boyer points out in chapter five of his book *Religion Explained: The Evolutionary Origins of Religious Thought*, they are founded upon the same set of inherent morals that exist within all humans. It is vitally important when making this comparison not to ignore the cultural differences that have led to the ultimate creation of these bio-ethics, for even Boyer acknowledges the importance of these differences. But it is equally important not to allow these cultural differences to deceive us into believing that these two formations of bio-ethical codes are so vastly different and unique that they could not be seen as easily comparable.

One the strongest supporting factors for this type of argument that Boyer provides is the section where he discusses children. He writes that often times it is falsely believed that children’s morals come exclusively from their parents/other adults that they are surrounded by while growing up. Boyer points out that while yes, indeed the parents and any other adults have a large influence upon those children, particularly as they grow older, it is incorrect to assume that the children are starting with a blank slate for which they must be completely trained and the script of morals must be written from the beginning. Instead it is far more likely that the child/children is born with a very narrowly defined view of morals, which apply only to very particular instances. These are the same morals that all children are born with regardless of culture, race, ethnicity, etc. Boyer states that from there the children are influenced by those older than them which forces them to craft a far broader concept of morals. Boyer uses the example of “bad.” Whereas a child may begin understanding that it is bad to antagonize the family pet, they will eventually broaden the horizon of their moral compass to understand that it is also bad to hit a sibling. In other words, they go from a very narrow/situation, moral code to a far broader and more general moral code that attempts to blanket large portions of incidences that may occur in that child’s life.

This is important because the evolution of the child’s morals, is highly similar to the evolution of bioethics, for both the Buddhist and Catholic traditions. Assuming Boyer and I are correct, both of these traditions spawn from an identical, base pool, which was only focused on very narrow situational instances. It is because of this that I am able to point out the core principles which both these bioethical codes share in the section above.

However, as the faiths grew, and technologies and medicines grew and began to expand outside the realm of these base situations the religions were forced to expand their own horizons and craft a far more general understanding. One of the biggest things that the comparative religion class (myself included) struggled with was the fact that we could not find straight forward, simple and direct answers to some of our questions, such as Physician assisted suicide, or euthanasia or other similar difficult questions. This is not merely a failure on the part of the bioethical codes to address them, rather it is intentional as a part of the bioethics “growing up” process. Much like the child who was forced to expand and craft a far more general moral approach as it grew older to understand that “bad” was blanketing several situations, bio-ethics are doing the same thing. As they have been forced to grow because of changes in the world (more practitioners, better medical technology, etc.) they have been forced to craft a far more general, blanket esq. approach to situations.

In the end both Boyer and I are seeking to show that it is a false assumption to say that religion props up our morals, and argue that it is in fact the other way around. While religion, and cultural differences are crucial to the expanding of and explanation of our morals, it is in fact a base inherent set of morals that crafts things such as our bioethical approaches. Due to this we are then able to compare two very different religions (one theistic, one not) and see that their respective bioethics are in fact not as different as one might first assume. From there we are able to understand why this is the case and not be forced to assume that it was simply coincidence that these two forms are so similar, and is instead the case because despite their differences they stem from the same base, internal and inherent school of thought.

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1. Bio-Ethics as defined by the Merriam-Webster dictionary is “a discipline dealing with the ethical implications of biological research and applications especially in medicine. (Webster) [↑](#footnote-ref-1)
2. It is crucially important to realize that in providing these guidelines for the medical professionals, the bioethical codes will often times directly address the individual patients. It is not uncommon for the bioethical codes to say what is and is not acceptable for a patient to partake in. This should still be understand as a guideline for the medical professionals however as they find themselves essentially required to follow the patients decision if it falls within the bioethical codes. [↑](#footnote-ref-2)
3. Further they are capable of being accepted in a purely secular/non-religious format as well, adding to their allure. [↑](#footnote-ref-3)
4. Those situations being: euthanasia, physician assisted suicide, removal of feeding tubes, etc. [↑](#footnote-ref-4)
5. Particularly of the Catholic faith here. [↑](#footnote-ref-5)
6. There are various other examples that may come into play in this discussion, however this particular one came up repeatedly during my own studies as Catholic bioethics appear to place an emphasis upon the question of cost and finances for both patient and his or her family/relatives that are contributing to their treatment. [↑](#footnote-ref-6)
7. A definition of the Principle of Double Effect will be given later. For now simply know that one of the basic components of said principle is that the agent cannot intend a bad effect. [↑](#footnote-ref-7)
8. There is a question of what constitutes a competent patient, however for the sake of progressing with the overall argument of this essay I am electing to skip this in depth medical discussion. Should one be interested please refer to Kelly et al Chapter 15 pgs. 146-148 [↑](#footnote-ref-8)
9. These end of life situations include such things as a patient with Alzheimer’s who cannot take care of themselves, someone in a persistent vegetative state, someone terminally ill with cancer for which there is no cure, or simply someone for which death is imminent. (It should be noted that the idea of death being imminent is never clearly defined and thus the practitioner is once again placed in a situation of a case by case basis in which they must make the correct judgement call.) [↑](#footnote-ref-9)
10. Such as say someone facing depression which causes them to essentially shut down and cease to engage with life. Tsomo points out that that individual may then be driven to overdose on medications thus hastening their dying process and ending their life before their time. [↑](#footnote-ref-10)
11. The Noble truths are: Duhkha (suffering exist), Samudaya (suffering has a cause), Nirodha (suffering has an end) and Magga (there is way or path to attain release from suffering). (Knepper) [↑](#footnote-ref-11)
12. One is theistic, the other is not. One believes in a soul, the other does not. Etc. [↑](#footnote-ref-12)