The Catholic Physician in an Era of Secular Bioethics

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*The religious truth is essential if we are to
make sense out of the world, make an order out of it,
which is not imposed for our own purposes.*

Martin C. D'Arcy¹

Abstract

This essay examines how commitment to the Roman Catholic moral and ethical traditions shapes the process, and content of bioethics and clinical decisions. An essential element of the vocation of Roman Catholic health professionals is to give genuine witness to that tradition in their daily clinical practices. Three questions will be addressed: 1) What is the justification for introducing religious commitments in clinical bioethics in a morally pluralist society? 2) What specifically does the Catholic medical tradition contribute to today's clinical decisions? 3) How are faith and reason to be balanced in clinical ethics? 4) Why are these questions relevant to papal calls for re-evangelization, or "re-proposal" of the faith, especially in the life of the physician?

Preamble: The Catholic Physician and the Papal Call to Evangelization

Our three most recent popes, Paul VI,² John Paul II,³ and Benedict XVI,⁴ have issued vigorous calls for evangelization, re-evangelization,

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The Linacre Quarterly 78(1) (February 2011): 013–028.

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0024-3639/2011/7801-0002 \$.30/page.

and “re-proposal” of the faith to the whole Church. Each has expressed concern for a drift they detect from the message of the Gospel toward lukewarm practices, and varying degrees of secularism, materialism, and relativism in the lives of Catholics. Especially relevant for Catholic physicians is the confusion and drift to relativism in acceptance of the Church’s teachings on key ethical questions—especially in this new era of bioethics.

Here, in addition to the new evangelization of his own life, the Catholic physician has an obligation to “re-propose” the truths of healing and suffering in Gospel terms in his own practice. This has been my main reason for offering these reflections. They are not intended to be a critical review of the literature, nor a critique of those works I have read or agreed and disagreed with for the last sixty years as practitioner and teacher. In this new era of bioethics the need for the Christian presence in medical ethics is indispensable.

Throughout my reflections I have tried to abide by the sage warning of Pope Paul VI:

If we ourselves are not convinced of our faith, if we are not firmly grounded in its truth and faithful to its teachings, all our attempts to make the word of God accessible to others will be meaningless and will be destined to fail.⁵

Introduction

For the Christian doctor, medicine is always more than a career or occupation. It is truly a vocation—a response to a divine call to manifest God’s love for others through fulfilling the obligations of a medical life. This in turn requires living a personal life consistent with Gospel teaching and incorporating that teaching in the personal care for the patient and the moral choices that are integral to that care.

This vocation has become far more complex in our day for several reasons. First, we live in an increasingly diverse moral milieu whose trajectory is secular and relativist. Second, the advances in biotechnology are ever more complex and more challenging to traditional conceptions of what it means to be human. Finally, clinical decisions are cooperative endeavors in which physicians, families, patients, and institutions may disagree on moral values. In this often roiled mixture, the Catholic physician must maintain his or her professional and personal integrity.

I. Why Include Religious Commitments in Ethical Decision Making?

Let us consider first the immediate objections to integrating faith commitments into clinical ethics that will occur to believers and non-believers alike. These are serious obstacles with solid foundations in history and experience. They cannot be ignored, but I believe they can and should be overcome.

First, there is the obvious historical evidence of conflict even among Christian denominations on some of the most fundamental ethical issues. Christians start with a common belief in man's spiritual destiny, God's creative act, and the necessity of personal salvation. But some argue as utilitarians, some as deontologists, some as situation ethicists, and others as emotivists. Some believe in an unchanging objective moral order, others in an evolving order in which man and God are co-creators. Roman Catholics grant reason and ecclesiastic authority a place alongside Scripture. They believe that the Church's Magisterium, or teaching authority, is vested in the Roman Pontiff. The bishops in union with the pope have the God-given authority to interpret Scripture. Other Christian denominations, many of which do not have a teaching authority and do not recognize that of the Catholic Church, regard human reason as too enfeebled by original sin to be relied upon. They rely on personal interpretations of what God wants them to be and do.

Second, and equally problematic, are the variations in the way Scripture is used in ethical discourse. Are scriptural texts to be taken as literal rules, or rather as guidelines to be followed more in the spirit than in the letter, or are they sources of discernment enabling the Christian in the moment of dilemma to choose rightly? Each alternative results in a different approach to ethical dilemmas. As noted already, Catholics believe that the Church's Magisterium has the authority authentically to interpret Scripture.

As a result, ethical discourse among Christians too often ends up in frustration on such crucial issues as abortion, euthanasia, and in vitro fertilization. Each denomination is convinced that it has the truth and castigates those who do not accept it. In the past, conflicts of this kind within the Christian community have given rise to war, social unrest, and unedifying scandal. Worst of all, such conflicts cast doubt on the idea of Christianity as a religion based in love of God and man. The religious wars and persecutions of the past are still fresh in human memory. Even today, the uncharitable and self-righteous attitudes of some Christians who wish to force their beliefs on others are a source of worry. Too many forget that militant and forced conversion is in the end no conversion.

In light of these objections, it may seem perverse to argue for inclusion of religious commitment in ethical decision-making. Would this not damage the emerging consensus on procedure, which has succeeded precisely because religious commitments have been excluded? Would it not undo the careful work of decades of consensus building and defeat the peaceable pursuit of medical ethics in democratic, morally pluralistic societies? What justifications can we offer for possibly upsetting the fine balance that seems to obtain at present?

One reason to include religious commitment is that religious belief is still an undeniable reality in the lives of most Americans. Many still

acknowledge a transcendent source of morality which demands their allegiance in making moral choices. Consciously or unconsciously, these commitments shape the whole process of ethical decision making. They are the moral presuppositions upon which moral choices are ultimately made and from which the most serious disagreements may arise.

Also, failure to account for religious commitments is a tacit endorsement of procedure and analysis over substantive and normative ethics. There is much to be said for the procedural emphasis and analytical rigor of contemporary medical ethics. Nothing in this essay is meant to demean this rigor. But procedural rigor is not enough. After an ethically valid procedure has been followed, the question remains: is the resulting decision itself morally right and good? This question should be asked with increasing frequency by morally conscientious physicians and patients. For the Christian physician, the ethical decision must be congruent not only with logic but also with doctrinally correct religious commitments.

The Christian physician, moreover, cannot cooperate in a decision that is morally offensive no matter how defensible the process by which it is made. *What* is decided is more morally relevant than *how* it is decided. The integrity of Christian ethics transcends conflict resolution. This is especially the case in ethics consultations on which the legal “settlement” for a moral conflict cannot replace the morally correct decision.

A competent patient may, for example, request direct assistance in voluntary euthanasia. Looked at simply from the process of decision making, many argue that we should respect the patient’s autonomy. But the action requested is itself morally unacceptable. As euthanasia becomes legal, as it is in some states in the U.S., the conflict between secular and religious norms will become as acute as it is now on the subject of abortion. Under these circumstances, the Catholic physician would be required to refuse or withdraw from care of the patient even though the decision was made by a competent patient in accordance with the secular standards of informed consent. Clearly, both the physician and the patient are responsible moral agents entitled to respect. Neither can impose his or her moral values upon the other. It is important to underscore this point. On the one hand, some would argue that the religious beliefs of the physician should be subservient to the patient’s autonomous wishes. On the other hand, the Catholic physician must refuse to cooperate in an intrinsically immoral act. He has a right, which civil law must recognize, to refuse to participate in actions he in conscience judges gravely immoral.

On the physician’s part, to act for the good of the patient includes attention to all of the patient’s interests—spiritual, as well as medical and material.⁶ To violate beliefs, whether religious or not, that are intrinsic to a patient’s self identity is to violate the intrinsic dignity of the patient. It is an essential obligation of the healing relationship, there-

fore, that both physician and patient recognize and respect each other's religious values.

If the health professional shares the patient's beliefs, he has a serious obligation to assist the patient to make a morally authentic decision. He can help the patient identify the moral issues and suggest appropriate pastoral counseling when the patient is in spiritual doubt. This often is the only effective resource for coping with the tragic choices so common in chronically debilitating or fatal diseases. This is an obligation too often neglected even by Christian physicians and nurses.

Even when the health professional is intellectually and emotionally opposed to the patient's beliefs, there is still an obligation to recognize the patient's religious values. The physician who cannot, in good conscience, agree with the patient's beliefs in this way should withdraw from his care. This must always be done respectfully and without vindictiveness or rancor. To override the patient's beliefs by deception, to ridicule them as "irrational," or attribute them to some mental aberration is not defensible. Respect for persons means precisely that—respect for the patient as he or she is, not as the physician wants him or her to be or believe. Respect for the patient's dignity does not extend to cooperation with an immoral act.

It is equally indefensible to take advantage of the patient's vulnerability or anxiety by forcing one's own beliefs on the patient. Some Christians believe if the patient is a non-believer or a "fallen away" believer that theirs is an obligation to convert him. It is one thing for the physician to assist the patient to find meaning or succor by giving witness to gospel truths in one's own behavior. It is quite a different thing to force one's own beliefs upon the patient.

Finally, there is an obligation to take religious commitment into account if one professes to practice "wholistic" medicine. Unfortunately, many who most vigorously champion the inclusion of psycho-social dimensions in "wholistic" care specifically exclude the spiritual and religious dimension. This would be a peculiar form of "wholism" since it is impossible to separate the spiritual from the personal and psycho-social elements in a patient's life. If the full dimensions of personhood are to be respected, then the spiritual dimensions cannot be ignored, even by the non-believing physician.

Healing, which means "making whole again," often requires restoring the patient's self-identity fractured by illness. This will mean helping the patient to cope, in his or her own way, with the spiritual confrontation with personal finitude that any serious illness presents. Taking account of religious commitments, therefore, is as essential as technical competence in achieving the end of medicine—a right and good healing action for a particular person.⁷ Indeed, it is part of the definition of medical competence. This does not mean that the physician can replace the

priest, minister, or rabbi. Rather, it does mean being sensitive to the fact that a serious illness is as much a spiritual as it is a medical crisis.

II. How Does Religious Commitment Shape Moral Choice?

The process of moral choice in medicine is built on a four level framework. How the participants interpret each level shapes not only the process but also the content of their moral decisions. The four levels of ethical decision making are these: 1) the conception we hold of the physician-patient relationship, 2) the way we interpret the *prima facie* or applied principles of medical ethics, 3) the ethical theory we use to define the good, and 4) the ultimate sources on which we ground our conception of moral right or wrong. The first three levels are, in the final analysis, derived from and shaped by the fourth level—the ultimate source of our morality.

On the *first level*⁸ is the conception we hold of the physician-patient relationship and the conception of healing that flows from it. A variety of models of this relationship are current today. On one currently popular view, the medical relationship is interpreted as a legal contract for services. On another, it is likened to a commodity transaction similar to any other commercial transaction. A third view regards the healing relationship as essentially applied biology. A fourth view interprets the relationship as a covenant of trust in which the physician is expected to act primarily in the best interests of the patient even if that requires some effacement of his own self interest. The ethics of the relationship will vary according to which of these models we accept. If the relationship is a contract, the ethics of law will prevail; if it is applied biology, the ethics of applied science will predominate; if the relationship is a business transaction, then it will be guided by the ethics of the marketplace. And, if it is a covenant, the ethics of virtue and trust will take first place.

The *second level* in the decision-making structure depends on the way we construe the commonly used *prima facie* principles of medical ethics—e.g., beneficence, autonomy, and justice—and their three derivative duties—truth-telling, promise-keeping, and confidentiality. Each principle is open to a variety of interpretations, as is evident in the ongoing debates about principlism as developed by Beauchamp and Childress.⁹

Beneficence, for example, may be limited to simple non-maleficence. On a somewhat stricter note, it may be taken as doing good for the patient as long as it means no inconvenience for the doctor. On a higher level, it might entail a possible duty to act in the patient's interest even at the cost of financial loss or physical risk for the doctor. At the highest level, beneficence might entail, as with Mother Teresa (or Dr. Albert Schweitzer), heroic self-sacrifice in the interest of the sick and the poor.

Autonomy may in like fashion be interpreted variously. For some, respect for autonomy might mean absolute subservience to the patient's will regardless of what the patient requests. Others place limits on autonomy when the patient requests something that either violates the physician's moral values, harms someone else, or results in harm to the patient him/herself. The locus of decision making has shifted from the doctor to the patient in the last twenty years. It is the major thrust of the era of bioethics. The precise construal we place on autonomy markedly influences the process of moral choice.

The principle of justice has many interpretations as well. Is it to be defined on the basis of equity, merit, social position, power, need, or ability to pay? Does a society owe any special obligation to the sick persons residing within it? How we distribute any scarce healthcare resources will be directly determined by the meaning we attribute to distributive justice.

At the *third level* in medical-ethical decision making is the choice of an ethical theory, e.g., natural law, deontology, consequentialism, subjectivism, virtue, etc. Each theory is based in some conception of the good. That good may be utility, adherence to duty, what the patient wants, the demands of human nature, or spiritual destiny. Each conception of the good provides a different answer to the concrete clinical ethical dilemmas. This is particularly true when the subjects of our concern are the vulnerable, the poor, the aged, or infants and children: the social utility of all these people is compromised, and they are, as a consequence, disvalued as persons in utilitarian societies. Why ignore natural law as an ethical theory?

In Catholic moral teaching the vulnerable and "disvalued" members of society possess the same dignity as every other human person. Their dignity is assured scripturally, since each is created in the "image of God" and rationally in terms of the natural law. The inherent dignity of every human person is fundamental in the personalist anthropology of John Paul II. It is reaffirmed in his encyclical *Fides et ratio* in which the philosophy and the theology of the human person re-enforce each other.¹⁰

The positions we take at these first three levels of decision making (the levels of the physician-patient relationship, of ethical principles, and of ethical theory) cannot be divorced from the commitments we make at the fourth and most fundamental level—the level of the foundational sources of our morality. At this level, every human being makes a commitment to some view of the world, of man, and of the existence or non-existence of a transcendent order. This fourth level forms the irreducible source of a person's morality, the final justification for what he or she thinks is right and good.

Here again patients and doctors may differ among each other. For some, the individual is the creator of his own values. He is the sole determinant of what is right and good. For others, the ultimate source of

morality is the appeal to unaided human reason, i.e., to philosophical ethics. Many others would make the texts of the sacred Scriptures the sole arbiter of moral good: they are fundamentalists and fideists who seek specific and concrete moral prescriptions from the Bible and reject rational argumentation as irrelevant. In the Roman Catholic moral tradition, both reason and revelation, as well as ecclesiastical authority, are accepted sources of morality.¹¹ At the opposite pole are those for whom biology, sociobiology, or neurobiology are the ultimate sources of morality. An increasing segment of the population roots its socially determined morality in culture and history, opting for an ever-changing morality with no fixed principles except the public will.

Clearly in the end the configuration of our moral choices depends on which of these ultimate sources of morality we accept. This can be more concretely illustrated by showing how a commitment to Catholic Christianity might alter the choices we would make at each of the four levels in the process of ethical decision making described above.

First, a commitment to Roman Catholic Christianity provides a philosophical and theological anthropology upon which to base the ethical principles used in medical-moral decisions. The lack of such an agreed upon anthropology in contemporary secular ethics is a major reason for many of its frustrations. The principles of beneficence, autonomy, and justice, for example, are taken by contemporary ethical theorists to be *prima facie* principles. But *prima facie* principles need grounding in something more fundamental, like a theory of human nature. Without such a theory, it is difficult to validate *prima facie* principles. They become self-justifying and arbitrary justifying absolutes.

Humans, on the Roman Catholic view, are creatures of God, composites of body and spirit oriented to a spiritual destiny, called to personal salvation and to a concern for the salvation of other men and women. This is the conception of Christian humanism which Pope John Paul II saw as sufficiently important to make the topic of his first encyclical *Redemptor hominis*.¹² He outlined his Christian personalism more fully in his later encyclicals—*Evangelium vitae*, *Veritatis splendor*, and *Fides et ratio*. This view of man gives a meaning to human existence beyond immediate human intention, desire, or need. It ascribes an intrinsic dignity to each human life. This dignity grounds moral principles like respect for persons, beneficence, and justice in the obligations owed to humans as humans, as creatures of God.¹³ These documents incorporate the “comprehensiveness of the Christian philosophy,” its heavenly promises, and the cross “embodied in its creed.”¹⁴

On this view—which is also rooted in the natural law as understood historically by Plato, Aristotle, Aquinas, and contemporary philosophers—certain decisions (like abortion, euthanasia, and embryonic stem cell research) are never permissible. Consequentialism, moral subjectivism, relativism, and biological materialism as primary ethical theories are inadmissible and can be shown to be rationally untenable.¹⁵ Thus the

physician-patient relationship could never be treated as a commercial contract, an exercise in applied biology, or as the mechanical repair of body parts. Beneficence would be more than mere non-maleficence. Autonomy would never be absolute, nor would distributive justice for medical care be based solely on the ability to pay.

Another way the Catholic perspective alters ethical decisions is to give meaning to illness and death. For Christians, suffering and death are not the unmitigated evils they are to the contemporary world. Viewed from the perspective of Christian theology, every suffering human life takes on meaning.¹⁶ Illness becomes an enabling rather than a uniformly disabling experience. It can serve various purposes like reconciliation with God, atonement for past sins, reparation for others' sins, a source of example and inspiration to others. It can draw families to greater love of each other in their solicitude for a sick or dying member.

Christians recognize that suffering is the way of the cross which Christ Himself had to travel and which each of us must also journey. The Christocentric view of human nature also answers Job's dilemma. Why must the just man suffer? For Job the answer came in face-to-face confrontation with God's majesty as Creator of a world whose purposes Job would never be able to fully fathom. For the Christian, identification with Christ's suffering gives a meaning to human suffering that requires no logical exposition or defense of the kind Job and his friends sought from the Lord. Job finally ended by surrendering to the majesty of God without knowing God's reasons. The Christian submits because he has an ineffable model in Christ, whom he is called to emulate.

On this view of suffering, utilitarian or sympathetic impulses to shorten human life deliberately, to devalue the "quality" or economic worth of the lives of disabled infants, the aged, the retarded, or the handicapped are morally indefensible. Quality of life, economics, or social worth cannot be defended as criteria for withholding or withdrawing life sustaining treatment in comatose patients. For the Christian each human life has meaning and dignity and inherent worth.

A naturalistic ethic, without a grounding in religious commitments, leaves a gap between cognition of the right and good and the motivation to do the right thing and to be good. This disjunction is one of the major problems in contemporary moral philosophy. Some hope that a better understanding of moral psychology will close this gap.¹⁷ Some moral theorists turn to psychology to "purify" our motives or our aberrant psychological drives in order to move us more surely from knowing the good to doing the good.¹⁸

Without depreciating these efforts to understand our moral motivations, it does not seem likely that the gap between cognition and motivation can be closed by more cognition. On the other hand, a genuine commitment to a Christian way of life closes that gap immediately. For the true Christian, to recognize what is right and good is to be motivated to do it. In actual practice, Christians can recognize the good, yet suppress

it and do evil. When this occurs, they recognize that they have fallen from or rejected God's grace. This is very different from recognizing the good and not acknowledging any obligation to do it, or denying that there is any good in the first place.

For the Christian, to act morally is a command from God defined in scriptural texts like the Decalogue or the Sermon on the Mount. The Decalogue is clear in its admonitions; the Gospels are equally compelling. The enlightened Christian seeks to act out of love, not out of fear. Failing this, however, God's call to do His will, to live in accord with his commandments, and to love one's neighbor is unequivocal.

Christian commitment, in addition, provides an ordering principle which can resolve conflicts between moral principles. This is the ordering principle of charity, the supernatural virtue which calls for genuinely unselfish acts on behalf of our fellow men and women. Charity is the summation of Christ's own mission, which Christians are called upon to emulate. Charity is a virtue that transforms each *prima facie* moral principle and integrates it into a Christian principle integral to the Christian way of life. "Charitable" beneficence entails a clear effacement of self-interest in the interests of the sick person; "charitable" justice goes beyond what is strictly owed to embrace preferentially those who are poor or rejected or especially vulnerable. "Charitable" respect for persons is more than a legalistic recognition of the rights to autonomy and privacy.

Charity does not ignore ethical principles nor substitute vague moral sentiment for rational ethical decisions. It does, however, ask how each principle applies in the light of the Sermon on the Mount or the example of Jesus' daily healing of the sick. It emphasizes the kind of persons we ought to be rather than the solution to a particular moral puzzle. Charity thus restores virtue to a central place in moral philosophy. In this sense, it coincides with the most recent trend in philosophical ethics which attempts to restore character and virtue in moral behavior.¹⁹

This emphasis on virtue—whether the natural or supernatural virtues—is particularly significant for biomedical ethics. A patient, given the predicament of illness, is vulnerable, dependent, and compelled to trust the physician. Every action decided upon must finally be channeled through the physician who carries out the decision, whether it is made by a competent patient, the surrogate of an incompetent patient, or a legal guardian. In every medical act, it is the physician who must interpret the spirit of the patient's wishes and interests. The physician's character stands inevitably between the patient and harm. No contract for service, no informed consent, no hospital or public policy can anticipate the exigencies of every therapeutic moment. One might justifiably argue for limitations on the physician's discretionary latitude but all trust cannot be eliminated. The virtue of fidelity to the patient's interests and to the promise of beneficence implicit in the healing relationship is central to the physician's morality. It is the final safeguard against

those subtle temptations to use the patient's exploitable predicament for the physician's or the institution's self-advantage.

A Christian perspective not only puts the focus on virtue, but it defines charity as the ordering virtue. The classical cardinal virtues—prudence, temperance, fortitude, and justice—are not ignored. Rather, they are nuanced, ordered, and elevated in sensitivity by charity, as is the whole analytical process requisite for rational decision making.²⁰

A Christian perspective also buffers the strong individualistic trend of so much of contemporary biomedical ethics.²¹ Christianity is community centered. It eschews the moral atomism of the libertarian or the absolutist interpretation of patient autonomy. Patient and physician are bonded to each other and to the larger community of others in need. The sick remain members of the Christian community with a special claim on the community's solicitude.

Finally, the Christian physician practices his profession not as a mere occupation or career but as a vocation. The Christian shares with all men and women the obligation to respond to God's double call—to personal salvation and to help in the salvation of those with whom we come into daily contact. The special nature of medicine as a human activity makes the vocation to medicine a vehicle with special salvific opportunities. As Thomas Merton puts it, "The differences between the various vocations lie in the different ways each enables man to discover God's love, appreciate it, respond to it, and share it with other men. Each vocation has for its aim the propagation of the divine life in the world."²²

The physician who seeks to practice his profession as a true Christian vocation knows he/she cannot exhaust all its spiritual possibilities. The Christian physician has always before him the image of Christ the Divine Healer, a model to be emulated but never equaled. The Christian physician must be thoroughly competent. But also he must, through his daily work, propagate "the divine life in the world," as Thomas Merton so well put it.

A Christian vocation to medicine calls for an integration of what it is to be a physician with what it is to be a Christian. Profession and faith cannot be isolated from each other without damage to both. To unite them has always been difficult but never more so than today. For today, the Christian physician functions in a world largely secular and morally heterogeneous. The challenges of scientific positivism, commercialism, moral relativism, and self-interest are direct and powerful. But even more challenging are the moral quandaries inherent in the unprecedented technological capabilities of modern medicine. A Christian vocation to medicine entails the obligation to make one's faith commitment an explicit part of ethical decision making.

Integrating Catholic Christian ethics into clinical decision making does not exhaust the possibilities of a Christian vocation to medicine. The substantive and normative content of the Roman Catholic tradition

and moral theology must be integrated as well. And both must be accompanied by dedicated service to the sick in charity, patience, and courage.

III. The Relationship of Faith and Reason in Ethical Decisions

At the outset, I listed some substantial objections to taking religious commitment into account in ethical decision making. I wish to repeat that these objections are not trivial and that they must always be kept in mind if the current dialogue in medical ethics is not to degenerate into unproductive and recriminatory debates that undermine the growing consensus on procedural ethics. To avoid this, the committed Christian has a serious obligation to engage in ethical dialogue without sacrificing either analytical rigor or the integrity of his faith. Parochial assertions without rational argument, on the one hand, and facile compromise of principle simply for the sake of consensus, on the other, are equally self-defeating. They frustrate the effort to take religious commitment into account. They also reinforce the skeptic's suspicion that Christian ethics must ultimately be irrational if it flees from rational discourse.

To avoid this kind of intellectual double jeopardy, the Christian physician is required to establish a proper relationship between right reason and right faith. This is a perennial problem for the Catholic intellectual who wishes to engage in intellectual discourse with the cultural ideas of his time. We will confine our examination of this relationship of faith and reason to the relatively narrow arena of clinical ethical decision making.

To begin with, a right relationship between faith and reason in ethical discourse requires a recognition of the epistemological distinction between these two realms; that is, between philosophical and theological ethics. Both use reason, and, therefore, both must follow the usual rules of logical discourse. Philosophical ethics, however, depends solely on the use of unaided human reason. Theological ethics uses the same rules of reason, but they are enriched by revelation. Thus philosophical ethics accepts as evidence only what is ascertainable by reason or observation, while theological ethics begins with a faith commitment, an acceptance of the fact of revelation. In the Roman Catholic tradition, the datum of the Scriptures is further enlarged by tradition and the teachings of the official Magisterium. In theological ethics, reason is not abandoned, nor are faith and reason in contradiction. Rather they complement and supplement each other. Much of what theological ethics posits is also derivable by reason.

In ethical dialogue with those who reject the sources of evidence which Christians admit, we must hold to these distinctions. With those who accept only philosophical argumentation, we must be willing to go as far as unaided human reason is able to go. We cannot expect to make a point simply by recitation of scriptural or ecclesiastical authority. This means the discourse may go only so far. But this is not a reason for refus-

ing to enter the discourse or breaking it off. There are several very good reasons for continuing the discussion on purely philosophical terms.

For one thing, Christians can give evidence that religious commitment is still respectful of reason, its rules as well as its limitations. The believer must be willing to expose his own positions to critical and logical scrutiny. Moreover, nonbelievers may exalt reason, yet advance arguments that violate the rules of ordinary logic or are weak or incoherent. If non-believers are not introduced to the way those with a faith commitment justify their positions, they will never be exposed to the possibility of understanding or accepting such arguments.

Finally, whether they agree or not, secular ethicists are often amazed, and even disappointed when a believer hides or compromises his faith commitment. Under such circumstances it is hard for the secularist to avoid the suspicion that recourse to faith is a weak, spurious, or hypocritical way of protecting a conceptually destitute position.

For these reasons, it is a moral obligation of Roman Catholic Christians to engage in serious ethical discourse with all the participants in ethical decisions. To be sufficiently well-informed to be able to do so effectively is a requisite condition for practicing medicine as a vocation.

To be effective, a second caveat must be observed: namely, the believer must act charitably towards what he may consider an erroneous or even insulting counter position. The quickest way for a Christian to defeat his position and to discredit his whole faith is to act uncharitably, condescendingly, or censoriously to those with whom he disagrees. Such behavior undermines the claim that Christian belief can improve the moral behavior of those who profess to follow its teachings.

Being charitable does not entail acceptance of a relativist ethic as so many Catholics fear. The distinction between the beliefs a person holds and that person's status as a human being is time honored in the Roman Catholic tradition; another important distinction is between an immoral choice and an immoral action. No one can enter the mind of another person so completely as to weigh the competing influences of environment, internal predisposition, will, and intellect needed to judge the moral guilt of another human being. It is incongruous for Christians, who believe God is their judge, to usurp God's prerogative by pronouncing their own judgments about the personal guilt of others. The confessional is better suited for such judgments.

One certainly may hold to an objective order of morality and judge the objective moral validity of a decision or act without condemning the person responsible for them. To make this distinction charitably yet unequivocally is intrinsic to the vocation of the Christian ethicist. Christian ethics is ultimately not a set of rules or a way to win ethical debates, but a way of living. If charity does not form the whole human person, and manifest itself in action and word, then no amount of reason will convince a non-believer. Correct ethical positions have been defeated too many

times by the self-righteousness of the over-zealous Christian. The way we deal with even the hostile opponent often reveals more about the veracity of our message than our logical arguments. Every such encounter is an opportunity to give evidence that Christian ethics is a humanizing not a dehumanizing endeavor. To lose that opportunity is to betray the aim of Christian ethics, which is not the promulgation of abstract rules but the formation of right conscience in every human person.

Christian ethics, then, requires that we respect the persons with whom we disagree. They are to be taken seriously, listened to, and given credit for sincerely wanting to do the right and the good thing. When we disagree, we must do so without impugning motives. This does not imply acceptance of the deficiencies of a secular ethic. It does mean admitting the logical debilities of our own positions when they exist.

Our moral positions as Christians are not fully defensible without recourse to sources of evidence that the secular ethicist rejects. Recognition of this fact may help us to comprehend more fully the degree to which we are dependent upon scriptural or magisterial authority. It may also show how a faith commitment opens alternate avenues beyond principle and logical analysis and thus expands the way ethical dilemmas may be examined.

In ethics, as in any branch of philosophy, the Roman Catholic tradition owes much to the critical yet respectful way St. Thomas entered into dialogue with the pagan philosophers, learning, modifying, and expanding their thought with intelligence and charity. His is the model the Christian physician may follow with profit in his own daily dialogue with physicians, ethicists, or patients, secular or religious, in the process of making serious moral choices.

These distinctions and correlations between reason and faith, that is, between philosophy and theology in ethics, are essential if Catholic physicians are to exercise an intellectual and moral ministry as part of their healing ministry. When theology abandons or weakens its commitment to revelation, ecclesiastical authority, or tradition, it becomes another philosophy among the many others competing for rational acceptance. When philosophy discovers principles and concepts that expand and fulfill the higher potentialities of the human spirit, it leads to theology. By exhibiting both faith and reason in proper relationship to each other, the Catholic physician expands the possibilities in ethical decisions and simultaneously serves both his patients and his faith commitment.

Conclusion

Medical ethics has expanded more rapidly in the last twenty years than in the whole of its previous 2500-year history. That expansion has derived from a convergence of forces—the spread of democracy and public education, the rate of medical progress, the growth of moral heterogeneity, and the entry of economics, law, and politics into medical decisions.

Throughout this period, the dominant spirit of modern bioethics has been philosophical, analytical, secular, and procedural. Theological ethics and religious commitment have been systematically excluded from the secular discourse. Religious conviction, however, remains a significant reality in the lives of physicians, patients, and institutions, shaping the process of ethical decision making in profound ways.

The Christian physician, and especially the Roman Catholic, has an obligation to take religious commitment into account in medical ethical decisions, especially in a secular world. This is an intrinsic element of the medical vocation. To do so with the requisite balance of analytical rigor, fidelity to faith commitments, and charity is a service to non-believers as well as believers. This balance is, in any case, the special obligation of Christian professionals: "The more you know and the better you understand, the more severely will you be judged, unless your life is the more holy."²³

Notes

¹ Martin C. D'Arcy, *Humanism and Christianity* (New York: Meridian Books, 1970), 190.

² Pope Paul VI, apostolic exhortation *Evangelii nuntiandi* (1975), http://www.vatican.va/holy_father/paul_vi/apost_exhortations/documents/hf_p-vi_exh_19751208_evangelii-nuntiandi_en.html.

³ Pope John Paul II, apostolic exhortation *Christifideles laici*, nn. 4, 34, http://www.vatican.va/holy_father/john_paul_ii/apost_exhortations/documents/hf_jp-ii_exh_30121988_christifideles-laici_en.html.

⁴ Pope Benedict XVI, homily for first vespers, Solemnity of the Holy Apostles Peter and Paul (St. Paul Outside the Walls, Rome), June 28, 2010, http://www.vatican.va/holy_father/benedict_xvi/homilies/2010/documents/hf_ben-xvi_hom_20100628-vespri-pietro-paolo_en.html.

⁵ Pope Paul VI, *What Must God Be Like?* (Denville, NJ: Dimensions Books, n.d.).

⁶ E.D. Pellegrino and D. Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care* (New York: Oxford University Press, 1988).

⁷ E. Pellegrino, "Toward a Reconstruction of Medical Morality: The Primacy of the Act of Profession and the Fact of Illness," *Journal of Medicine and Philosophy* 4 (1979): 32–56.

⁸ This classification is the author's own, based on experience and observation.

⁹ T. Beauchamp and J. Childress, *Principles of Biomedical Ethics* (New York: Oxford University Press, 2001). The principles on which Beauchamp and Childress focus in their widely used and influential book are deeply flawed and have been incisively criticized by many competent scholars. See, for example, John Finnis and Anthony Fisher, O.P., "Theology and the Four Principles of Bioethics: A Roman Catholic View," in *Principles of Health Care Ethics*, ed. Raanan Gillon (Chichester: John Wiley & Sons, 1993), 31–44.

¹⁰ Pope John Paul II, encyclical *Fides et ratio* (1998), http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_14091998_fides-et-ratio_en.html.

¹¹ John Paul II, encyclical *Evangelium vitae* (1995), http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html; idem, encyclical *Veritatis splendor* (1993), http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_06081993_veritatis-splendor_en.html; idem, encyclical *Fides et ratio* (1998), http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_14091998_fides-et-ratio_en.html.

¹² John Paul II, encyclical *Redemptor hominis* (1979), http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_04031979_redemptor-hominis_en.html.

¹³ Congregation for the Doctrine of the Faith, *Dignitas personae* (2008), http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20081208_dignitas-personae_en.html; Vatican II, *Gaudium et spes*, Pastoral Constitution on the Church in the Modern World (1965), http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_cons_19651207_gaudium-et-spes_en.html.

¹⁴ D'Arcy, *Humanism and Christianity*, 198.

¹⁵ John Finnis, "Utilitarianism, Consequentialism, Proportionalism ... or Ethics," in *Fundamentals of Ethics* (Washington: Georgetown University Press, 1983), ch. 4, 80–108; Germain Grisez, "Against Consequentialism," *American Journal of Jurisprudence* 23 (1978): 21–72.

¹⁶ John Paul II, apostolic letter *Salvifici doloris* (1984), http://www.vatican.va/holy_father/john_paul_ii/apost_letters/documents/hf_jp-ii_apl_11021984_salvifici-doloris_en.html.

¹⁷ A. MacIntyre, "Moral Philosophy: What Next?" in *Revisions: Changing Perspectives in Moral Philosophy*, eds. A. MacIntyre and S. Hauwerwas (Notre Dame: University of Notre Dame Press, 1983), 1–15.

¹⁸ Albert Ple, *Duty or Pleasure, a New Approach to Christian Ethics* (New York: Paragon House, 1987); R.B. Brandt, *A Theory of the Good and the Right* (Oxford: Clarendon Press, 1979).

¹⁹ A. MacIntyre, *After Virtue* (Notre Dame: Notre Dame University Press, 1986); idem, *Whose Justice? Which Rationality?* (Notre Dame: Notre Dame University Press, 1988).

²⁰ E. Pellegrino and D. Thomasma, *The Christian Virtues in Medical Practice* (Washington, D.C.: Georgetown University Press, 1996).

²¹ H.T. Engelhardt Jr., *The Foundations of Bioethics* (New York: Oxford University Press, 1986). See also Engelhardt and Michael Rie, "Morality for the Medical-Industrial Complex: A Code of Ethics for the Mass Marketing of Health Care," *New England Journal of Medicine* 319 (1988): 1086–1089.

²² Thomas Merton, *No Man Is an Island* (New York: Harcourt, Brace, Jovanovich, 1955), 153.

²³ Thomas à Kempis, *The Imitation of Christ* (Milwaukee, WI: Bruce Publishing Co., 1940), 3.