In God We Trust?

Exploring the Relationship Between Religious Guidance and Medical Bioethics

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Long gone is the era when the only comfort that could be offered to a dying person was palliative care and bedside prayer. Matters of life and death that were once thought to be within the exclusive purview of a supreme deity or karmic balance can now be influenced by physicians. With the advent of modern medicine, people are living longer than ever before, with the average lifespan nearly doubling in the past century. Options for end of life care have expanded dramatically, so much so that people can now be kept alive artificially for decades.

The medicalization of death has spurred critical questions about the value of life, the position of humans in making decisions about morality and mortality, and the role of religion in navigating this new landscape. This rapid expansion of medical technology and ever-growing ability of modern medicine to intervene in the process of death and dying is increasingly complicating the relationship between religion and science. The roles of religious leaders are evolving, the duties of religious followers are expanding, the open-mindedness required of physicians is increasing, and the work of religious scholars has never been more relevant.

One approach to marrying contemporary medical issues with religious tradition is through the interpretation provided by religious guidelines. Many religious traditions provide principles that guide followers in making decisions about both actions in life and practices in death. These guidelines can be explicitly written in doctrine or inferred. While some of these rules are written with apparent specificity, there is a need for them to also be increasingly malleable as medical technology advances. Though these guidelines vary across religions and address a multitude of issues related to medical technology, one thing they have in common is their contextual flexibility. They also

allow for individual conscience to serve as a factor in decision making when religion does not provide definitive answers.

In this paper, I will examine both the flexibility and rigidity of these principles across multiple religious traditions and evaluate their underlying reasoning. I will also explore the causes of these new interpretations, their applications, and their place within humanity's collective discourse about increasing medicalization. I will provide as examples the Principle of Double Effect within Catholicism and the use of fatwas for informing medical care according to Islam.

Before delving into the fusion of religious ideology and medicine that has evolved with the advancement of technology, it is helpful to understand the fundamental differences in terrain between secular and religious medical ethics. After a basic introduction to the foundational features of secular medical ethics, one can begin to compare and distinguish them from bioethical principles informed by religion. Secular medical ethics prioritizes three key concerns: emphasis on autonomy, reduction of suffering, and focus on empirical values.

The first feature, emphasis on autonomy, is summarized by Dartmouth religious scholar Ronald Green as follows: "the right of all individuals to make their own moral decisions freely" (Green, 1). By emphasizing the autonomy of the patient, he is made the prime decision-maker in his own care. The second focus, reduction of suffering, highlights the discretion of the patient in avoiding painful, restrictive, or unpleasant medical treatment. The final concern of secular bioethics is the prioritization of observable, empirical values. This emphasis considers the worldly ramifications of a patient's situation and seeks "to render the conditions of life in this world tolerable"

(Green, 1). The centrality of the individual and his decision-making ability, wellbeing, and reduced suffering are tantamount in secular medical ethics.

Theonomous bioethics cast a decidedly different gaze on the role of the patient. Unlike secular bioethics, faith-driven bioethics tend to place less significance on the autonomy of the individual. Instead, religious bioethics often view external considerations to be of greater importance than individual preference. Sometimes this can mean recognizing and submitting oneself to the ultimate decisional authority of a non-human entity, such as a deity, and might promote intercession to determine and understand "God's will". In other religious traditions, this might mean considering the impact on the family unit and could encourage family discussion and support in making end of life decisions. In either case, from the perspective of religious bioethics, the autonomy of the individual for his own sake is often given less weight.

Three additional values which are key to understanding theonomous bioethics are beneficence, nonmaleficence, and justice. Catholic bioethical scholar David Kelly defines beneficence as "the obligation to do good for the patient and others" (Kelly, 64). This principle requires an appeal to a wider perspective than the individual's alone. The second principle, nonmaleficence, is defined by Kelly as, "the obligation not to harm the patient or others" (Kelly, 64). This principle speaks to the oft-held religious belief that life has inherent value. Kelly defines the final principle, justice, as "treating people fairly" (Kelly, 64). This final value is suggestive of the importance of fairness that religious bioethical standards strive to create. Though the principles of secular and religious bioethics have some differences, they both provide a basis for bioethical standards.

It is in this context that interpretation of religious doctrine becomes important. Questions about end of life care such as, “Who should decide?” and “On what grounds?” are not easily answered. Though many religious followers turn to their religion in trying times, the information in religious texts is not always written in a way that is easily accessible and blatantly applicable to problems suffered by religious believers. It would be unreasonable to think that most believers possess the intellect, theological background, necessary time, and proper training to accurately interpret, adapt, and apply religious teachings to their medical treatment, such as end of life care. However, this does not reduce the desire of many followers to be guided by the wisdom of their faith tradition. It is this growing need that religious scholars’ interpretations and developments of religious bioethical guidelines arose to meet.

Religious guidelines are intended to provide basic principles for believers and assist them in living out their faith. In formulating these principles, religious scholars ask what their religion suggests or demands of its followers. These guidelines are intended to function from ‘higher power’ to man in the same way that compassion functions between men. These guidelines embody a sense of altruism and empathy in their attempt to offer direction in some of the most difficult decisions a person will ever be faced with making.

Religious authorities formulate and shape guiding principles according to religious doctrine, religious tradition, and previous interpretations by learned religious practitioners. Some religions offer a rich history of moral teachings that are foundational to informing these principles. Other religions have less written work to contribute to the synthesizing of such principles, leaving it up to scholars to make more liberal interpretations. Both of these positions present unique challenges. On the one

hand, it is advantageous for religions to have a wealth of doctrine and practice on which to draw; on the other hand, maintaining tenable and flexible principles in the face of abundant and specific information can be difficult. For religious scholars whose traditions offer them less information, they are both forced to make greater inferences but also given more freedom to generate consistent and applicable rules. Viewed through this lens, the work of religious scholars of different disciplines is equally but uniquely difficult.

A key distinguishing feature of these guidelines is their situational and contextual malleability. Religious traditions themselves recognize that their texts always require some degree of interpretation and application. This becomes increasingly true in the complex and intricate cases that are raised by modern medical advancements. Certainly most foundational religious texts were written long before the life-changing and life-sustaining advancements of modern medicine, so generosity is required to properly and meaningfully interpret doctrine in relation to these issues.

The principle responsible for spurring my interest in this subject comes from the Catholic tradition. Catholicism has a long, rich bioethical history. Catholic bioethics in particular are traditionally founded on the Christian belief in intrinsic human worth and dignity (Kelly, 10). This worth is not derived from the value of people according to others but from the value of people according to God. Because humans are both creatures of God and cocreators with God, the role they play is twofold: they are both subject to God's will, as well as stewards of life. For Christians, the origin of any particular illness is God's wrath as punishment for original sin, not punishment directed towards the sick person himself.

Because extensive work has been done within the field of Catholic bioethics, there is a distinct hierarchy of authority established by God through which believers can follow a "normative pattern" of decision-making. According to this normative pattern, a follower should proceed in the three following ways: the teachings of the Bible, the sacred Christian scripture; the understandings of Biblical teachings exhibited by traditions and formal authority within the Church; and the exercise of human reason (Green, 2). These steps provide the individual with a course of action to follow in order to seek religious guidance. This is necessary in the Catholic tradition because of the wealth of bioethical positions held by the church.

One Catholic bioethical principle specifically fascinated me and was my inspiration for exploring the role of religious guidelines in medical care: the Principle of Double Effect. The Principle of Double Effect (PDE) was the primary operational principle before the creation of Vatican II Catholic medical ethics (Kelly, 104). Still used in both religious and secular contexts today, PDE purports to give "precise and definitive answers" to the question "Is it right to perform an action from which two or more effects result, some of which are good and may rightly be intended and some of which are bad and may not rightly be intended?" (Kelly, 104).

The Principle of Double Effect is most useful in cases where an action would cause both a good and a bad effect. An action is only permissible if all four of the following conditions are met:

(1) The act itself is not morally wrong.
(2) The bad effect does not cause the good effect.
(3) The agent does not intend the bad effect (as an end to be sought).
(4) The bad effect does not outweigh the good effect (Kelly, 105).

The first condition, “The act itself is not morally wrong.”, is as straightforward as it appears. Provided the act is not considered morally wrong in and of itself by Catholic moral theology, it passes this first standard.

The second condition, “The bad effect must not cause the good effect.”, becomes more complicated. If the bad effect occurs, triggering the good effect, the act is considered wrong. However, reframing the act can sometimes avoid it being ruled impermissible by this condition. For instance, Catholicism identifies masturbation as a sin. However, if masturbation was framed as “genital touching” and occurred while a man was cleaning himself in the shower, this could pass the second condition because the bad effect (extramarital sexual pleasure) did not cause the good effect (cleanliness) (Kelly, 106). While specific acts have come to be classified under certain names to eliminate this sort of moral grey area, it is still sometimes unclear which term should be used to refer to a certain act.

The third condition, “The agent must not intend the bad effect.”, requires that people ought not desire evil. This condition differs from the first by taking into account the intentions of the agent. For example, if a married couple that is struggling to conceive seeks fertility treatment, the man will likely be required to provide a semen sample. While masturbation is considered wrong if done for its own sake, if we consider the husband’s intention to conceive children as the end being sought in the “moral sense of the term”, it would pass the third condition (Kelly, 107).

The fourth and final condition, “The bad effect must not outweigh the good effect.”, is straightforward. This condition merely provides a requirement to consider the proportionality of the good and the bad being done.

As has already been evidenced, these criteria can both offer helpful guidance and generate confusion when they provide conflicting or uncertain answers. This problem is only exacerbated as questions become more complex, which they tend to do in scenarios related to death and dying. Questions surrounding issues such as life-sustaining treatment, abortion, and physician-assisted suicide are just a few examples of scenarios to which these criteria could be applied and potentially offer unclear answers.

Like the Catholic tradition, Islam is a major religious and political force around the globe. Because of its widespread practice and long history, Islamic bioethics is also a well-established field with a significant body of work. One idea foundational to the formation of Islamic bioethics is the belief in the sanctity of life. Though all life is deemed precious and considered to be a sign of God's divinity, human life is the most outstanding (Shomali, n.p.) Human dignity is also a critical tenet of the Islamic faith. As beings endowed by God with free will and the capacity for reason, human beings are both cherished and responsible for fulfilling the goal of creation (Shomali, n.p.). In this way, the role of Muslims according to Islam closely mirrors the portrayal of Christians in the Catholic tradition.

Within Islam, there is a specific structure that guides Muslims through their daily lives. The primary source of wisdom is the Qur'an, the Islamic holy book containing divine law. Information meant to inform the daily lives of Muslims also comes in the form of the hadiths and sunnah, which are the oral communication derived from the Prophet's teachings and the prevailing customs of a particular community that are passed on generationally, respectively (Ahmed, n.p.). Derived from the Qur'an and hadith is shariah, the Islamic law that governs what practices are permissible within Islam (Webb, 111).

Also similar to Christianity, interpretations of Islamic principles that are used to guide Muslims in living out faith practices in their daily lives can come from multiple sources. While the Qur'an is considered the supreme authority, Muslim scholars and Islamic teachers play a significant role in interpreting oral and written traditions. Much like the Catholic church, the "unity of traditional sources of knowledge" helps to promote uniformity in the beliefs and practices of Muslims around the world.

Where differences do exist, they can sometimes be attributed to cultural differences, not religious ones (Webb, 112). However, unlike Catholicism, Islam has no central authority who pronounces official doctrine. As such, multiple but conflicting interpretations of Islamic texts can be considered equally valid with no ultimate method of settling any disputes (Webb, 115). Fatwas are legal opinions and interpretations of issues pertaining to Islamic law that are written by Islamic scholars. Muslims can seek fatwas if they have a question that they wish to be answered from an Islamic perspective. Fatwas are researched and provided by Islamic scholars who rely on the three following sources as the basis of a ruling:

(1) The Qur'an
(2) The Sunnah
(3) Consensus of scholars of previous generations (Ahmed, n.p.).

Fatwas categorize actions into one of five categories: obligatory, commendable, permissible, despised, or not permitted. All actions are considered permissible unless there is evidence provided from one of the three aforementioned sources. These rulings often contain textual evidence to support and explain the reasoning of the scholar (Filiz, n.p.). If no scripture is found from the first three sources to provide an answer to the

question, the Islamic scholar performs ijtihad, where he uses his own logic and reasoning to provide the best possible advice.

For instance, if an Islamic surgeon knew she was going to be performing surgery for fifteen hours straight and would not be able to conform to the mandated prayer requirements, she could ask an Islamic scholar for advice on how to proceed. She might be advised to pray to the best of her ability during surgery or to delay her prayers until the surgery is finished. While fatwas are often highly regarded and carry significant weight for believers, the surgeon has no duty to follow that ruling. In fact, if she receives a fatwa that does not please her, she could seek another fatwa from a different Islamic scholar immediately which might provide her with a more desirable outcome.

While these rulings can provide critical guidance to Muslims making challenging and complex decisions, the fact that no one fatwa is any more valid than another creates a problem similar to one that is created through the Catholic Principle of Double Effect: fatwas are helpful insofar as they provide much sought-after guidance to followers, but there is also potential for these rulings to be abused to confirm the improper desires of the believer. So how ought we understand the role of religious guidelines, and how ought they be utilized and interpreted by followers? Do they generate valid and useful distinctions?

It is certainly true that some religious guidelines can be manipulated to justify an outcome the agent desires instead of providing authentic religious direction. This possibility presents a problem that is perhaps just as great as the benefit that might be gained from proper application. The use of religion to support immoral acts is genuinely problematic and should be a heavy consideration of religious practitioners. However, I argue that a person seeking confirmation for a mal-intended act would be able to find it

almost anywhere he looked. This is not a problem created by religion but a flaw of self-serving humans. While it should be the responsibility of each religious tradition to develop, interpret, and apply their guidelines with authentic intent and cautious consideration of this potential problem, religious traditions should not be blamed for the ill-use or misapplication of genuine, flexible religious 'advice'.

Even sincere attempts at applying these principles is far from easy. If read too strictly, these guidelines fail to offer any contextual flexibility to followers. Conversely, if they are interpreted too liberally, the religion itself risks having its tenets diluted and authenticity challenged. A fine line exists in balancing the usefulness and truthfulness of applying these principles.

Because both Islam and Catholicism are Abrahamic religions, they share historical roots which could account for some of their shared values. However, I contend that the similarities between these values and their methods in developing guidelines have more to do with the basic human values of compassion and empathy, which transcend religion, than with the shared history of the religions themselves. I understand these guidelines as genuine attempts for people to make sense of the ever-changing world in which they live.

Practically speaking, the flexibility provided by these guidelines allows for religions to continue to change and evolve with the passage of time. These principles are able to preserve religious traditions and offer their belief structures longevity through continued progression and interpretation. They also provide an important avenue for discussion about the pressing moral and ethical concerns that surround us.

For many people, religion functions as a foundational system of belief: it not only shapes how they perceive their own place in society but also how they understand the

world around them. Perhaps people gravitate toward religion because it offers a defined moral code and provides criteria for living a worthwhile life. The desire to find meaning in difficult situations is an inherent human tendency, and the exercise of spirituality is the most widespread way of acting on this human proclivity. In this light, it seems only logical that religious practitioners would also seek to provide guidance and direction to those who are striving to live in accordance with their most intimately held beliefs. Upon careful consideration, it seems that religious bioethics and secular bioethics are attempting to provide the same thing: guidance, comfort, and compassion to those with the greatest need. And that should be something we can all believe in.

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