The Moral Meaning of Religion for Bioethics

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Religion's fundamental involvement with questions of disease, health, and medicine has given rise to concepts making substantial contributions to the field of bioethics. The purpose of this article is to examine such ongoing contributions in a general way, and then to review how the issue of whether medical technology should be used to prolong life might be approached from the standpoint of several different religious traditions.

Religion is inescapably concerned with questions of health, medicine, and disease. In the normative scriptures of the Judeo-Christian tradition, images of God as healer and physician are powerful and prominent. At the same time, religious communities have historically seen the existence of disease as confirming evidence of the presence of evil and sin in the world; indeed, the nature and extent of disease, as in the case of plague, for example, can present serious theologic questions about the moral character of the Deity.

Moreover, our very concepts of "health" and "disease" reflect values that are frequently influenced by religious presuppositions. Thus, whether an alcoholic is considered a sinner, a criminal, or a victim of genetic or environmental factors beyond his or her control involves evaluations that can be conditioned by theologic perspectives on free will, human nature, and appropriate social conduct. Similarly, the "suffering" caused by illness, while undesired, may not be considered meaningless from a religious standpoint. And an impaired newborn may yet be considered a "gift" of God with a special religious meaning, rather than an unwanted burden for its parents.

The complex ways in which religion encompasses and qualifies health, medicine, and disease help explain its multifaceted relation to bioethics. Regarding bioethics itself, tremendous technologic advances in the United States in the mid-1960s and broader moral concerns about individual self-determination and social justice converged to generate this very distinctive and innovative field of ethical inquiry. At that point theologians found themselves in the unique position of being able to give bioethics an initial impetus and substantive direction, because they brought to bear on its subject matter the substantial resources of the moral reflection, historic traditions, and practices of religious communities. Some very new questions about life and death could be put into context and more readily approached from the direction of already-formed convictions about respect for the individual's integrity and his or her body, care and treatment for the dying, a demand for equity in the provision of health care, and a concern for including the socially voiceless and vulnerable within the boundaries of the moral community.

This article will consider how religion

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has held and can hold moral meaning for bioethics and enrich it—both in a descriptive, empirical manner and in a normative, conceptual manner. It will also examine how one complex bioethical issue (whether available medical technology should be used to prolong life) might be approached from the standpoint of different religious traditions.

RELIGION AND THE SECULARIZATION OF BIOETHICS

As a matter of simple historic evolution, it is safe to say that contemporary bioethics is substantially indebted to religion. The very concrete considerations that fall under the domain of bioethics, such as whether a particular person should be treated medically or allowed to die, are often rightly credited with prompting a major transformation in philosophic ethics from an abstract, analytical discipline to an applied one. By contrast, the religions of Western culture, embedded in practicing historic communities, have always had concrete dimensions of morality (as manifested in the imperative of neighbor-love) and spirituality; initially, therefore, their affinity for questions of bioethics was direct and not open to question.

This influence of religious perspectives, especially strong in the formative years of bioethics, is now no longer as extensive or as explicit in the United States, though it may be in many nations where bioethics has only recently begun to gain a foothold. Therefore, it is important to examine retrospectively what has been termed the "secularization of bioethics" in the United States as a way of possibly illuminating the prospective nature of the relationship between religion and bioethics in other countries.

One meaning of the term "secularization" is *removal* of central institutions (medicine) or values (health) from the influence of religious thought and practice. This has undeniably occurred to a significant extent in the development of bioethics in the United States. The field is now suffused with philosophic and legal paradigms, principles, and discourse; religion seems morally interesting only when a particularly difficult issue arises, such as refusal of medical treatment for a minor on religious grounds.

Part of the reason is that bioethics issues, much more than in the past, are vexing matters of *public* policy. Determination of death, for example, is no longer considered the exclusive preserve of medical practitioners, but one that needs public scrutiny, perhaps by a government advisory panel. The question of whether a particular patient should receive an organ transplant to prolong his or her life no longer involves simply organ availability and compatibility, but also the concern of legislators who believe the money spent on "rescue" medicine to save one life might be better spent on "preventive" medicine, such as prenatal care for expectant mothers, that will ultimately benefit many people.

This prominent public policy orientation of contemporary bioethics has worked against consideration of religious perspectives in a couple of important ways.

Religion in the United States is considered an essentially "private" matter. It must not be discriminated against—on grounds of respect for freedom of conscience—but neither can it be "established" or appealed to as a basis for public policy. Thus, in the very composition of a pluralistic society there is an inherent bias against conceptions of human goodness or welfare that are attributable to particular convictions, including religious convictions, that are not generalizable or shared by the entire society. Since all citizens are presumed to have a stake in "public" policy, the basis for policy on

a controversial bioethics issue must reside in some common convictions, rather than on religious grounds that may prove divisive.

Also, from *within* theologic circles long-standing disputes worked to minimize the significance of religion for bioethics. In particular, theologians (as well as philosophers) questioned whether religious views really made any *distinctive* (that is, different from philosophic) contributions to bioethics debates, especially as these debates came to be directed at finding a suitable policy for the entire public. If they did not make a distinctive contribution, so the reasoning went, philosophic approaches could work just as well and were preferable because they were presumed to be less divisive in a pluralistic society.

But even if the differences of religion for ethics could be successfully articulated for a public audience, some theologic ethicists questioned whether this was an *appropriate* audience. They suggested that the primary vocational responsibility of a theologian is to respond to the spiritual and moral claims of his or her own religious tradition and practicing community; in speaking to a broader audience than one's tradition, or doing bioethics on behalf of a "public," the integrity of the vocation of theologian is compromised. These two *theological* constraints on an invigorating relation between religion and bioethics continue to persist and to present an important challenge for theologians in the United States and other countries.

But "secularization" can also mean that values and beliefs once explicitly affirmed as religious may command widespread acceptance, even if their religious grounds do not. Using this definition, the "secularization of bioethics" may mean that religion has an important leavening impact on bioethics even if its influence is not recognized as such. Religious concerns about the "sanctity of human life," human "stewardship" for nature, and protecting the vulnerable in the human community can support practices and principles of medical treatment, technology, and care that are presented publicly on secular or philosophic grounds. We can develop this aspect of secularization further by considering the relation between religion and the normative principles of bioethics.

RELIGION AND THE BIOETHICS PARADIGM

The moral controversies of contemporary bioethics are typically analyzed with reference to what has been termed "the bioethics paradigm," which consists of a "trinity" of moral concepts—those of beneficence, justice, and autonomy.

Beneficence, at its minimum, requires moral agents to refrain from harming others; it can also involve positive obligations to do good to others and promote their welfare. Provision of medical treatment conforms to this principle because it typically benefits a patient.

The principle of *justice* obligates one to ensure that the benefits of health care (or in some cases the burdens, such as taxes for hospitals) are distributed fairly and equitably. For example, the benefits of experimental research on human beings can be inestimable for many people, but it is important that those subject to the risks of experimentation not be drawn unfairly from a particularly vulnerable class of people—such as children, prisoners, or the mentally retarded—or be selected on the basis of nonmedical criteria such as race, ethnicity, or social class that can reflect discrimination.

The principle of *autonomy* obliges us to treat other people as ends in themselves and respect their freedom, liberty of action, and self-determined choices. Respect for autonomy is presupposed in

moral positions and legal decisions that require patients' informed consent to treatment and that recognize patients' rights to privacy and to refuse medical treatment.

Each of these governing principles, while capable of defense and explication in the discourse of secular moral philosophy, is compatible with fundamental themes in religious traditions. The principle of beneficence, both historically and conceptually, is rooted in the commandment of neighbor-love. There is also implicit in this commandment a universalistic impulse that accommodates a shift in moral concern from the one to the many, thus encompassing the norm of justice.

In addition, major religious traditions of Western culture have affirmed that we share a common origin and destiny: We are created as social beings to live in community with other persons, so that the collective good and equality must be in the forefront of our moral universe.

Moreover, these traditions understand all human beings to be created in the image of God (*imago Dei*); and this *imago Dei* concept not only reinforces a sense of commonality and equality but also respect for individual autonomy. Thus, moral norms with profound meaning for religious traditions have served and can continue to serve as background presuppositions of the bioethics paradigm.

Nevertheless, these affinities should not be mistaken for identity. From within the perspectives of a religious community, the meaning and content of the normative principles of bioethics will be deepened and transformed. Neighbor-love does indeed encompass duties of refraining from doing harm and having at least minimal expectations of benefitting others; but in a religious context these expectations will typically be heightened to the extent that some degree of self-sacrifice will be required so that the good of others is pursued actively.

The principle of justice may also be vested with different meaning in a religious context. In some theologic traditions, such as that of the theology of liberation propounded by some theologians and priests in Latin America, justice is informed by a "preferential option" for the poor. That is, in considering social justice issues, including such things as access to quality health care, the needs of the society's most vulnerable members are given priority over strict adherence to equality. We do not all begin life with the same choices, resources, and capacities; and the "preferential" qualification of justice can be understood as an attempt to redress those natural and social inequalities that exist for reasons beyond our control, and that deprive some people of full participation in the life and benefits of society.

In a similar manner, the *imago Dei* concept transforms understandings of the meaning of autonomy. In contrast to an exclusive focus on autonomous choice and freedom of will, the *imago Dei* concept asserts that people are more than their wills; they are *embodied* selves; and so, just as much as their rational faculties, their physical, temporal bodies are deserving of moral respect.

This conviction has practical implications when the ethics of organ procurement policies are examined. Certain policies may be considered theologically suspect or even unacceptable because of their implicit disrespect for the body (in the case of routine salvage policies, for example) or commercialization of it (in the case of an organ market).

Moreover, autonomy frequently presupposes an excessively narrow, individualistic vision of moral life, a temptation limited by the solidarity and community with all other persons expressed in the *imago Dei*. The theologic concept therefore contains inherent limits on freedom and individual choice that may not be ad-

equately conveyed by the normative principle of autonomy.

Religious traditions will therefore not consider the moral dimensions of bioethics to be exhaustively subsumed under the normative principles encompassed by the bioethics paradigm; indeed, an ethical model that proceeds on such an assumption is in fundamental respects limited and substantively deprived. This is not only because a religious perspective may alter and transform the meaning of these norms, but also because the paradigm itself presents a somewhat distorted picture of the moral life. Specifically, in focusing on "problem-solving" in bioethics, the paradigm fails to adequately reflect the narrative structure of our lives and the stories all persons use for "problem-seeing." Significantly, "seeing" and "setting" moral problems in bioethics often occurs against the background of religiously informed narratives.

PLAYING GOD AND GOOD SAMARITANS

Perhaps the most prominent metaphor for understanding bioethics in popular culture is that of "playing God." That perception typically conveys a negative evaluation, in that it is considered pretentious for human beings to "play God" with respect to creating life (through reproductive technologies), terminating it (by withholding medical treatments), or determining what type of people there will be (through genetic screening or engineering). Yet both this perception and negative evaluation assume the significance of a religious narrative, that of Creation, for seeing and interpreting the particular moral question. Indeed, without this religious presupposition, the phrase "playing God" would be unintelligible. My point here is that irrespective of the impact of religion at the level of bioethical problem-solving, it can be indispensable at a *prior* stage for *recognition* of what the moral issues are.

Once we have grasped how religious stories can fundamentally shape the way bioethical problems are understood, we can then raise some very interesting questions. What, for example, does the metaphor of "playing God" convey morally that makes it such a commonly invoked expression in debates over reproductive technologies or genetic engineering? A partial answer is that it expresses a sense that human beings are taking control over, or usurping authority for, the process of creating life—in a way that at the very least prompts serious moral reservations. For we are in very important ways different from the nature of the Being presented and re-presented in theologic reflection. We have limited capacities for predicting the outcome of actions, controlling the courses of events that we initiate, or accurately evaluating the results of an action. The "playing God" metaphor, then, draws on a basic religious story to remind us of our finitude and fallibility, considerations that are of substantial moral significance when we contemplate "creating new life-forms."

In another context, however, the "playing God" metaphor may be invoked in a much more positive sense to prescribe, rather than critique, conduct. The story of God as one who is nonpreferential and indiscriminate in distributing resources necessary to life, who makes the sun and the rain to "fall on the just and unjust alike," provides a positive moral direction for many bioethicists confronted with the vexing issue of allocating scarce resources. That is, our allocation and rationing policies should likewise be nonpreferential and should affirm the fundamental equality of all hu-

man beings. This might, in contrast to the brave new world of reproductive technologies or genetic engineering, be construed as a "correct" way to play God in bioethics.

Another instructive example of how religious narratives can provide affirmative moral guidance in bioethics is presented by incorporation of the "Good Samaritan" image into the ethos of the medical profession. The Good Samaritan parable of Jesus has frequently been understood as the paradigm expression of the meaning of neighbor-love in the New Testament. It establishes expectations of self-sacrifice, care, and compassion on the part of moral agents toward anyone in need, even one who may be considered a stranger. Originally, of course, these expectations were established within a religious community. However, the story may well be used in other contexts, such as that of the medical profession, as a way of interpreting the profession's identity and moral meaning and articulating the responsibilities and commitments of physicians toward their patients. In this context the story does not function so much to resolve a moral problem as to set the moral and professional parameters within which the problem is then discussed.

Since our modern society has deep roots in a religious heritage, it should not be especially surprising that religious stories and narratives such as these (many others could be identified) provide a cultural perspective for understanding the moral problems found in bioethics. What is surprising is that this impact of religion upon bioethics is very seldom acknowledged. That is important, for we cannot know what conclusions to reach on a bioethical issue unless we have a clear idea of the questions formulated; and, I suggest, as often as not the questions formulated have been shaped by religious narratives.

RELIGIOUS PERSPECTIVES ON THE PROLONGATION OF LIFE

Up to now, this analysis has concentrated on very general ways that religious perspectives may influence, direct, and limit bioethics. The next point to be considered briefly is how different religious traditions—specifically Orthodox Jewish, Roman Catholic, and Protestant—approach one particular bioethics issue, the use of life-sustaining medical technology.

The theological premise of the *imago Dei* is prominent in each of these traditions and helps establish the moral parameters for discussion: Even in dying, and perhaps especially in dying, we are deserving of respect, care, and compassion. Also, each tradition has historically emphasized the sovereignty of God over life-and-death decisions, a fundamental theologic claim influencing our perspectives on the use of technology. Beyond these points of general convergence, however, themes particular to each tradition help shape distinctive positions.

In the tradition of Orthodox Judaism, life is sanctified as part of the work of the Creator and possesses absolute value. If life is threatened, it is deemed permissible in rabbinic reflection to violate all the laws of the Torah except the prohibitions against murder, idolatry, and adultery in order to save it. Thus, while the Orthodox Jewish tradition asserts God's ultimate sovereignty over life and death, it has also been open to technologic advances that hold promise for prolonging life. This has typically meant favoring all available means of life-support for patients who would die without life-sustaining treatment.

This strong commitment to the sanctity of life has also meant that Orthodox Judaism has been very reluctant to embrace technologic and medical developments that appear to risk shortening life. For ex-

ample, the tradition has consistently opposed use of brain criteria to determine death, relying instead on traditional heart-lung criteria. This has meant a practical presumption against organ transplant, since organ procurement policies assume the validity of brain criteria for death. Even though an organ transplant may save the life of another, in a theologically real sense (informed by the Torah), the "donor" should not be considered "dead" until circulation and respiration cease.

In contrast, an historically important moral element in Roman Catholic reflection has been that while life is a fundamental and intrinsic value (because it reflects the goodness of the Creator), it is not an *absolute* value. Life is but the necessary condition for achieving greater human ends, which typically can be achieved only by an individual relating to a "community" of other human beings. Here the use of life-prolonging medical technology is considered a positive moral benefit to the extent that it maintains these relationships or sustains the individual's capacity to orient his or her life to the achievement of these greater ends.

In certain circumstances, however, the possibility of life in relation with others, the "quality of life," is very much diminished or altogether absent—as in the case of a permanently comatose patient such as Karen Ann Quinlan. In such cases, the Roman Catholic tradition has considered it permissible to withdraw or withhold certain forms of medical technology from dying patients; the reasoning commonly invoked by the tradition (which has been very influential in secular bioethics) has typically claimed that "ordinary" treatments are obligatory while "extraordinary" treatments are morally optional or discretionary.

The debate within the tradition then becomes which treatments fall into which category. For example, most Catholic moralists will accept that mechanical ventilation can be "extraordinary" treatment and can permissibly be withdrawn under appropriate circumstances; but there is much less consensus on whether it is permissible to withhold antibiotics or withdraw feeding tubes providing nutrition and hydration.

It is also possible that, in the course of a disease process, pain and suffering may become so excruciating as to permit only the most minimal modes of human interaction. The Roman Catholic tradition has historically prohibited suicide or assisted suicide, as well as active euthanasia, as unjustifiable killing and a usurpation of divine sovereignty. However, under the "rule of double effect" it has also asserted that it is permissible to provide substantial medication, such as morphine, for pain relief, even if the result is to hasten death. This would not be considered "active killing" in the Roman Catholic tradition, because the intent is compassionate, to relieve pain, even if death is foreseen as a "second effect" of the action. On the other hand, an actual intention to kill, by administering a lethal dose of medication for example, would violate the "rule of double effect" and would be considered unjustifiable.

The Roman Catholic tradition's emphasis on the relational quality of human life has enabled it to accommodate the idea of defining death by brain criteria much more than is possible in Orthodox Judaism. This in turn has provided a medical condition for organ transplant that is theologically reinforced by the theme of "community," for donated organs may save the lives of others who are part of a broader community or social whole.

Regarding the Protestant outlook, as is typical of Protestant theology in general, Protestant perspectives on life-prolonging medical treatment are very diverse. They range from a vitalistic commitment

to the sanctity of life resembling Orthodox Judaism's, through a willingness to accept "quality of life" considerations in deciding whether to terminate treatment that is like the Catholic position, to a greater tolerance for even active euthanasia or medical killing to relieve suffering that overlaps with secular positions. This diversity itself reflects a fundamental Protestant theme—theologic commitment to the freedom of the believer. Yet this freedom, together with its implications for greater personal discretion in moral matters, can be limited in Protestant positions by both the *imago Dei* concept and that of "stewardship." The concept of "stewardship" (also present in Jewish and Catholic thought to some extent) asserts that we are entrusted by God with responsibility for our temporal lives and physical bodies, so that acting with disregard toward our lives or those of others is a violation of this trust. There are thus theologic resources within Protestant traditions that may establish presumptions against active euthanasia and in favor of organ transplants.

CONCLUSION

The significance of theologic perspectives cannot, as is so often the case, be considered of limited relevance to bioethics. Religious traditions and communities bring to these very difficult questions historically shaped substantive understandings of the nature and destiny of human beings and the moral norms they should live by. The value of religious understandings for bioethics is not that they provide answers that all must accept, but rather that they raise questions we need to confront.[2]

[2]J. M. Gustafson, *The Contributions of Theology to Medical Ethics*, Marquette University Press, Milwaukee, 1975, pp. 93–94.