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he Park Ridge Center

Bulletin

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Religion in Bioethics

Philip J. Boyle
Editor-in-Chief

'Outing' Religion in Bioethics

Ethics committee members generally don't wear religion on their sleeves. In a field so rigorously secular, they don't dare. Only twice in the past fifteen years have I seen it happen. Once, a member justified a recommendation using a sacred text and was met with silence—as if the speaker had said nothing at all, or had uttered a curse. Either way, the result was the same: no discussion, no comment, no engagement of the religious reasons.

Ignoring religious arguments provides a non-confrontational way to assert that religion has no part in public conversations about ethical issues. Those whose reasoning is informed by religious ideas are reluctant—fearing ridicule or marginalization—to voice their convictions.

Religion informs and influences many people who work within health care; even if it is outwardly ignored it may still be operating covertly. For those who believe that religion has no place in such conversations, it is difficult to ignore the proverbial elephant in the center of the table.

Those with religious convictions must ask themselves: should my beliefs be left at the door of the work place? If not, what difference will expressing them make in health care? How far should believers press their views and how much cooperation and tolerance should they have for opposing views?

This issue of the *Bulletin* seeks to render visible religious reasoning in healthcare discussions. Thirty years ago, religious thinkers led the nascent field of applied medical ethics. But the academic field of bioethics, as well as discussions within healthcare institutions, have become progressively more secularized. Some lament the exclusion of religion from healthcare ethics discussions, pondering why it happened or wondering about the difference religious voices would make. Would patient care improve? Would it facilitate the work of ethics committees? Would healthcare professionals and institutions act differ-

ently if they paid more attention to religious convictions?

Some expect religious voices would widen the outlook by attending to additional values that are often absent from ethics conversations—values such as generosity, altruism, sacrifice, compassion, community, and love. Others expect that religious values will lead to reinterpretations of secular ideals, such as informed consent. Still others hope that religious voices will give a broader—perhaps even utopian—view of what can be hoped for in caring.

If healthcare professionals want to expand their outlook, they will need to commit to ensuring that religious voices count. Not only will they want to consider what the religious perspective can bring, but also pay attention to the process of rendering audible religious voices. To that end you might want to muse on the following questions, to situate your own views on this matter, or to estimate the weight of religious voices in ethics committees or other locations where health, faith, and ethics converge.

Can you identify conversations where explicitly religious reasons have been offered in resolving an ethics dilemma?

How have others welcomed the person and their religious ideas?

Were the ideas taken seriously or simply ignored?

Whether the institution is secular or faith-based, has the ethics committee ever discussed what part, if any, religious reasoning plays in their deliberations?

Has the committee ever compared a moral analysis provided by a traditional bioethics of autonomy, justice and beneficence, to one explicitly derived from a faith perspective?

How would religious considerations give standing to values such as compassion, generosity and the like?

Religious voices in health care will remain "in the closet" until there has been explicit public examination of these and similar questions.



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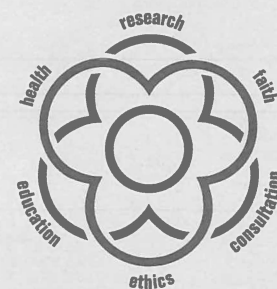
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The Park Ridge Center's sixfoil portrays the unending and many faceted interaction that takes place among three major areas of human endeavor: health, faith, and ethics.

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Finding Common Ground

Religion's Role in the Ethics Committee

By Lisa Sowle Cahill

Although our pluralistic culture tends to assume that there must be a wall between religious and "secular" ethics, with only the latter variety having a proper role in public bioethics, this is not really true. Moreover, a good deal of communication is possible between religiously based and "secular" or philosophical ethics. Specifically religious themes and stories can even play a part in stimulating the moral imagination in groups with no shared religious tradition. Let me address each of these points in turn.

Our political culture maintains a fairly strict separation of church and state, in order to promote individual liberty and tolerance in our common life. Religious dogma, it is feared, might be imposed illegitimately, and lead to the suppression of minorities and of the right of every person to follow his or her own conscience. Therefore, we tend to divide religious morality from the "secular reason" that supposedly sets the standard for public policy and biomedical decisions in pluralistic settings. Ethics committees, of course, exist in such settings. They typically bring together persons from diverse personal, moral, and religious backgrounds, who must analyze some urgent practical problem and arrive at a consensus position. Ethics committee members rarely, if ever, use specifically religious arguments. When they do, such arguments may well be seen as inappropriate.

But we should not assume that hospital ethics committees can and should insulate themselves from the influence of religious beliefs and ideals. The authors of the U.S. Constitution had fresh memories of the wars of religion and of the religious persecutions that had torn

apart Europe in the centuries immediately preceding the founding of a new nation on this continent. However, the founders' very prizing of individual conscience and freedom had roots in Christianity and in the seventeenth-century British social contract theorists, like John Locke, who explicitly linked their views of citizenship and society to religious values. (It should also be noted that neither their religious backgrounds nor their political values prevented our founders from limiting liberty and the pursuit of happiness to Euro-American males.)

The values of autonomy and privacy that are often assumed to be "rationally self-evident" and thus legitimately "public" and "secular"

Specifically religious themes and stories can play a part in stimulating the moral imagination in groups with no shared religious tradition.

are in reality themselves tradition-based values. They are important and relevant to biomedical decision-making. But they are neither neutral and tradition-free, nor the only values that should govern the deliberations of ethics committees. Other important values include human life and health, family relationships, and the common good (including justice in access to healthcare resources).

Religious communities and commitments can help sensitize us to dimensions of ethics beyond autonomy, dimensions which are fundamentally important components of human life and society. For example, religious doctrines of creation, sin, and salvation represent the finite and fallible nature of human beings, and they remind us that we exist in

relation to other beings and to a realm of meaning that transcends merely human projects. Specific churches' practical moral teachings remind us that such values should take concrete form in the ways we conduct our lives and relate to others. Although the exact nature and application of such norms may have to be debated among people coming from different religious and moral traditions, this is not a problem for religiously derived norms only. There is no community-free zone of moral neutrality into which ethics committee members, for instance, can enter to resolve differences. That can only be done through a process of persuasion and compromise, where all participants respect-

fully listen to one another's moral insights and gradually enlarge the sphere of what is shared in common. Religious beliefs, moral formation, and personal experiences will influence the perspective one brings to this process.

Many of the moral insights of religious traditions, like those of other kinds of communities, can be expressed in language that speaks across the boundaries of cultural and moral differences, evoking engagement and response. For instance, "image of God" can be expressed as basic respect for others, "love of neighbor" as an ethos of compassionate service to the sick and suffering, and "the preferential option

— continued on page 14



Religious Values Reconsidered

By Gilbert C. Meilaender

Many of the early figures in the bioethics movement were scholars in the field of religion, and in the several intervening decades bioethics has largely fallen into the hands of scholars trained in other disciplines. [Scientist] Robert Morison once wrote that as late as 1981 the developing field of bioethics was still more dominated by theologians than by secular philosophers. I doubt if such dominance still existed even then; certainly it does no longer. Indeed, [Hastings Center founder] Daniel Callahan has suggested that bioethics gained public acceptance by pushing religion aside (even if unintentionally). In its place he detects movement toward "a different kind of moral language in the mainstream of public policy, toward a language of rights" that seeks "moral

consensus . . . in the face of a diverse cultural situation." Bioethics may need to return to its earlier self, expanding its horizons and no longer understanding its function chiefly in terms of social consensus.

This will mean, in part, inviting back those "alternative imaginations" that religious communities and theological traditions provide. The same principles that Beauchamp and Childress [in their book, *Principles of Biomedical Ethics*] put forward may still often shape our discussion, but they will take on new resonance. The selves whose autonomy we respect will be understood as grounded in community and in relation to God. The imperatives of beneficence may sometimes seem too minimal. Our sense of justice will be constantly reshaped by concern

for those who are weak and cannot speak in their own behalf. Of course, such approaches may sometimes ask more of our fellow citizens than is possible, or more than we ourselves can always be persuaded to undertake, but at least we will not have begun our reflection with the intent of seeking no more than public policy currently envisions. If compromise and adjustment are necessary in our common life, that can and should be left to the processes of democratic governance—a politics that, because it does not claim our souls, paradoxically can allow matters of the soul into public argument.



From Body, Soul, and Bioethics by Gilbert C. Meilaender. ©1995 by the University of Notre Dame Press. Used by permission of the publisher.

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A Tale of Two Creatures

Jewish and Christian Attitudes Toward Cloning

by DENA S. DAVIS

Religious responses to the prospect of human cloning have ranged from the thoughtful to the predictable to the hysterical. Cloning is a very new issue, and it will be a while before the various traditions have made much headway in grappling with it.

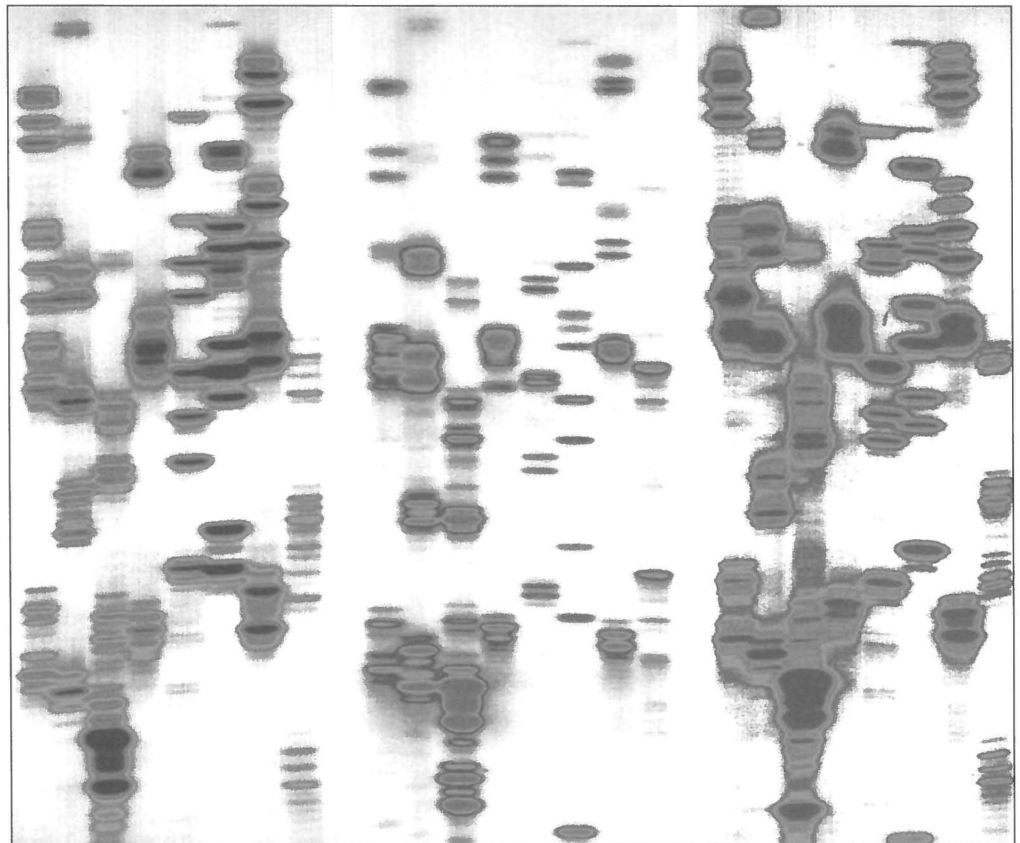
Traditions that have come up with something that looks like a definitive response include those, like Roman Catholicism, that already have a theological construct—in this case, “the right of every human person to be conceived and born within marriage and from marriage”—into which cloning fits reasonably well, and thus it joins the list of illicit reproductive technologies, such as gamete donation. On the other hand, other religious leaders, such as the Southern Baptists, do not blanch from making statements devoid of argumentation, i.e., the statement *Against Human Cloning*, which simply says that Baptists are known for “their strong affirmation of the sanctity and uniqueness of human life,” and therefore request that cloning be made illegal. Not surprisingly, the definitive statements are negative, while more positive approaches tend to be tentative and open-ended.

In any case, I would like to offer an analytic structure with

which to approach the study of religious responses to cloning. Negative reactions, generally, are tied to the story of Dr. Frankenstein—a tale which expresses our fears about humans getting into

the creation business. More positive reactions are linked to what I will call the golem approach, based on the lesser-known Jewish legend.

Given that most people are familiar



“Jin, Calvin, and Lisa” by Chicago artist Iñigo Manglano-Ovalle, is from *The Garden of Delights*, a series of large color photographic portraits of DNA. Commissioned in 1998 by the Southeastern Center for Contemporary Art, *The Garden of Delights* uses recent developments in the genetic sciences to explore the representation and portrayal of individual identity.

with the story of Dr. Frankenstein and his Monster, there is no need to summarize it here. But I will recount quickly the legend of the golem of Prague.

The Golem of Prague

Although the idea of a golem has long existed in Jewish legend, it crystallized with the stories created by Rabbi Judah Loeb in 16th century Prague. Prague in those days was a mystical and magical place, full of creative people ranging from the great astronomers Tycho Brahe and Johannes Kepler to a crowd of alchemists who claimed they could turn lead into gold. Presiding over all this was the Emperor Rudolph, often thought to be mad, certainly

The Frankenstein myth exhibits an attitude of fear toward technology and science, while the golem legend expresses a much more positive attitude.

erratic in his on-again, off-again protection of his Jewish subjects. Rabbi Loeb, whose grave you can see today if you go to the Jewish cemetery in Prague, was the most important rabbi, and indeed the most important Jew, in the ghetto. He was a renowned miracle worker and magician. There are many, many stories about how Rabbi Loeb saved his people, and he came to be known as Judah the Lion.

Once when he was High Rabbi of Prague, the people felt more threatened than usual by hostile Christians. The elders of the community went to him for help. Rabbi Loeb prayed long into the night and then fell asleep, during which he dreamed that he received a command from heaven to create a golem, a man made of clay, to protect his people. Over the course of a week, the Rabbi, his son-in-law, and a pupil prayed, fasted, and went to the mikvah [ritual bath]. Finally, in the dead of night, they molded a creature from wet clay, and put in his mouth a paper on which they had written the name of God. The three men bowed to all the cardinal points, while pronouncing the following: "Lord made a man from the clay of the Earth and breathed the

breath of life into his mouth." When next they looked, they were no longer three but four. The Golem had come to life.

The Rabbi named the golem Joseph, dressed him in some old clothes, and took him to his house where he lived as a servant. The Rabbi made sure that, just as ritual objects cannot be used for mundane purposes, Joseph would not be used for domestic tasks like bringing in wood. He was only to be used for the purpose of protecting the Jewish people. He did a very good job at this, particularly around the time of Passover, when some Christians persisted in trying to revive the "blood libel"—the slander that Jews murdered innocent Christians in order to make matzoh.

The reason for the golem's destruction varies with different accounts. In one legend, relationships between Christians and Jews in Prague improved so much that he was no longer needed. In another, the golem frightened the people by running amok in the ghetto until he was stopped by Rabbi Loeb. In any case, Loeb and his two assistants killed the golem by removing the name of God from his mouth, and by doing backwards all the rituals they had initially performed in his creation. Supposedly, the golem's clay remains still exist in the attic of the Altneschul (Old-New Synagogue) in Prague, and various stories recount the misadventures of lesser men than Rabbi Loeb who sought to revivify the golem for their own venal purposes.

Discussion

There is, of course, much in both the Frankenstein and golem stories that does not pertain to cloning. It is clear in all the accounts that the golem, which lacks intellect in some stories and the power of speech in others, is not considered a full human being. (Otherwise, of course, Rabbi Loeb would have been guilty of murder when he killed him!) Obviously, this is not a path we want to walk down today, as all religious commentators have affirmed that the child born of cloning, or of any other assisted reproductive technique for that matter, is fully human. James Childress, one scholar of religious ethics, affirms a "strong consensus, perhaps even unanimity, among

Jewish and Christian thinkers, that a child created through somatic cell nuclear transfer cloning would still be created in the image of God." Nothing I have seen from other religious traditions suggests that there is disagreement on this point.

I want to mine these two stories for attitudes toward technology and toward human uses of power. If we compare these two legends, we see that the Frankenstein myth exhibits an attitude of fear toward this transgressive act of creation—and by extension to technology and science in general—while the golem legend expresses a much more positive attitude. This calls to mind Kabbalist scholar Moshe Idel's hypothesis that "modern man, alienated as he is from the divine, is afraid of the inherent theological implications of his creative powers; the medieval masters, probably because of their sense of closeness to God, were able to strive toward . . . aims that are beyond the modern frame of mind."

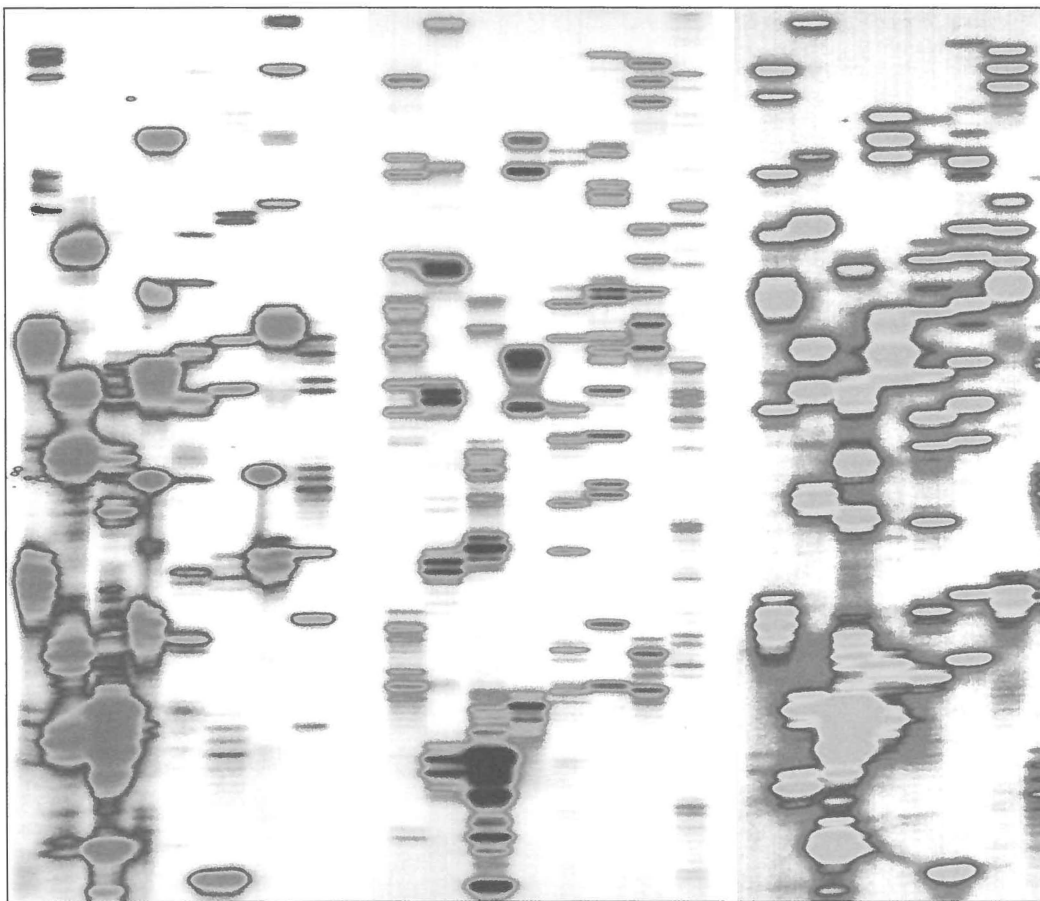
The Actors

The actors in the two legends are as different as night from day. In Mary Shelley's book, Dr. Frankenstein is a callow youth, intellectually precocious but emotionally and socially retarded. His reasons for creating his creature are purely those of pride and power—he wishes to push the boundaries of science merely to show that he can do it. He gives no thought whatever to the consequences of his actions.

By contrast, Rabbi Loeb is a mature man when he creates his golem. This act of creation is simply one more step in a life of protecting his people from injustice and destruction. Although the Rabbi, too, seems a bit of a show-off, he subordinates his magical powers to the single goal of protecting his people.

Moral Themes

The moral themes expressed in these two legends are also completely different. Young Dr. Frankenstein recognizes no limits to human endeavors, no sense of encroachment on sacred turf; perhaps more accurately, he sees limits only as challenges to be surmounted. When he succeeds in creating the monster, he is terrified by its weird and misshapen aspect. He runs from it, never expressing any concern



“Jane, Lori, and Naomi” by Iñigo Manglano-Ovalle

Reprinted courtesy of the artist.

about where it might be or what it might be up to, either in terms of its own needs for food and shelter, or in terms of its danger to other people.

The golem is created within a context of limits, surrounded by sacred rituals that acknowledge God as creator, and in response to the mandate from God that Loeb receives in his dream. Loeb both acknowledges the fearsome, liminal nature of the act of creation and comfortably fits it into the strong moral structure of his daily life.

With regard to cloning, a number of religious thinkers, primarily from outside the Western traditions, have echoed the themes of limits and responsibility. An editorial on cloning in *Hinduism Today* argues that “Hinduism neither condones nor condemns the march of science. . . the simple rule is this: Cause no injury to others and let dharma—the law of good conduct and harmony with the universe and its many forces and creatures—be the guide for all such explorations.” Buddhist writer Damien Keown can see no purpose for cloning, except to use

the cloned individuals in ways in which we would not normally use human beings, and thus he concludes that Buddhism ought to oppose it. Ronald Nakasone, however, has a different perspective:

Since, for the Buddhist, change is the nature of reality, the questions are how to accommodate change and expand our moral imaginations. Change pushes the boundaries of what we once considered to be the norm. . . the cloning of human beings. . . is really about expanding our notion of humanity and our moral parameters.

The Meaning of Co-Creation

Although Mary Shelley’s novel is not overtly religious, the key theme is Dr. Frankenstein’s transgression of boundaries and “playing God.” Mary Shelley herself, in her introduction, describes her protagonist as a “pale student of unhallowed arts,” and describes his actions as “mock[ing] the stupen-

dous mechanism of the Creator of the world.”

When Rabbi Loeb calls the golem into being—out of clay, as God created Adam—he is participating in an act of co-creation that is not only permitted but required by Judaism. As Jewish ethicist Elliot Dorff points out, people are “God’s ‘partners in the ongoing act of creation’ when we improve our lot in life.” At every step of the story, Loeb is acting in partnership with God.

From this concept of humans as co-creators with God comes Judaism’s extraordinary commitment to medicine, as well as the lack of respect for the “natural” as a moral category. Thus, it is no surprise to find that Jewish ethicists have been cautiously positive about the potential of cloning of humans both for medical purposes and as a way of overcoming infertility. As Rabbi Barry Freundel said,

“Judaism affirms an optimism in the face of scientific uncertainty about unanticipated consequences that is

Dr. Frankenstein recognizes no limits to human endeavors, no sense of encroachment on sacred turf; perhaps more accurately, he sees limits only as challenges to be surmounted.

rooted in divine control and care.” Part of this optimism is expressed in one of the Golem stories, where Joseph runs amok and begins to destroy the ghetto. By pulling the name of God out of the golem’s mouth, the Rabbi is able to render him harmless. The human, with God as partner, is in control even when the consequences are unforeseen and unintended.

A similar optimism is expressed in the *Hinduism Today* editorial I mentioned before:

For many religionists, it is frightening to have humans tinkering with God's universe. There's no manual, they fret. What if we break something permanently? The Creator made it with loving intent and divine intelligence, they offer, and it is arrogant, foolhardy and downright sinful for humankind to play God with something as profoundly consequential at the human genetic instruction.

It is possible to understand such a prudent warning and still disagree. While the argument makes sense with a Biblical God, Hinduism does not sepa-

Jewish ethicists have been cautiously positive about the potential of cloning of humans both for medical purposes and as a way of overcoming infertility.

rate man and woman from God so completely. Humanity is God; and God is humanity. Indian yogis and mystics speak of the cocreative process of evolution. Humans are not merely following a distant diety's decrees in fulfillment of the Divine Plan; they are engaged, alongside the Architect, in engineering that Plan; or you could say God is working His will through humankind, including scientists.

Conclusion

It is still too early to say anything definitive about religious responses to cloning. And it is probably not a good idea, however tempting, to try and draw any conclusions from such early work as the 1998 cloning report to the National Bioethics Advisory Commission, solicited by President Clinton. It's interesting, for example, that all the Christian views in that

report are dramatically negative—but I don't know why the more liberal denominations are not represented there. I also think it's interesting that a predominant theme in the conservative Christian responses is the one set forth by Stanley Harakas:

Cloning would deliberately deny by design the cloned human being a set of loving and caring parents. The cloned human being would not be the product of love, but of scientific procedures. Rather than being considered persons, the likelihood is that these cloned human beings would be considered "objects" to be used. Given the fallen and sinful condition of our personal and social lives, it is easy to project selfish, greedy, and heartless uses of "manufactured" human clones.

Harakas' view has much in common with Mary Shelley's. His reaction reminds me of Shelley's goal in her book, to "speak to the mysterious fears of our nature and awaken thrilling horror." In contrast, all the Jewish commentators I have been able to find are insistent that, to save a life, it is permissible to clone a child in order to, for example, donate bone marrow to an older sibling. They appear to share Rabbi Dr. Moshe Tendler's conviction that a child created for this purpose "would then be doubly loved."

As we continue to observe—and perhaps take part in—the religious debates over the cloning of animals and humans, I submit that keeping the stories of Frankenstein and the golem in the back of our minds will help us understand.



This work appears with the permission of the Hofstra Law Review Association and is substantially derived from "Religious Attitudes Toward Cloning: A Tale of Two Creatures" which will appear as part of a Symposium on Human Cloning to be published in Volume 27, Issue 3 of the Hofstra Law Review.



THE PARK RIDGE CENTER 1999 INTENSIVE COURSES

The Park Ridge Center will hold a series of intensive courses on a variety of topics in the bioethics field:

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Organizational Ethics: Mini-Intensive —
April 14-16

Spiritual Issues in Health Care —
May 6 or October 28

**Care at Home and in the Community:
Ethical Insights and Practices —**
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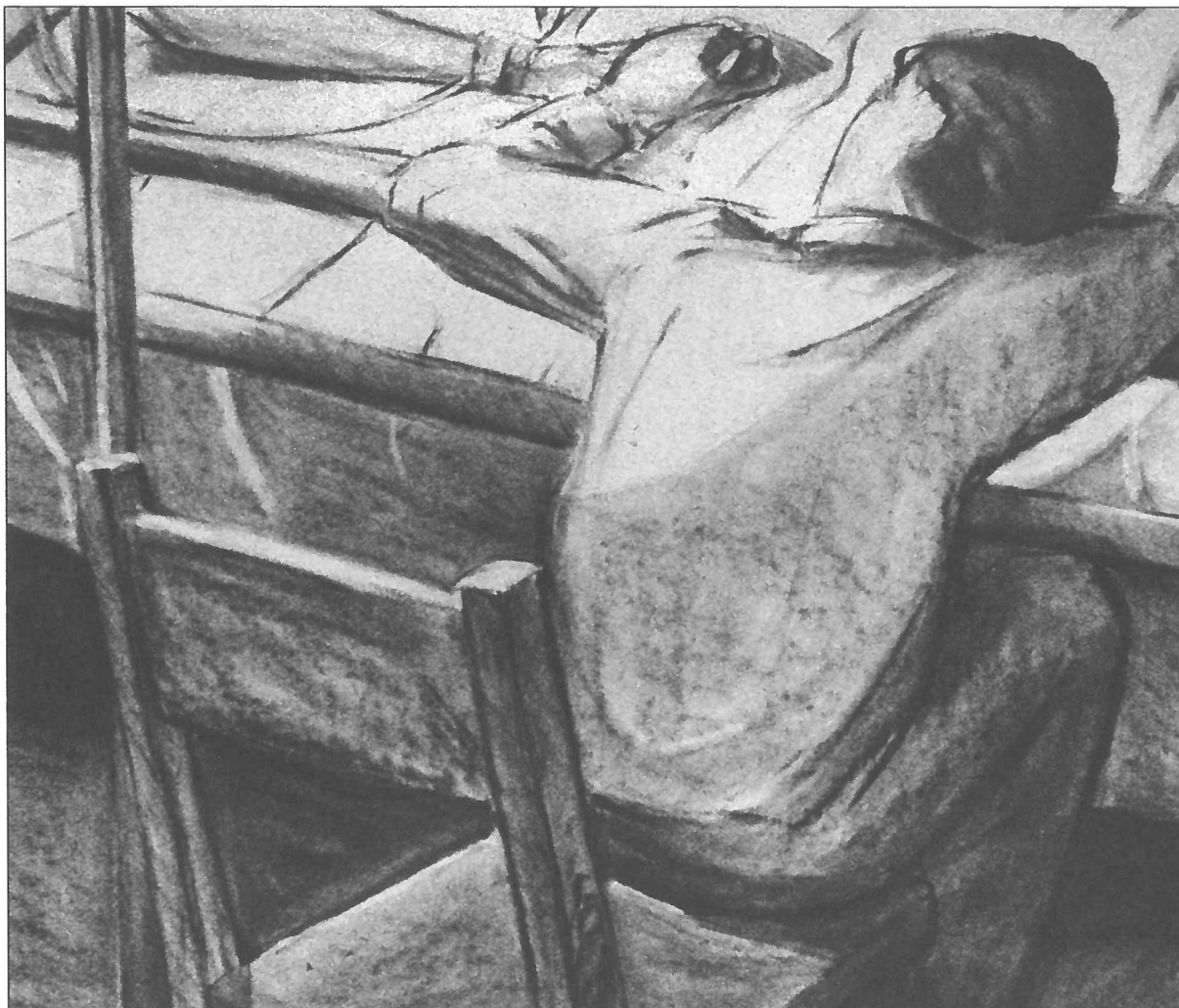
**Organizational Ethics in Faith-Based
Institutions —** August 18-20

**Spiritual Wisdom for Parish Nurses:
Stories and Strategies —** September 18

Organizational Ethics Intensive —
October 18-22

**Ethics and Alzheimer's Disease:
Attending the Person and the Spirit —**
November 4-5

For more information, contact Bernice Chantos at 312-266-2222, extension 255, or via Fax, 312-266-6086.



Reprinted courtesy of the artist.

“Visitor II”, from the series Bearing Witness, by Boston artist Michael David.

To Tell or Not to Tell

Must the Doctors Inform Her She’ll Be Infertile?

By John Lantos

The patient was a seventeen-year-old girl from an Orthodox Jewish community on the East Coast. Three weeks prior to admission, she had gone to her rabbi’s wife to discuss Jewish laws regarding marriage in preparation for her upcoming wedding. As was the custom in her community, the wedding had been arranged. She had met her fiancé only once.

In the course of the marital counseling, it was discovered that she had dysfunctional uterine bleeding. This led to a medical evaluation, the eventual discovery of uterine cancer, and

referral to our hospital, one of the top centers in the world for treatment of this cancer. The recommended treatment was radiation followed by a hysterectomy, which would of course leave her infertile.

When her father heard the medical recommendations, he requested of the doctors that they not tell his daughter that the treatment would leave her infertile. He thought that the news would be emotionally devastating—both in itself and because he feared that it might lead to the cancellation of her marriage. Because she would be infertile, her fiancé would

no longer be obligated to marry her. The call for the ethics consult asked, “Do we have to tell her that she will be infertile?”

Well, in one sense, it was easy. Informed consent, respect for persons, truth telling. From a risk-management point of view, it was a no-brainer. You tell her; if she refused treatment, that’s her choice. It may be tragic, but it isn’t a tort. Treat without consent and she sues later; it is at least malpractice and maybe assault and battery. From a bioethics perspective, these legal considerations reflected appropriate moral concerns.

Whenever ethics and risk management agree, a red flag should go up.

Not to tell would be paternalistic, and in bioethics there is no greater sin than paternalism, although that might be hard to explain to her father.

But from another perspective, it seemed a little more complex. Were we really concerned about the patient's interest or about the hospital's? Whenever ethics and risk man-

agement agree, a red flag should go up. Furthermore, the legal and moral principles that we were relying on were neither timeless nor universal. If she had not been in the United States, or if it had been twenty-five years earlier, nobody would have told her. She was a minor. Her parents had the right to make decisions for her. In addition, her religion did not

acknowledge the importance of autonomy. As her father said, "She must have the treatment. It is required by law. Why add to her suffering now, when she needs hope and strength?" Clearly, he had her best interests at heart.

The ethics committee meeting was a little acrimonious and inconclusive. Arguments flew about beneficence and autonomy, patriarchal religions and sexism, culture, families and parents. The conversation was intense.

We gave the gynecology service lots of good arguments on both sides but no consensus. They decided that she had to be told.

A family meeting was convened. The doctor didn't pull any punches. He wanted to tell her the honest truth, to make certain she understood, not to give any false hopes. He succeeded. After an hour of such talk, the conversation ebbed to silence. A pall hung over the room. Finally, the girl muttered something and walked out of the room. Her mother ran after her. Her father slumped down in his chair. "What'd she say?" we asked. "She said she doesn't want the treatment." He looked at us as if we were monsters.

Did we do the right thing? We followed all the rules. Our actions were based on adherence to the most idealistic moral principles. In a certain sense, what we did was unsalvageable. In the most difficult and trying circumstances, we had confronted ugly truths instead of hiding from them. We had helped a patient, who clearly had the capacity to make her own decisions, to understand the choices before her, and to make a choice based on her own deeply felt moral values. This was a triumph for patient autonomy, for feminism, for children's rights, a culmination of twenty-five years of work in health law, civil liberties, and bioethics. But it felt as if we had betrayed everything that medicine stands for and had become zealots in a cause that looked less like moral excellence and more like political dogma.

Unlike many stories, this one had a happy ending. The girl returned a few days after the family conference

Back from the Borderlands

By Renée C. Fox

U.S. bioethics emerged in the late 1960s and early 1970s, during a period of tumult in religious communities and the society at large, when secularism "crested as a social movement" on the American scene—a movement in which some theologians figured prominently. In addition, the academic milieu in which the majority of U.S. participants in bioethics—whether philosophers, theologians, physicians, or lawyers—received their professional training, and in which many now work, are "resolutely secular" institutions that "nurture and reward secular habits of thought." Partly as a consequence of these patterns, "most religious ethicists entering the public practice of ethics," writes physician-philosopher Leon Kass, "leave their special insights at the door and talk about 'deontological vs. consequentialist,' 'autonomy vs. paternalism,' 'justice vs. utility,' just like everybody else." In common with other professionals engaged in bioethics, they define their religious beliefs as private matters . . . and remain largely silent about them.

Thus reflection on basic and transcendent aspects of the human condition and on enduring questions of meaning that are integral to health, illness, and medicine have been relegated to the borderlands of bioethical concerns . . .

What philosopher Simone Weil has called these "ponderable imponderables" are described by moral theologian Courtney S. Campbell as "problems [that] cannot be solved but must still be faced." For the most part, however, U.S. bioethicists have not faced these problems. They have left them out of the bioethics repertoire or, as theologian Stanley Hauerwas would contend, they have deliberately and steadfastly excluded them.

The secular rationality of U.S. bioethics in combination with its autonomous individualism has contributed to the narrowing of its outlook in still another way. It downplays communal values and qualities of the heart, like caring, kindness, devotion, compassion, generosity, service, altruism, sacrifice, and love. These values involve recognizing and responding to close and distant others in a self-transcending way—to "neighbors" and "strangers," members of future generations in distant lands, as well as "sisters" and "brothers" who inhabit this time and this familiar place.



Excerpted from A Matter of Principles? Ferment in U.S. Bioethics, edited by Edwin R. DuBose, Ron Hamel, and Laurence J. O'Connell.

saying she'd changed her mind and wanted treatment. She signed the consent form without reading it. What had changed? Over the weekend, she'd spoken to her rabbi. Without any disrespect for the doctors, he said, "If God wants you to have children, you'll have children. Not to believe that would be worse than death. It would be idolatry."

Her fiancé did not forsake her. In fact, as we were later to learn, he spent two hours each day praying for her, reciting the entire Book of Psalms every morning. Six months later, her cancer in remission, they were married. They planned to adopt children.

A happy ending! So what's the problem? As Abraham Lincoln noted in describing the start of the Civil War, everybody struggled to do what was right as they saw the right. The rabbi interpreted Torah and Talmud to come to a truth that differed somewhat from the truth of the doctors. Could the doctors have offered hope in the same way the rabbi did? Perhaps. But they felt morally bound to convey the truths of science, not religion. The parents stood with a foot in each truth community, clearly trusting the doctors with their daughter's life but not trusting the doctor's moral vision. The young woman chose life over death and obedience to her parents and teachers over an individualistic tragedy that her doctors and lawyers would have allowed.

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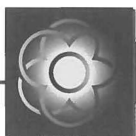
From the series "Eight Embraces" by Michael David.

What about her fiancé? He, it seems to me, went beyond what was required or expected. How many teenage boys would remain steadfastly loyal to a girl they had only met once, and marry someone whom they new would never be able to have a baby, might even have trouble having sex, and might die? Caught up in a situation beyond his experience or imagination, he made a choice that embodied the highest moral ideals and that determined the ultimate outcome of the story. The happy ending was not a triumph for individualism, autonomy, patient's rights, or truth telling. It was a

triumph for steadfastness, loyalty, interdependence, and faith. It was less about people following the rules and more about people living in a world in which situations constantly force them to go beyond the rules. The ethics committee, it seemed to me, was doing something that had far less to do with ethics than what that young man was doing. And what he did, rather than what they did, was what really mattered.



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Integrity and Integration

Complementary and Alternative Medicine in Conventional Healthcare

As conventional medical providers become more aware of the popularity of complementary and alternative medicine, they are more open to integrating such practices into the services they offer.

Many practitioners of alternative and complementary medicine respond positively to this interest. An integrated practice of complementary and alternative and conventional medicine promises to increase the availability of their techniques, expand their client bases, and, if covered by insurance, benefit patients who now must pay for treatments out of pocket.

Optimists view integration as offering patients the best of both worlds. But is this true? Does this movement offer the best of both worlds, or does it represent an exploitation of one by the other? Do patients benefit from integrated delivery, or are the values and treatment modalities in conventional and alternative medicine so radically different that they cannot be integrated without compromise? What are the practical problems of integration, and how can they be overcome?

To answer these questions, Park Ridge Center will convene a day-long workshop on May 14. Center staff

members and experts within the fields of both conventional and complementary and alternative medicine will explore the practical and ethical dimensions of the movement toward integration. The workshop will be divided into three thematic working sessions:

Session One: The Integrated Practice

The first session will explore the general terrain of integrated practice. Participants will examine the parameters of different types of integrated practice and consider some of the difficulties posed by such linking. These include accreditation of non-traditional practitioners, determining the mix of services to be offered, communication and referrals between practitioners of different treatment modalities, and risk management and quality assurance issues.

Session Two: Risks and Rewards for Complementary and Alternative Medicine

In session two, participants will consider the risks and rewards of integration for complementary and alternative medicine, including potential threats to complementary and alternative modes of treatment when they are

integrated into conventional medical practices. One reward of integration might be a greater credibility for alternative therapies within the health care arena; a threat is the possibility that insurance and conventional medical management practices fundamentally will alter complementary and alternative medicine's traditional approach to patient care.

Session Three: Risks and Rewards for Conventional Medicine

Finally, session three will explore the risks and rewards integration offers to conventional medicine, including the possibility that incorporating alternative treatment modalities represents a diminution in the scientific practice of medicine. On the other hand, integration may provide an opportunity to develop new methods for efficacy assessment. The model of patient-centered care common to much of complementary and alternative medicine may affect conventional medicine, offering opportunities for a conventional practitioner to incorporate his or her own spiritual traditions into the practice of medicine.



A report of the day's proceedings will be published this summer.

Exploring the Jewish Perspective

The Park Ridge Center recently received a planning grant from the Michael Reese Charitable Trust to create a program on Judaism and Healthcare Ethics. During the year-long planning phase, the Center will convene an advisory group of Jewish scholars, rabbis, community representatives, and healthcare practitioners. The committee, chaired by Rabbi Peter Knobel of Beth Emet The Free Synagogue in

Evanston, IL, will guide this important development phase.

Judaism, with its richly developed history of moral reflection, has much to offer the discussions brought by changes in medicine that raise fundamental questions about human personhood, privacy, discrimination, and justice; reproduction and world population; aging; xenotransplantation; dying and death; and biotechnology.

Sporadically, a specifically Jewish concern has been voiced, for example, around BRCA 1 [breast cancer] testing. What Judaism has to say about specific, already identifiable ethical problems has received little public visibility. Yet, Judaism's ethos and commitment to justice is an available but relatively untapped resource for identifying ethical

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Avoiding Tragedy

Unearthing Ethical Problems in the Child Welfare System

What does foster care have to do with health, faith, and ethics?

A year ago the Center received an unusual request. The Inspector General of the Department of Child and Family Services (DCFS) of the State of Illinois called, saying she needed help resolving conflicts that too often ended up in the headlines: beatings, massive injuries, and even death of children in the foster care system. She was convinced that such tragic cases were, at heart, unresolved ethical dilemmas, and she wondered whether better handling of moral issues would improve the lot of vulnerable children and head off tragedy. Thus began a state-wide collaboration between the Center and DCFS.

Illinois' foster care system has experienced a dramatic increase in the number of children it handles and a shift toward using private agencies to place and monitor children. The immediate consequences of these changes have included reduced oversight, heavy caseloads, inadequately trained staff, and poor communication. Child welfare professionals are increasingly inexperienced, overworked, isolated, and must manage caseloads more than three times larger than a decade ago. Private agencies, themselves often new to child welfare work, cannot effectively support their staff because they too are without the training and knowledge to recognize and address problems as they arise. Social problems such as drugs, inadequate housing, and hard-to-obtain medical care, fuel the difficulties and uncertainties in the system.

To address these problems, the Center and DCFS have launched an interdisciplinary pilot project to map out the ethical problems that beset the foster care system. Unlike the health care industry, child welfare agencies have not had the opportunity, process, or tools to address ethical issues. Child welfare professionals are

not trained to recognize moral problems; indeed, they frequently feel buffeted by overpowering external forces such as highly regulated bureaucracy and the courts.

In addition to process issues, the project group identified substantive ethical problems that afflict welfare children. One constellation of problems concerns placement of foster children. State laws require "reasonable efforts" to reunite a family, but when is enough enough, especially when troubled parents are involved? The federal Interracial Placement Act only confounds issues. To promote quicker placement of minority children, the act mandates—with steep fines for noncompliance—that race not be considered in the placement of children. Yet the foster care system has spent years trying to promote cultural competencies for its workers, believing that race matters for children's well-being.

Other ethical problems include conflicts surrounding reporting

requirements and confidentiality. But where in this research are the health and faith aspects that are central to the Park Ridge Center's mission? Many of the private agencies that provide child welfare services are faith-based, such as Catholic Charities and Lutheran Social Services. Sometimes an agency's policies are consistent with church doctrine but at odds with the goals of the professionals who must carry them out. In addition, agencies must decide how far they should go in accommodating religious diversity that is not their own.

After a year of research on the documented experiences of children, reports in the literature, and interviews, the Center will produce an ethics training program and create a statewide network for child welfare professionals. Such advance preparation, targeted toward developing models for critical thinking about ethical concerns, can dramatically improve the quality of life for children in need.



JEWISH PERSPECTIVE

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issues in healthcare and for working toward their resolution. Judaic law, wisdom literature, and other written and oral sources can offer abundant guidance about general and specific questions both to Jews and non-Jews.

The project is timely for another reason. Jewish community hospitals were once common in cities with a substantial Jewish population. These hospitals, originally a necessity because of discrimination at other hospitals, practiced Judaism's ethical, social, and spiritual values in a relatively homogenous environment. As ethical and spiritual prob-

lems arose, the medical staff, the community's religious and lay leaders, and others could discuss them in a setting born of a common commitment, history, and ethos (if not agreement about specifics). Today, rapid shifts in the organization of medicine have disrupted traditional sources of connectedness for considered and ongoing discussion of ethical issues from a Jewish perspective.

The program will provide opportunities for such discussion through seminars, conferences, and publications. Its long range goal is to establish a resource center where questions and concerns on the relationship of Judaism and health care can receive full attention.



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for the poor” as social justice that moves first to include the most marginal members of society. All of these also limit the role of market incentives in medicine and encourage

consider themselves thoroughly secularized. The effective storyteller is always modest and often humorous in recounting the tale, but inevitably receives a sympathetic hearing even from the confirmed atheist. Religious traditions capture the collective wis-

All moral discourse comes out of historical communities of identity. Members of these communities can together learn what fulfills moral obligations, respects human dignity, and serves the common good.

caregivers to place “autonomy” in the context of a network of support and genuine care.

In this task, even specifically religious language and stories can sometimes stimulate listeners to look at situations and options in a new way, in which values like the above will seem more real and compelling. I have heard stories about figures in the Hebrew Bible and parables from the Christian New Testament told in an evocative way by bioethics committee members to colleagues of varied faiths, or who

dom of the past and invite an affective, emotional, and very human type of moral discernment to which no abstract theory could do justice. Not everything that goes into the moral dimension of a religious commitment can be translated into a neutral common vocabulary. One reason for this is that no such thing exists. Another is that religion involves a whole way of life of which moral behavior is but a part. But every moral viewpoint is tied at some level to experience and to practices of a moral community. It is

best to understand the task of ethics committees as the achievement of agreement and judgment that includes joint perspectives in reaching common ground, without abandoning the roots or particular identities of any discussion partners.

Religious faith and its moral perspective cannot be checked at the door of the ethics committee’s meeting room. Nor need they be for fully reasonable, inclusive dialogue to take place. All moral discourse comes out of historical communities of identity. Members of these communities can together learn what fulfills moral obligations, respects human dignity, and serves the common good. Moral sensitivities indebted to religious faith can attune us to special aspects of moral situations and help us discern where true virtue lies, even in “human” terms. And specifically religious stories and sayings can stimulate the imagination, reorganize our priorities, and motivate us to act in ways that complement the principled analyses of moral philosophy.



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Faith's Place at the Table

Why Religion Deserves to be Integrated into Bioethics

By Martin E. Marty

"We're living in a schizophrenic way." That admission came from Jeffrey Kahn, who directs the University of Minnesota Center for Bioethics, during a "Socratic dialogue" on the role of religion in medical ethics. The program organizers had me pretending I was television producer and host Fred Friendly, strolling with a microphone and jabbing provocative questions at a panel of 10 experts.

Dr. Kahn, sitting at one end of the panel, spoke with personal conviction, pointing out that the Minnesota Center focused "not so much on religion as ethics," which is what it is chartered to do. No one at the center was trained in theology. Moreover, "the center had to be very careful about discussing religion—in part because religion has proved to be so divisive in the discussion of another medical issue, abortion."

At the other end of the table sat Tim McGuire, editor of the Minneapolis *Star Tribune*. His newspaper, he said, treats medical controversies such as cloning "as a scientific story with moral dimensions and concentrated on its moral rather than religious dimensions." But the paper also has a lively "Faith & Values" section, whose writers treat those religious dimensions. McGuire spoke to the need to include religious elements, arguing that omitting them and isolating the moral dimensions leaves the story "a little antiseptic." McGuire saw "the drawbacks to religion remaining in the background." But, like Kahn, he noted that the press tries to treat moral issues without taking sides: "you don't deal with it from the Catholic perspective, or the Jewish perspective, or the perspective of any other religion."

Kahn said that focusing on the

moral dimensions "makes you listen to the arguments and take sides based on how the issue is presented, rather than taking a view because it is endorsed by a specific faith." Yet, he confessed, excluding religion and religious perspectives creates a false dichotomy. That's when he summed up the state of bioethics with his observation that "We're living in a schizophrenic way."

How, then, do those of us who try to treat and overcome the schizophrenia proceed? How do we argue for religion's place at the bioethics table? To use a religious term, we begin in repentance, acknowledging the sad fact that one fundamental understanding of religion's role is not to inform or provide perspective but to divide people, to heat up their arguments, to have them defend institutions and creeds instead of pursue truth.

The religious voice, on cloning or any other issue, is grounded in many resources in addition to reason: intuition, memory, tradition, community, experience, hope, and affection.

Now, I hang out a good deal with religious bioethicists and theologians, and I have to say that the picture from Minneapolis, while a widespread one, is not fully accurate. Most theological ethicists—indeed, most religious people—are not barricaded behind dogmas, even though they do draw upon and are responsible to traditions and communities. Still, behind the stereotypes of the religious dogmatist, there are some realities to be faced.

Second, one addresses this issue by working to produce a level playing field between the secular and the religious; not only believers are sectarian and divisive. Have you

ever heard arguments about anything worthwhile between Platonists and Aristotelians, idealists and pragmatists, situationists and absolutists? The press regularly has to cover conventions of anthropologists, sociologists, psychologists, and philosophical ethicists as if they were in battle zones between denominations, back when denominations actually fought each other. (Today, the consuming conflicts are *within* Catholicism, Islam, Presbyterianism, not among them.) Avoiding religion is not a way of avoiding divisive and often destructive conflict. And just as philosophy has healing and reconciling resources, so does religion.

That leaves, third, the most serious reason to include religion in bioethical discourse. It "thickens" the conversation, addressing as its

spokespersons do, the reasons of the heart that reason does not know. At the same time, religion is not necessarily hostile to the force of reason, often welcoming it as a divine gift. But the religious voice, on cloning or abortion or any other issue, is grounded in many other resources as well: intuition, memory, tradition, community, experience, hope, and affection. To echo Kahn's phrase, it makes you listen.



The Socratic Dialogue, which took place in Minneapolis on April 28, 1998, was a collaboration between the Minnesota Public Radio Civic Journalism Initiative and the Public Religion Project.

The Park Ridge Center

Bulletin

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