
Theology and the Discipline of Bioethics

by Janine Marie Idziak

It has recently been contended that theology contributes nothing to bioethics. I argue that current work in bioethics does not suffer from the theological deprivation that some have claimed. Using examples from new reproductive technologies, foregoing life-sustaining treatment, truth-telling to the terminally ill, and euthanasia and assisted suicide, I describe four ways in which theology makes a substantive and distinctive contribution to bioethics. First, theological concepts and beliefs can generate normative principles for bioethical decision making. Second, theology can provide reinforcing reasons for philosophical positions. Third, theology brings to bioethics a particular methodology in its use of argumentation based on sacred texts. Fourth, theological considerations can lead to different judgments on bioethical dilemmas than does a purely nonreligious ethics.

Commenting on the development of bioethics, Daniel Callahan, director of the Hastings Center, observed that "the most striking change over the past two decades or so has been the secularization of bioethics."¹ While the discipline of bioethics emerged in the late 1960s and early 1970s within the context of religious questions and work by theologians, there is a perception that religious influence on bioethics has radically declined.² There is also a perception that theology really has nothing distinctive or useful to contribute to bioethics. Lisa Sowle Cahill, for example, has remarked that "from the perspectives of bioethics literature and medical practice or research, it often appears that theology brings little to bioethics which is even identifiably religious."³ Indeed, Cahill judges that "it may seem that religious faith and theological reflection fail to offer any guidance that could not have been arrived at by any other means."⁴

While these skeptical assessments are being offered, religious communities continue to act as if engaging in bioethical inquiry out of that faith tradition does make a difference. It is not considered enough, for instance, that the ethics committee of the American Fertility Society has issued reports assessing the morality of new reproductive technologies; religious denominations have developed their own position papers as well.⁵ Churches have established their own bioethics centers such as the Park Ridge Center (Lutheran)⁶ and the Pope John Center (Catholic).⁷ And in the scholarly literature,

an article such as William May's "Religious Justifications for Donating Body Parts"⁸ clearly assumes that a purely secular bioethics has not exhausted what there is to say about organ donation.

Current work in the field of bioethics does not, I believe, suffer from the theological deprivation that some have claimed. There is a substantive and distinctive contribution which theology makes to the discipline of bioethics, and there is a genuinely theological literature on bioethics being written.

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One area of major concern to bioethicists is the new reproductive technologies, including such procedures as artificial insemination by donor, in vitro fertilization and surrogate motherhood. One significant aspect of these technologies is that they move reproduction outside the marital relationship by allowing the use of donor sperm and/or ova. In trying to assess the moral legitimacy of these new technologies, ethicists working within a religious framework have made recourse to the Bible. An example is the report on in vitro fertilization (IVF) formulated by the standing committee of the Division of Theological Studies of the Lutheran Council in the United States.⁹

The Lutheran committee "unanimously concluded that IVF does not in and of itself violate the will of God as reflected in the Bible, when the wife's egg and husband's sperm are used." In this

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statement, appeal to the Bible as the criterion for judging IVF is explicit. The qualification "when the wife's egg and husband's sperm are used" is important, for some committee members judged IVF to be morally permissible only when subject to two limitations. And what is noteworthy for our purposes is that these limitations are biblically grounded. First of all, "because the biblical injunction to be fruitful and multiply was given by God to a man and a woman united in the one-flesh union of marriage," (Gen. 1:28; 2:21-25) it was proposed that "only the sperm and egg of a man and a woman united in marriage may be employed." Thus "any use of donor sperm or eggs involves the intrusion of a third party into this one-flesh union and is contrary to the will of God," and "for the same reasons surrogate wombs must not be used." The second restriction is that "all fertilized eggs must be returned to the womb of the woman";¹⁰ "any experimentation with, destruction of, or storage of unneeded or defective fertilized eggs" is precluded.¹¹ And the reason for this second restriction is that "the unborn are persons in God's sight from the time of conception"¹² as demonstrated by such biblical texts as Jeremiah 1:5: "Before I formed you in the womb I knew you, before you were born I set you apart; I appointed you as a prophet to the nations."¹³

Looking to the Bible in evaluating the new reproductive technologies is not without problem. For example, the biblical case in which an infertile Sarah gives her maidservant Hagar to her husband Abraham in order that he might have offspring (Gen. 16:1-16) has been cited as a precedent for surrogate motherhood.¹⁴ One can wonder whether this incident embodies a theological truth or merely reflects the culture of the time. Moreover, ethicists appealing to the Bible have come to contradictory conclusions about the new reproductive technologies. In *Genetics, Ethics and Parenthood*, for example, Karen Lebacqz develops at length a biblical concept of "family" as extending beyond genetic links.¹⁵ This position implies the permissibility of the use of donor sperm and ova¹⁶ in direct contrast to the Lutheran position. Nevertheless, it remains true that appeal to the Bible is a method of argumentation and a criterion of judgment not found in purely philosophical approaches to the problems of bioethics.

Another area of major concern to bioethicists is the withholding and withdrawing of life-sustaining treatments. In the work of ethicist Richard McCormick, distinctively theological considerations have led to the formulation of a normative principle for making such decisions in the case of seriously ill newborns.

McCormick takes as his point of departure a statement by Pope Pius XII on life-sustaining treatments:

But normally [when prolonging life] one is held to use only ordinary means—according to circumstances of persons, places, times and culture—that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most people and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends.¹⁷

McCormick proposes that the question, "What are these spiritual ends, this 'higher, more important good'?" is to be "answered in terms of love of God and neighbor." McCormick explains: "This sums up briefly the meaning, substance and consummation of life from a Judeo-Christian perspective. What is or can easily be missed is that these two loves are not separable. St. John wrote: 'If any man says, "I love God" and hates his brother, he is

An important ethical dilemma is the issue of telling the truth to patients who are terminally ill.

a liar. For he who loves not his brother, whom he sees, how can he love God whom he does not see?" (1 John 4:20-21). This means that our love of neighbor is in some very real sense our love of God." And McCormick adds, "If this is true, it means that, in a Judeo-Christian perspective, the meaning, substance and consummation of life are found in human relationships, and the qualities of justice, respect, concern, compassion and support that surround them."

McCormick then raises the question of how "the attainment of this 'higher, more important [than life] good'" is "rendered 'too difficult' by life-supports that are gravely burdensome."¹⁸ He again responds in terms of relationships: "One who must support his life with disproportionate effort focuses the time, attention, energy and resources of himself and others not precisely on relationships, but on maintaining the condition of relationships. Such concentration easily becomes overconcentration and distorts one's view of and weakens one's pursuit of the very relational goods that define our growth and flourishing. The importance of relationships gets lost in the struggle for survival."¹⁹

These considerations, in turn, "point in the direction of a guideline that may help in decisions about sustaining the lives of grossly deformed and deprived infants," namely, a guideline of "the potential for human relationships associated with the infant's condition." Specifically, "If that potential is simply nonexistent or would be utterly submerged and undeveloped in the mere struggle to survive, that life has achieved its potential," and concomitantly, it is permissible to forego life-sustaining treatments for the infant.²⁰ Using this standard, it would be permissible to forego life-sustaining treatments for an anencephalic infant but not for an infant with Down syndrome because the former lacks "relational potential" while the latter does not.²¹

In sum, McCormick begins with the theological concepts of "spiritual ends" and a "higher good which is more important than life." These concepts are explicated theologically in terms of love of God through love of neighbor. This, in turn, leads McCormick to focus on human relationships and to the formulation of the "relational potential" standard for making treatment decisions about seriously ill newborns. A normative principle for bioethical decision making has been generated by distinctively theological concepts and beliefs.²²

Besides the withholding or withdrawal of life-sustaining treatments, another ethical dilemma in the area of death and dying is the issue of truth-telling to patients who are terminally ill. Consider the following case.

A sixty-year-old woman, with no living relatives or family, undergoes a routine physical examination in preparation for a brief but much anticipated trip to Australia. During the examination, the physician discovers that the woman suffers from a terminal case of cancer. One week after the routine physical exam, the patient asks her physician, who has treated her for years, a series of questions about her health. One of her questions is, "Did you discover anything in the examination that might indicate a serious problem either now or in the future?" The physician believes that his patient will not suffer from the cancer at all while in Australia and answers the question by saying, "The examination shows that you have never been in better physical condition." The physician has good evidence to indicate that no treatment would be effective against the cancer and has consulted with two specialists who corroborate his diagnosis. The physician worries about telling such a lie to his patient but firmly believes that it is a justified lie.²³

On purely philosophical grounds a good case can be made that the physician behaved inappropriately and ought indeed to have been truthful with the pa-

tient about her terminal condition. First of all, it could be argued that conveying truthful information to the patient is part of the contractual relationship between physician and patient. After all, this patient came to the physician for a physical exam precisely to find out about her condition. Moreover, the physician's lie may, in the long run, harm his relationship with this patient of many years, for the patient may lose trust in him when she finds out about her terminal condition. Some have argued against truth-telling to terminally ill patients on the grounds of possible harmful consequences to the patient such as experiencing profound depression or even being driven to suicide. Experience has proven such fears to be largely unfounded. In fact, knowing the truth about her condition may well be of benefit to the patient. The patient may already sense that something is wrong, as indicated by the very question she put to her physician. In such cases, patients are often relieved when their condition is brought out into the open. Knowledge of her terminal condition will also give the patient the opportunity to put her affairs in order and to determine how she wishes to spend the remainder of her life. Perhaps there are activities which, in her view,

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have a higher priority than a trip to Australia and which she would choose if she knew her true condition. And knowledge of her terminal condition will also allow the patient to have greater control over her dying. She can decide, for example, whether she wishes to participate in a hospice program.²⁴

In *The God Who Commands*, Richard Mouw sets out different reasons for truth-telling, reasons drawn specifically from Christian theology:

Take the standard textbook case of the woman who has terminal cancer, but whose doctors think it is not in her best interest that she know the facts about her condition. If the patient is a Christian, then certain factors must be taken into interest to be allowed to struggle with the spiritual significance of a specific affliction. Like St. Paul in his struggles with his "thorn in the flesh," the Christian must ask, "Why has God allowed this to happen to me, and what constitutes a faithful response to this development?" In this case, the woman must be allowed to assess

the role which this experience of disease plays in her overall "career" as a human being. And because of what she believes by virtue of her acceptance of a Christian perspective, she will understand her own career as extending into resurrection. She must go through the struggle of evaluating her own suffering and impending death in the light of Paul's declaration: "I consider that the sufferings of this present time are not worth comparing with the glory that is to be revealed to us" (Rom. 8:18)²⁵

Thus truth-telling to the terminally ill can be justified on purely philosophical grounds, but we can look to theology to provide additional reasons for taking this course of action.

Theological concepts and beliefs can generate normative principles for bioethical decision making.

Besides finding coincidence in the conclusions reached, there are also ethical dilemmas in which theological considerations lead to a different position than that espoused by nonreligious bioethicists. An example is the current debate over active voluntary euthanasia and assisted suicide.

Philosopher James Rachels has long argued that the distinction between "killing" and "letting someone die" is morally insignificant.²⁶ In an article on a physician's responsibility toward hopelessly ill patients, ten of the twelve co-authors judged that "it is not immoral for a physician to assist in the rational suicide of a terminally ill person."²⁷ Although euthanasia and assisted suicide have been opposed on purely philosophical grounds,²⁸ religious commentators have voiced particularly strong reservations and even unqualified opposition to these practices.

Some have attempted to justify euthanasia and assisted suicide on grounds of personal autonomy.²⁹ This contrasts with a religious vision of human life as "a gift of God's love" which we "are called upon to preserve and make fruitful."³⁰ Humans "have stewardship over life but not absolute dominion." We "hold life in trust and have a solemn responsibility to help it achieve its potential for love and service to others."³¹ Thus, according to this religious vision of stewardship, it is not the prerogative of human beings to dispose of their lives at will.

Advocates of active voluntary euthanasia and assisted suicide "frequently express concern that they will be incapacitated by illness and as a result will be unable to control their own environment, ren-

dered dependent on the care and ministrations of others." For these individuals "euthanasia represents an escape from helplessness, an escape from dependency on others."³² Robert Wennberg contends that a Christian will view such dependency in an entirely different way:

I wish to suggest that the possibility of dependency should not be quite so repellent to the Christian, for to accept one's dependency upon the love, the care, and the help of others is part of an ultimate sense of dependency that is meant to characterize the Christian life as a whole. From a Christian perspective, to be dependent upon the care of others is to suffer no indignity if such care is accepted in humility and love as ultimately a gift from God, upon whom we are all at every moment dependent. Dependency itself, then, is not objectionable. . . . My point . . . is that Christians are not to allow a pride that finds dependency itself intolerable to prompt them to embrace suicide as a way of escape.³³

Wennberg also makes the point that Christians must take into account the impact of such action upon the community of faith of which they are a part and upon the larger uncommitted community of which they are likewise members:

For such an act of life termination may be perceived as a shocking rejection of God's rightful sovereignty over life and death, as a repudiation of God as a sufficient source of strength in time of trouble, as a raging against divinely appointed suffering, and finally, as an act of total spiritual despair. This is a relevant moral consideration which, if not to be seen as decisive, is not to be ignored either, because Christians by the manner of both their living and their dying seek to declare Christ's lordship to a world that does not always view matters with perfect spiritual vision or with adequate love and understanding.

Thus Wennberg concludes that "suicide is a questionable vehicle for making a Christian statement about the meaning of life by the manner of one's death, in part because of how that death will be understood and possibly misunderstood by others."³⁴

In sum, what does this survey of the literature indicate about the relation between theology and bioethics? What does theology contribute to the discipline of bioethics? First, theological concepts and beliefs can generate normative principles for bioethical decision making. Theology can likewise provide additional, reinforcing reasons for positions which one may adopt on philosophical grounds. Further, theology brings to bioethics a particular methodology in its use of argumentation based on sacred texts such as the Bible. And finally, theological considerations can lead to different judgments

on bioethical dilemmas than do purely nonreligious ethics. Theology makes a contribution to bioethics that is both substantive and distinctive.

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