CHAPTER ONE

Medicine, Bioethics, and Religious Voices

In recent years, the demographics of the population of the United States have been changing throughout the entire country. Though diversity is not new to the United States, the change is in the degree of the diversity, both in terms of numbers of people and variety of traditions, cultures, and religions. The increase in diversity comes from immigrants who establish themselves in this country and then bring their families. Additional factors that exponentially increase the cultural, religious, and ethnic diversity come from the fact that people from Africa, Asia, Latin America, and other areas have been established in the United States long enough to have the second, third, and fourth generations of their families born and reared in this country. As these American-born generations mature, they often develop their own expression of their religious and cultural backgrounds. Furthermore, as individuals from these various groups interact, form relationships, and establish partnerships, there is a blending of perspectives, leading to the development of yet other worldviews. This diversity of religions and cultures, and their multiple expressions, has had a profound impact on healthcare, on the concept and delivery of quality care, and on how bioethical issues are understood.

In this chapter, after demonstrating the influential role of religion in the clinical setting and its subsequent influence in the academy and in public policy, I argue that bioethical discussions need to be broadened to include religious traditions beyond those grounded in Christianity and Judaism. If doctors, nurses, and other healthcare professionals desire to administer quality, culturally competent care, they must take both their own and their patients' religious perspectives and commitments into serious consideration. In this pluralistic world, where countless ideas and worldviews are continually coming into contact, Hinduism, with its multitude of traditions and numerous gods, provides an exemplary model for how individuals can function, communicate, and make difficult moral decisions in and amongst the chaos of life.

Bioethical discussions have been occurring in at least three different arenas: the academy, the clinical setting, and in public policy forums. At its genesis

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in the early 1960s, theologians played formative roles in the field of bioethics. However, as time passed, these primarily biblical religious perspectives were surpassed by secular, universal, philosophical voices in leading textbooks and at leading bioethics centers. This marginalization of religious voices (primarily Christian) dominated academic discussions, and in turn, this development influenced clinical and public policy settings. Although the deemphasis of religion in the academy has had some influence in the clinical and policy arenas, the significance of religious beliefs for patients and practitioners as they face difficult decisions is evident. Religion may have been downplayed in the academy, but in clinical settings and public policy arenas, it indirectly and explicitly continues to permeate the experiences of those actually engaged in bioethical struggles at the bedside. The power and influence of these clinical experiences in turn affects the position of religious voices within the academy and public policy arena.

Though calls for consistency, rationality, and universal applicability influence and are important for the clinical setting, they are often not its primary focus. The questions and experiences of those in the clinical environment became a powerful influence and may have played a role in a shift that occurred within both the academic field of bioethics and the realm of public policy. In the 1990s, the same scholars who argued for the marginalization of religion within bioethics began acknowledging the cost of excluding religious voices and reevaluating the contributions of religion. When struggling with issues of birth, life, and death, many often turn to some form of religious or spiritual counsel and support.

THE RELATIONSHIP BETWEEN RELIGION, MEDICINE, AND BIOETHICS

There is a well-established relationship between the practice of medicine, medical ethics, and religion. In their essay "What is Bioethics? A Historical Introduction," Kuhse and Singer indicate that for many cultures the religious leader and healer was one and the same individual. For example, the shaman was often both doctor and priest, simultaneously utilizing herbs, exorcisms, and prayers to heal the members of the community.[1] The ancient Indian *Ayurvedic* tradition provides another excellent example of an inextricable connection between the medicine of the Vedic Indians and their religion. This Hindu medicine never became divorced from the rest of life's pursuits, especially not from the religious life.[2] According to the father of medicine in China, Sun Ssumiao, medicine "is an art which is difficult to master. If one does not receive a divine guidance from God, he will not be able to understand the mysterious points [. . .]."[3] Martin Marty reminds us that Judaism, Christianity, and most of the world's religions began, developed, and continue as healing cults. Relationships between the practice of medicine and various Western religious perspectives, primarily Protestant, Catholic, and one Jewish tradition, are the

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focus of the book *Caring and Curing: Health and Medicine in the Western Religious Traditions.*[4]

This association between religion and medical ethics extends back to antiquity. Kuhse and Singer trace a connection that includes eras that predate the Oath of Hippocrates. In the sanctuary of Asclepias there is a monument that instructs doctors to be like God, to treat, heal, and be a savior of slaves, of paupers, of rich men, and of princes.[5] In the same vein, Sun Ssu-maio calls on a physician to have mercy on all those who suffer and are sick. Being guided by god, the doctor should "pledge himself [sic.] to relieve suffering among all classes. Aristocrat or commoner, poor or rich, aged or young, beautiful or ugly, enemy or friend, native or foreigner, and educated or uneducated, all are to be treated equally."[6] According to the Indian *Caraka-Saṃhitā,* a physician-in-training first devotes himself to the guru. After he is instructed in the sacred fire ceremonies, he is taught the healing arts and charged to serve and heal everyone equally "without arrogance, with care and attention and with undistracted mind, [and] humility [. . .]."[7] Concerning how physicians are to conduct themselves, these ancient texts reflect fluidity between the practice of medicine, religion, and their code of ethics.

Religion played a pivotal role in the development of the field of bioethics. Discussing the relationship between the field of bioethics and religion, Albert Jonsen argues that there is "a moral tradition that runs wide and deep, although in our days, quite silently, through American culture."[8] He calls that tradition "American moralism." By this term, he means "the deep source in which a certain way of thinking and feeling about the moral life is engendered and nourished."[9] The roots of American moralism are firmly grounded in Christianity, particularly Calvinism. After presenting his argument regarding the tie between American moralism and Calvinism, Jonsen maintains that the North American interest in bioethical issues grew out of this "American moralism."

The 1970 publication of Paul Ramsey's *Patient as Person* was one of the defining events in the development of the field of bioethics. According to Jonsen, Ramsey's desire to bring order and clarity to the confusion accompanying the advances in medical science was grounded in the theology of Calvin and Edwards.

As new medical technology developed in the early 1960s and 1970s, the federal government established committees to consider the ethical and moral implications of the technologies and their use. Jonsen was a member of one of the first ethical panels established by the federal government in 1972, namely, the Totally Artificial Heart Assessment Panel. He was also a commissioner of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. Looking back, Jonsen is skeptical of the work of this Commission's "status as a serious ethical analysis." He suspects that the desire of members of Congress and the public "to see the chaotic world of bioethical research reduced to order by clear and unambiguous principles" is in part a product of Calvinistic thinking.[10] According to Jonsen, Calvinist perspectives

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influenced moral thinking in a variety of religious traditions within America, Protestant and Catholic alike, and underlie American moralism in general.

Jonsen's thesis provides a particular example of how religious voices were present at the revival of the field of bioethics in North America. Though Calvinism represents only one of the many Christian voices, those perspectives, with a few Jewish voices interspersed, were the primary contributors to the early discussions in bioethics. Along with the dominant voice of Ramsey representing a Calvinist tradition were the Roman Catholic voices of Curran, McCormick, and others. While the teachings of the Magisterium regarding sexual and reproductive ethics can make it appear as if there is unanimity within Roman Catholicism, this is in fact not the case. There are a variety of perspectives that exist within Roman Catholicism, among both the laity and theological scholars.

Many ethical issues arose as a result of the social, cultural, and political changes of the time. Significant advances in biomedical science and their clinical applications, such as heart transplantation and dialysis, became a driving force that brought about a revival in medical ethics. Advancements in such fields as recombinant DNA and gene therapy contributed to the development of what is now called bioethics. As discussed, by the end of the 1960s and 1970s, medical technology extended the possibilities of human life in both directions. On the one hand, dialysis machines, mechanical ventilators, and organ transplant technology prolonged the lives of those who would have otherwise died. On the other hand, assisted reproductive technologies enabled women to give birth to children in ways never before imagined in modernity.

Developments in assisted reproductive technologies bring up challenging new issues surrounding the beginning of human life. For example, 15 July 1978 marks the birth of Louise Brown, the first baby born as a result of IVF. This in vitro technology allowed one woman to donate her oocytes and embryos to another. The development of embryo cryopreservation and thawing techniques led to the first live birth from these techniques in 1984. Further developments in gamete intrafallopian transfers (GIFT) and zygote intrafallopian transfers (ZIFT) became available in 1985 and 1986, respectively.[11] These technologies lead to questions, ethical issues, and choices between options that perhaps were previously known only within the imagination, but unknown in the realities of daily life.

Questions and issues raised by the challenges of, and advances in, biomedical technology are not simply medical; they are moral and ethical as well. For example, a majority of the debates regarding the creation and utilization of human embryos, embryonic stem cells, and cloning revolves around the question: what is the moral status of the embryo or fetus? These debates are often contentious because they highlight issues regarding what it means to be a unique individual, what it means to be a human being. These technological advances raise the moral question of when human life begins. When is the

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fetus considered a human person, entitled to rights and protection afforded other human beings? Another example of how these medical advances relate to moral issues becomes evident when one considers questions of distributive justice: How just is it to spend one million dollars to save one twenty-five-week premature baby, while the health of children in the same city, in the same neighborhood, is threatened by malnutrition and lack of immunization? All of these questions and moral dilemmas inevitably involve the significance of life, suffering, and death.[12] Throughout history, birth, life, and death are often draped and cradled in the garments of religious rituals and religious beliefs.

Just as religion played a role in the practice of medicine and in the development of medical ethics, so too religion was present and played a formative role at the genesis of the bioethics revival. Protestants such as Joseph Fletcher, Paul Ramsey, and James M. Gustafson, Roman Catholic moral theologians Richard McCormick, Charles Curran, and Germain Grisez, along with Jewish theologians such as David Feldman and Immanuel Jakobovits, were all participants in this revival. Callahan describes a situation where, through the mid-1960s, the *only* resources for bioethics were in some way or other based in religion.[13]

Along with being founders in the field of bioethics, these religious thinkers served as members of formative committees such as The National Commission of the Protection of Human Subjects of Biomedical and Behavior Research (1974), and The President's Commission for Study of Ethical Problems in Medicine and Biomedical and Behavior Research (1979).[14] The Institute of Religion, founded in 1954 at the Texas Medical Center, sponsored one of the first major bioethics conferences in the United States in the late 1960s. Joseph Fletcher, Paul Ramsey, and other Christian thinkers presented major addresses at this conference. Additionally, Christian theologians and philosophers played a role in the formation of the field by helping to create various bioethics institutes such as the Kennedy Institute of Ethics at Georgetown University and the Institute for the Study of Society, Ethics, and the Life Sciences, now known as the Hastings Center in New York. Many Christian theologians and philosophers were also the primary contributors to the first edition of the *Encyclopedia of Bioethics*.[15]

These religiously informed thinkers were so influential in the formation of the field of bioethics because they were able to clearly articulate important insights.[16] Cahill argues that these individuals "were particularly well equipped to advance medical ethics because religious communities had cultivated long-standing traditions of reflection on life, death, and suffering, and had given more guidance on the specifics of moral conduct than had moral philosophy at the time."[17] Citing Weber, Campbell remarks that the religious perspectives provide an interpretation of reality that responds to the "'metaphysical needs of the human mind' to seek order, coherence, and meaning in our lives, to understand ultimate questions about our nature, purpose, and destiny."[18]

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MARGINALIZATION OF RELIGION IN THE ACADEMY

Despite the contributions of religion to the origins of modern bioethics, there are those who argue that the field, as it developed in the public sphere in the United States, effectively excluded religious voices. As the field of bioethics came of age in the 1960s, secularism reached its peak as a social movement in the United States. In his essay "Religion, Theology, Church, and Bioethics," Martin Marty argues that this marginalization was grounded in "liberal culture" and "late Enlightenment rationality."[19]

This intellectual movement set up a dichotomy between reason and faith, secular and religious realms of existence. The secular, scientific, public realm was understood as grounded in the rational and universal. Good academic judgments were said to be grounded in empirical evidence and confirmable by any person who has the ability to reason. On the other hand, religion and the private realm were based on faith, on the emotional and the irrational. Stephen Lammers argues that the marginalization of religion occurred within bioethics. He names three specific realms of discourse where bioethics strove to overcome various fractious and lethal religious divisions: the academy, public policy, and the clinical setting.[20]

In this environment, there was neither room nor a perceived need for the particular voice of religion in academic bioethical discussions. An examination of the table of contents of standard bioethics textbooks, such as Beauchamp and Childress's *Principles of Biomedical Ethics,* Shannon's *Introduction to Bioethics,* and Mappes and DeGrazia's *Biomedical Ethics,* seems to support this notion. Although some of the writers of these texts were theologians, one finds *no direct* mention of religion.

Another example of this shift away from religion is evident in Callahan's portrayal of his own adjustment in orientation. Throughout much of the 1960s, he describes himself as a "religious person" who "had no trouble bringing that [religious] perspective to bear on the newly emergent issues of bioethics." By the end of the 1960s his religiosity had declined and all but disappeared. His academic training as an analytic philosopher convinced him that "moral philosophy, with its historical dedication to finding a rational foundation for ethics, was well suited to biomedical ethics." Since religion had become unnecessary in his personal life, Callahan questioned its relevance to bioethics and the "collective moral life."[21]

With the emphasis on secularism and the rise of religious pluralism, many shared Callahan's attitude and argued that ethical and moral discussions in the academic public square ought not to include God or religion. According to this argument, pluralism precludes the possibility of there being "any infallible way" of concluding debates where a single religious system is the clear winner. According to many, morality must be based on observed consequences, not beliefs or superstitions; if an action is wrong, it is wrong because it harms someone or violates their rights. Richard Holloway maintains that religious

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language, calling up the authority of God, is problematic, even worthless, in moral debates. Human reason, not "divinely clinching arguments," should provide the grounds for our discussions. Holloway believes that one can construct a rational, neutral, and universally acceptable morality. He and other scholars acknowledge that while, at the beginning of the modern revival of bioethics, religion may have played a formative role, its influence has rapidly declined and philosophical categories "more acceptable to the majority of persons" became prominent.[22]

There are various analyses that support the argument that religious voices have been marginalized in the public sphere and particularly in bioethical discussions. A standard work discussing the notion that religion was marginalized in the public arena is Stephen L. Carter's *The Culture of Disbelief: How American Law and Politics Trivialize Religious Devotion.* Carter does not specifically address the issue of marginalization in bioethics; nonetheless, his comments are applicable to our discussion. According to Carter, though millions of individual North Americans in the United States take their religious commitments very seriously, the culture in which they live does not. He describes the many ways modern culture in the United States trivializes religious devotion and often discourages religion as a serious activity.[23]

Cahill and others demonstrate how, as a result of the secularization of this society, even when religious communities choose to enter academic and public policy discussions, the conditions under which they participate in effect marginalizes them. They argue that religious discourse in bioethics is limited because, when in the public square, religions are required to utilize a "public language," as opposed to the religious language of their particular communities. Religious scholars started operating more like philosophers, attempting to rely more on moral principles that they felt could plausibly claim to be universal, rational, and "secular." Additionally, they worked toward developing policy and decision-making resolutions that would coincide with the legal traditions of the United States and command public support. This hindered and distorted the religious message, thereby marginalizing it.[24]

In addition to the milieu of secularism and pluralism, Callahan and others argue that there are issues internal to the religious traditions that contributed to their being marginalized in the academy, public policy, and clinical settings. Callahan suggests that during the 1970s, the theological seminaries and university departments of religion were drawn more to issues of urban poverty and race, and to questions of world peace in the nuclear age, not bioethics. Consequently, since these traditions were focused on other issues, religious voices faded in bioethics. Another internal contributing factor was attributed to confusion concerning the role of religion. According to this argument, leaders in some religious traditions could not decide if it was their responsibility to stand over against culture, transform it, or speak for it.

Thus, scholars have argued that because of religion's own uncertainty, the influence of the secular movement, the pluralistic character of the day, and

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the way in which the field itself was moving, religious voices were marginalized in academic bioethical discussions. Furthermore, as bioethical arguments entered more into public awareness, interests commanding the attention of the courts, legal system, medical professions, and other professional societies, there was increased pressure to utilize secular language and models to frame and discuss the issues. Callahan points to the 1975 case of Karen Ann Quinlan as an indication that the secular legal system would take the lead in bioethics. Henceforth, the cases in this field would provide the courts with challenging legal cases for which no precedents had been set.[25]

RELIGIOUS VOICES AND THE CLINICAL ARENA

Marty, Callahan, and others present convincing arguments indicating that religious voices have, at least to some extent, been marginalized within the academy and public policy arenas. Lammers acknowledges that this marginalization of religion in these realms has influenced the clinical setting. On the one hand, the emphasis on secularism influenced the dialogues within the practice of medicine. The language of the consumer market dominated, leading to an emphasis on autonomy and a market model of medicine. This new model addressed neither the limits of what medicine could do nor issues of human finitude. Furthermore, Lammers comments on how there seemed to be a decrease in the service orientation of the medical profession. On the other hand, he indicates that clinicians he worked with took the religious beliefs of their patients seriously. They also saw it as part of their job, as healers, to address their patients' religious commitments and concerns. To the extent that religious voices have been marginalized, healthcare providers, patients, and their families have lost a valuable resource for reflection and critical analysis.

However accurate the argument for the marginalization of religion may be in the academy, this is not the case for the clinical setting. Ultimately, in the midst of actual hospital experiences, where individuals are struggling with life and death issues, patients and clinicians alike find it difficult, if not impossible, to discuss their situations without reference to religious beliefs. While working as a registered nurse in labor and delivery, I had a patient who was pregnant after a third GIFT (gamete intra-fallopian transfer) attempt. After three zygotes were implanted in her uterus, the doctors offered to selectively reduce (abort) one of the developing embryos, thereby increasing the chances for a healthier birth of the remaining two fetuses and decreasing some of the risks associated with multiple gestational pregnancies. Even months later, as she retold her story to me, she was shaking her head in disbelief saying, "I couldn't do that. I couldn't let them kill one of my babies. God gave me these three precious gifts and I have to take care of them." She named each fetus, and as they developed one was diagnosed with anencephaly. She cried. Though she was well aware that "Joey," the anencephalic baby, "didn't have a brain" and

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would not live long after birth, she again refused the offer of selective reduction. She argued that God gave this baby life, however short, and she could not end it. Throughout the pregnancy, she continued to talk to and about all three of her babies as equals. When the triplets were born, she and her husband held Joey until he died.

For this patient and her family, constructing rational, universally acceptable responses to the issues and questions of assisted reproductive technology, abortion, and personhood were not foremost in their minds. On the one hand, she seemed to have no problem utilizing medical technology in order to conceive; moreover, she attributed its success to God. On the other hand, she refused to utilize this technology to selectively reduce one fetus, even if it might enhance her health and the health of the remaining fetuses, arguing that it would be going against God's plan. She was not concerned about this apparent inconsistency. Neither was she concerned about questions and definitions of personhood. Joey, as a developing fetus with anencephaly, did not have the potential to become an adult human being. He most likely was not self-aware and would die witin twenty-four hours of birth. He would never know his mother, yet she treated him and referred to him in the same manner as she did her other babies. Her religious beliefs not only guided her actions, they brought her comfort in the end.

Cahill eloquently identifies how and why religion is so inextricably related to bioethics and the clinical setting. She writes:

> Because they deal in the elemental human experiences of birth, life, death, and suffering, the biomedical arts provide an opening for larger questions of meaning and even of transcendence. Religious themes and imagery can be helpful in articulating these concerns and addressing them in an imaginative, provocative, and perhaps ultimately transformative way. Religious symbolism may be grounded in particular communities and their experiences of God and community, but perhaps it can also mediate a sensibility of transcendence and ultimacy that is achingly latent in the ethical conflicts, tragedies and triumphs that are unavoidable in biomedicine.

She continues, "[. . .] ethics opens onto the transcendence that human persons and communities encounter most fulfilling in the limit experiences of life, suffering, and death, and that compassionate and just solidarity in these experiences defines personal and social virtue in the medical context."[26] Though modern medical technology can assist us in healing, in bringing forth new life, and in extending life, it does not enable us to answer challenging questions such as: What does it mean to be human? When, if at all, does ensoulment occur? What is personhood? What happens when, or after, I die? The practice of medicine often intersects with our definitions and our understanding of what it means to be human. It brings to the forefront questions of mortality and meaning. These questions and issues are raised and are the focus of many religious discussions.

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For many clinicians, arguing that religious voices are marginalized is odd. Such attitudes do not coincide with the practical experiences of many patients and healthcare professionals who are *living* the bioethical dilemmas. Lammers writes:

> [. . .] the reality of finitude takes on an immediacy that can be hidden from us in other settings. Academicians and public policy persons can operate as if finitude were an illusion or a bother; nurses and physicians do not have that luxury.[27]

The practice of medicine often engages human experiences at moments of intense fear, joy, and unspeakable sorrow. In these moments, for many, religion is not some theoretical, abstract, academic concept. Religion is the space in which these individuals can both express their joys and struggle with the realities of suffering and death. It is the place people often turn to for meaning and sustenance. Religion is also a thread of connection, to tradition, to the past, to others, and to the future; it is often the thread of hope, and the thread that binds individuals together and helps them move forward in joy or sorrow.[28]

REEMERGENCE OF RELIGIOUS VOICES IN THE ACADEMY AND PUBLIC POLICY FORUMS

The influence of religion has remained a compelling force within the clinical setting, in part because patients and clinicians alike, engaged in the struggle of bioethical situations, call upon, address their concerns to, and find comfort in their various religious convictions. The continuance of religious voices in the clinical setting has perhaps in some way affected the academy. In the early 1990s, many of the same scholars who once argued for the marginalization of religion began acknowledging the cost of excluding religious voices and began reevaluating its contributions. Campbell states it well when he writes: "If it was premature to pronounce 'the death of God' in the 1960s, it seems equally mistaken to begin doing post-mortems on the demise of theological and religious perspectives in bioethics."[29]

As previously mentioned, Callahan, a philosopher who claims to have shed his unnecessary Christian identity, acknowledges that "whatever the ultimate truth status of religious perspectives, they have provided a way of looking at the world and understanding one's own life that has a fecundity and uniqueness not matched by philosophy, law, or political theory."[30] He goes on to question if unbelief and intellectual honesty demand a rejection of religious insights and perspectives, regardless of how valuable. Callahan's statements and questions most likely reflect influences from both enlightenment ideology and Christianity. They also reflect some remorse at his inability, or at least hesitancy, to utilize the resources of his religious tradition.

He and others identify a number of problems and limitations when religion is not included in bioethical discussions. First, in rejecting religion, one

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is closing one's eyes to and making unavailable all the accumulated wisdom and knowledge of long-established religious traditions. One need not be a Hindu, Jew, or Christian to benefit from the wisdom and experiences of others from the past. Eliminating religion often leads to an unwarranted dependence upon law as a source of morality. Legality is not equivalent to morality; an action may be legal but not necessarily moral or correct. Additionally, an emphasis on secularism can also be oppressive in that it can require individuals to pretend that their private lives and beliefs do not spill over into the public realm.

There are problems with an academic search for universal, neutral, and environmental influence-free solutions. Rather than providing satisfying, purely rational, universal answers, secularism forces individuals to pretend they are not simultaneously members of both particular communities and a general society at large. Wind correctly argues that individuals, be they policymakers, healthcare professionals, or patients, "do not park their beliefs at the bioethical door. Instead they smuggle them in—in plain wrappers—beneath the surface of much of our technical secular discourse."[31] Reich concurs when he argues that it is better and more beneficial if bioethics "were to acknowledge fully and integrate into its dialogues the voices of the people answering the questions, experiencing the suffering, living and dying."[32] The trend toward attempting to converse in universal, religious free language leads to an unnatural and unrepresentative situation, which widens the gap between those in the academic ivory towers and the patient and healthcare professional in the "trenches."[33] Here Reich and others are directly calling attention to the events occurring within the clinical setting and arguing that the voices heard there ought to be included within the discussion. So often the voices of patients and clinicians are interlaced with their religious convictions.

While the academic emphasis on marginalizing religious voices may have been influential in the public arena for a time, it appears that time has passed. Again, perhaps in part because of the influence of the experiences of those in the clinical setting, religious voices are present and are very influential in public discussions on bioethical issues. Of the many religious voices heard in the public sphere, we focus on Hinduism. However, to clearly demonstrate how perspectives grounded in Hindu traditions can have radically different implications, we will juxtapose our Hindu perspectives with those of the Roman Catholic Church. The primary reason for choosing to focus on the voices within the Catholic Church is that its position of power and influence is unmatched, both in the United States and internationally. Its authority and control extends far beyond its own members. The teachings of the Magisterium are heard and shape discussions in the halls of Congress, the White House, around the country, and around the world. Second, though the Catholic Church is not monolithic, the Vatican does set forth an official, authoritative teaching, particularly concerning reproductive issues. This provides good points of comparison, particularly when we examine elements of Hindu traditions.

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The Vatican is the only religious group that has an observer status at the United Nations. Because of its independent state status conceded by the Lateran Pacts of 1929, it is granted this privilege and thus has a voice in the UN. There are many examples of the Church's international influence. From the first international meetings regarding world population, beginning in the 1950s, the Vatican's firm opposition to contraception and abortion put it at odds with a majority of international development and population organizations. The voice of the Vatican was heard louder than ever before at the 1994 International Conference on Population and Development held in Cairo. The Church's objections to the wording in the conference documents delayed the entire conference for over four days.[34]

A domestic example of the influence of the Catholic Church is evident in how the American Fertility Society, a professional medical organization, went about developing its perspectives on the new reproductive technologies. In 1986, in its professional journal, *Fertility and Sterility,* the 1984–85 Ethics Committee of the American Fertility Society published "Ethical Considerations of New Reproductive Technologies." This document set forth the Society's then-held ethical positions on a variety of new assisted reproductive technologies.[35] Soon after the publication of this Committee's deliberations, the Vatican's Congregation for the Doctrine of the Faith published the *Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation* (hitherto referred to as the *Instruction*).[36] The *Instruction* did more than articulate the Roman Catholic Church's opposition to the utilization of assisted reproductive technologies. In its final section, under the title "The Values and Moral Obligations That Civil Legislation Must Respect and Sanction in this Matter," the Church calls for legislative intervention:

> When the state does not place its power at the service of the rights of each citizen, and in particular of the more vulnerable, the very foundations of a state based on law are undermined. The political authority consequently *cannot give approval* to the calling of human beings into existence through procedures which would expose them to those very grave risks [. . .]. Civil law *cannot grant approval* to techniques of artificial procreation, [. . .]. Legislation *must also prohibit* [. . .] embryo banks, post mortem insemination and "surrogate motherhood."[37]

The Vatican's call for the public, legislative prohibition of these technologies went beyond providing moral instructions for its congregants. The Church urged political leaders to take legislative action to disallow the availability of various assisted reproductive technologies.

The Vatican's *Instruction* prompted the 1986–87 American Fertility Society's Ethics Committee to reconvene. After reviewing the *Instruction,* the Committee located a number of differences and reevaluated and reasserted their positions on a variety of issues. Following the Society's Board of Directors approval, these proceedings resulted in a publication of a second report in 1988.

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The foreword to this document acknowledges the publication of the *Instruction* and reads as follows: "Because of the conflicting conclusion of the two documents, the present Ethics Committee (1986–87) of The American Fertility Society was convened and considered the Fertility Society guidelines in the light of the *Instruction.*"[38] Though the Committee did not actually change its position regarding the utilization of assisted reproductive technologies, the Committee did restate its positions in light of the issues raised by the Vatican. The Committee also responded to the arguments and reasoning of the Church.

The influence of Roman Catholicism continues. The ethical discussions over stem cell research and cloning demonstrate the continuing importance of religion in the public debate. In mid-July 2001, *Los Angeles Times* headlines read: "Pope Urges Bush to Reject Human Embryo Cell Research,"[39] "Bible Guides Senate on Stem Cell Studies,"[40] "Religion Divided on Stem Cell Issue."[41] *Newsweek* ran a story titled, "Battle for Bush's Soul." The lead line states: "The president is trapped between religion and science over stem cells. Lives—and votes—are at stake."[42] In a meeting between Pope John Paul II and President Bush, the Pope declared that the utilization of "human embryos for medical research is an 'evil' akin to abortion and infanticide." Bush responded by promising to "take that point of view into consideration" as he deliberated over the issue of federal funding for embryonic stem cell research.[43]

The role and influence of religion in the development and continuation of the field of bioethics is well established. With increased globalization and multiculturalism, the challenge facing contemporary discussions within bioethics is how to productively include the multitude of religious voices.

RELIGIOUS DIVERSITY

According to Margaret Farley, individual experience "plays an important role in moral discernment. It [individual experience] is a source of moral insight, a factor in moral judgment, a test of the rightness, goodness, and wisdom of a moral decision." Regarding the significance of the role of experience, she continues by saying: "It is central for finding and establishing an overall framework for moral discernment; it is important for formulating and applying general ethical principles and specific ethical rules; and it plays a key role in developing theories of moral disposition."[44] Globalization, pluralism, and multiculturalism all increase, not negate, the need for all to pay closer attention to the cultural and religious perspectives and experiences of patients, families, and healthcare providers.

Over the past decade, religious voices have experienced a resurgence in the academy's bioethical discussions. Prominent bioethical textbooks contain the undercurrents of religious influences. Now there are entire texts that take up the issues of various religious perspectives and bioethics. Wolfe and Gudorf's *Ethics & World Religions: Cross-Cultural Case Studies* (1999), focuses on various religious perspectives on a variety of ethical issues. Part V of this book is titled

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"Religion, Medicine, and Public Health." Each chapter of Wolfe and Gudorf's book begins with a particular case study, which is followed by essays providing various world religions' views on the case and the issues that arise.[45]

Hindu Ethics (1989) by Coward, Lipner, and Young contains three chapters presenting Hindu views on purity, abortion, and euthanasia. Crawford's *Dilemmas of Life and Death* (1995) discusses Hindu ethics regarding abortion, suicide, and euthanasia, and his *Hindu Bioethics for the Twenty-first Century* (2003) addresses specific issues such as cloning and the Human Genome Project. Keown commits an entire book to *Buddhism and Bioethics* (2001). Dorff and Newman's *Contemporary Jewish Ethics and Morality: A Reader* (1995), contains two chapters specifically related to bioethics. *Sacred Choices* by Daniel C. Maguire (2001), focuses on contraception and abortion in ten world religions. Though this list is far from exhaustive, it is sufficient to indicate how current books are explicitly focusing on a multitude of religious voices in the field of bioethics. These books provide examples of religious voices in the public sphere and in the academy.

As a result of the increase in globalization, multiculturalism, and pluralism, the once dominant religious voices, particularly ones influenced by Christianity, are no longer the only religious voices present.[46] By expanding bioethical discussions to include "nonwestern" religions in the United States, we enhance our understanding of the issues. More importantly, we engage, not leave behind, the ivory towers of theory and philosophy with the actual struggles, questions, and concerns of those confronting genuine bioethical situations. For patients and healthcare providers, discussions and answers regarding bioethical issues are the grounds upon which concrete actions are taken. These discussions lead to decisions regarding birth, the quality of life, and death.

CULTURAL COMPETENCY

Cultural, religious, and social traditions reveal and celebrate the uniqueness of each individual person, her family and community. As indicated above, the practice of medicine engages human beings in the ordinary events of giving birth, living, suffering, dying, and of caring for those giving birth, living, suffering, or dying. It is in the midst of these ordinary events that worldviews and religious beliefs surface and have a strong hold. Consequently, the growing multicultural, multireligious aspects of society have not gone unnoticed by U.S. governmental agencies responsible for health concerns.

In the 1980s, the U.S. Department of Health and Human Services established the Office of Minority Health (OMH). This office operated under the conviction that the administration of quality healthcare was dependent upon the abilities of medical personal to understand how their own and their patients' religious, sociocultural, and economic backgrounds affect beliefs and behaviors regarding health. Recognizing the increasing diversity of the patient populations and the necessities of addressing the resulting cultural, religious, and

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social issues, the OMH, along with other medical associations such as American Nurses' Association (ANA), American Medical Association (AMA), and Association of American Medical Colleges, called for national standards of "Cultural Competency."[47]

According to the OMH, cultural competency is defined as:

> Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.[48]

A briefer definition indicates that competent care is "providing care to patients and their families that is compatible with their values and the traditions of their faiths. This requires awareness of one's own values and those of the healthcare system."[49] In her article "Cultural Competence: A Priority for Performance Improvement Action," Salimbene discusses ten basic components of cultural competency. They are:

1. An awareness of, sensitivity to, and tolerance of differences in culture and language;
2. An ability to refrain from making assumptions (or judgments) about the beliefs, behaviors, needs, and expectations of patients or colleagues of a different cultural background from oneself;
3. An understanding of the role culture plays in formatting the health/illness prevention beliefs and practices of patients;
4. The ability to recognize the role that one's own culture and background plays in determining one's attitudes and beliefs not only about health and wellness but also beliefs about such things as what constitutes acceptable behavior, cleanliness, a healthy lifestyle, the roles of family and friends, and so forth;
5. Enough knowledge about the cultures that one serves to avoid breaching the patient's taboos, healthcare beliefs, or rules of interaction;
6. Enough knowledge about the cultures that one serves to anticipate possible barriers to access to or compliance with care;
7. The skill to deliver culturally and linguistically appropriate patient advice and education;
8. The skill to utilize interpreters effectively so that language barriers do not impact the extent or quality of care;

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9. The knowledge and flexibility to modify both one's mode of interaction and one's manner of delivering care so that it is culturally and linguistically appropriate to the patient while it meets the hospital's or clinic's standards of quality patient care; and
10. Confidence in one's ability to offer quality care to patients of other cultures.[50]

This is a recognition that patients' worldviews as well as their religious and cultural beliefs influence, and are tightly interwoven with, their attitudes towards health and medical care. Thus, to ensure delivery of the best healthcare possible, those engaged in the medical professions need not only be well trained in order to provide safe and effective care, they also need to be aware of and sensitive to the various populations their institutions serve.[51]

Having the knowledge and understanding of various cultural and religious influences, a healthcare provider can be sensitive to the particular needs of a patient; she may avert conflicts and be prepared to facilitate the delivery of timely quality care. Conversely, if ignored in the context of health and medicine, religious and cultural issues can be barriers to the promotion and implementation of good competent healthcare. Unfortunate and even horrific events have occurred because healthcare providers have failed to hear the concerns of their patients and have failed to consider the impact of the patients' culture and religion on their interpretations of what is occurring. Anne Fadiman's book, *The Spirit Catches You and You Fall Down,* documents the story of Lia Lee, an epileptic Hmong infant, and the unfortunate events that occurred between the medically competent but culturally incompetent healthcare providers and the Lee family.

At three months, Lia experienced her first seizure after someone entered the room allowing the door to slam. Her parents recognized her symptoms and diagnosed their youngest child with *quag dab peg,* "Spirit catches you and you fall down." In Hmong-English dictionaries *quag dab peg* is translated as "epilepsy." According to her parents, the noise of the slamming door disturbed her soul, caused it to flee from her body and become lost. In the above phrase, the *dab* is a soul-stealing spirit. They understood both the seriousness of her condition for her health, and at the same time they recognized it as a sign of one who is particularly fit for divine office: many epileptics become shamans. Lia's parents were simultaneously proud and concerned; without a physician's diagnosis, they knew she had epilepsy. The problem was that they were not aware of the English term "epilepsy," and their healthcare providers did not know that "Spirit catches you and you fall down" was the Hmong way of describing epilepsy.[52]

By not hearing and understanding the Lee family's cultural and religious interpretations of Lia's condition, the emergency room doctors did not have the full picture of her illness. Consequently, on two consecutive emergency room visits they misdiagnosed her and subjected her to a variety of invasive

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tests. Six months later, during her third emergency room visit, Dr. Murphy correctly diagnosed Lia and began the necessary treatments. Unfortunately, the healthcare professionals involved in the first two visits were unable to provide competent care because they lacked an ability to communicate adequately and to understand the religious and cultural explanations of Lia's symptoms.[53]

The emergency room doctors and nurses were frustrated when Lia's parents were "not compliant" with their prescribed treatments. However, these medical personnel sent the parents home with written instructions that they could not read. Competent care includes ensuring one is communicating with the patient and family members. It is disingenuous to accuse a patient of noncompliance when little effort is made to ensure that the patient actually understands the instructions. Unfortunately, these types of misunderstandings are not unique to immigrant communities.

There are countless examples where communication, or lack thereof, determines the competence or incompetence of care. A young six- or seven-year-old patient of mine had to be rescheduled for a head MRI because of his inability to lay still enough during the procedure. The plan was to conduct the procedure under conscious sedation, a light anesthetic, so the patient would be able to relax and sleep through the claustrophobic experience. While I was out of the room, the neurosurgery resident explained the plan to the patient and his mother. When it came time to take my young patient to his procedure, he began, uncharacteristically, to cry and resist. His mother and I tried to console him, but he was literally beside himself and would not allow himself to be removed from his bed. The resident requested assistance and at one point the boy was fighting off four male adults. I stopped everything, went to the head of the bed, looked at the boy, and quietly asked him what the problem was. With eyes full of fear and disbelief, he look at his mother and said, "How can you let them take me; he [the resident] said they were going to put me to sleep." He knew dogs and cats were put to sleep and did not return home.

Communication and misunderstandings can also be at the root of issues causing "noncompliance" on the part of the patient. While working as a home-care nurse in rural Virginia, I was assigned to an elderly "noncompliant" patient, one who refuses to take his medications. Upon arrival at his home, I sat down with the patient and reviewed the various medications he was taking. I carefully explained how I was going to fill a large pillbox, one with four time slots for each day of the week, with the appropriate medications for the appropriate time of day. As we discussed what each medication was for, he continued to express concern and resistance to taking his medications. After reviewing his medications with him for a second and third time, two and a half hours later, the patient's underlying concerns became apparent as he blurted out: "I don't wanna die!" He had been hospitalized because he had taken the wrong dose of a medication. His fear of repeating the same mistake was preventing him from realizing that the method we were employing would help him avoid the same mistake. I looked at him and in my best, newly acquired, southern accent, I

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responded: "Honey, you ain't gonna die, you only gotta remember about what time of day it is." The familiar accent and my words finally put his fears at ease and he expressed understanding for the first time.

All three of these examples, Lia, the young boy, and the elderly gentleman, highlight the importance of hearing and understanding the particular situation. Obviously misunderstandings are not exclusive to cross-cultural, cross-religious situations; many argue that "culturally competent care" is somewhat of a misnomer. Canales and Bowers, in their study of Latina nursing faculty, found that "culturally competent care" was not a salient element for their participants. However, what was "salient for these participants was the perception that *competent care includes cultural competence.*" According to this study, competent care requires that:

> the healthcare professional care for those perceived as different from self; that they learn to care as connected members of a community and the larger society; and that [. . .] [they] care with a commitment towards changing existing social, health and economic structures that are exclusionary."[54]

Competent care indeed encompasses culturally competent care. Healthcare providers need to have the ability to hear, understand, and address the variety of patients that come before them. Particular religious or cultural traditions will be heard, if the doctor, nurse, or other medical personal are adept at hearing the voices of their patients.

Providing quality medical care necessitates cultural competency. Though actual knowledge regarding various cultures is important, comprehensive knowledge of all of the religious and cultural forces influencing individuals is impractical, even impossible, and ought to be neither the primary goal nor focus of cultural competency. Rather, the ultimate goal is to encourage already clinically competent physicians, nurses, and other healthcare providers to be open and willing to learn about, respect, and work with persons from different backgrounds. Being able to recognize and work within and between different cultural and religious perspectives is imperative for clinical care to be competent in this century.[55] To this end, Canales, Bowers, Carrillo, Green, Betancourt, and others caution against categorizing and stereotyping patients.[56] Rather than developing "recipes" for healthcare professionals to follow when treating patients of various ethnic backgrounds, they propose an individual patient approach.

Appearing "different" does not necessarily imply one *is* different. Conversely, similarities in appearance do not necessarily reveal similarities in perspectives or worldviews. One cannot know, simply by looking at an individual, where he was born or raised. After meeting me, people have remarked on how well I speak English. They took note of me, assumed I was "foreign," and were surprised to hear me speak in unaccented, comprehendible English. The patient may look Asian, but having been raised in Iowa, she may have more in common with Caucasian Iowans than Asians from Laos or Los Angeles. The nurse,

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physician, and others need to engage the patient and "learn-through-connecting" with them; learn through listening. Each patient's situation is unique, influenced by personal background, culture, and religion. Thus, by interacting directly and discovering the core issues for that particular patient, healthcare providers can avoid cultural pitfalls and competently treat the individual.

Competent healthcare professionals will acknowledge that religious ideology may play a role in how patients interpret their illness and treatment. The United States is not only home to many of the religions that exist in the world, it is also home to the diverse expressions of these religious traditions.[57] In this multicultural pluralistic context, giving heed to religious voices demands an ability to hear a myriad of tones. Not only are there individuals who were raised in Catholic and Protestant homes, or Orthodox and Reform Jewish families, there are those from Buddhist, Hindu, Jain, and Muslim families. Each of these religious traditions have different denominations and different generations speaking from within them. Furthermore, there are the voices of those who come from a combination of any one or more of the above.

Again, Canales and others argue that, ultimately, there is no distinction between competent care and culturally competent care. Competence necessarily includes cultural competence. Beyond sensitivity and cultural knowledge, the healthcare providers need practical strategies for communicating with patients and individualizing care so that it is appropriate for each patient.[58] The focus here lies with the individual patient's worldviews, his or her hopes, fears, and understanding of life, suffering, and death. The process of actually engaging worldviews other than one's own has the potential to be both threatening and therapeutic. It can be threatening because the healthcare professional's original presuppositions may be challenged, and therapeutic because once the individual gains a better understanding of how the patient is viewing and experiencing the situation, the healthcare provider may be better able to address the fears and concerns of the patient. This understanding can lead to a dialogue and competent care. Thus, successful cross-cultural care, competent care, involves a triad of attributes: empathy, curiosity, and respect.

COMPLEXITY OF HINDU VOICES

Having discussed the influence of religion in the practice of medicine and bioethics, and having emphasized the need for and importance of cultural competency, let us now focus our attention on one particular world religion, namely Hinduism. Hindus constitute a population in the U.S. of nearly one million people, in addition to the over eight hundred million Hindus who live in India and elsewhere. The editors of the *Journal of the American Academy of Religion* (*JAAR*) dedicated the December 2000 issue to the question, "who speaks for Hinduism?" This is inherently a difficult and controversial question to answer, though not unique to Hinduism. The articles in this *JAAR* present an array of arguments representing various voices from within and without the tradition,

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from "confessional" and "objective" perspectives, from both Indian and North American scholars, and from different "native" voices. Together the essays emphasize the importance of listening to and engaging in the wide variety of voices present within Hinduism.

In his essay "On Hindu, Hindustān, Hinduism and Hindutva," Arvind Sharma discusses the origin and complexity associated with the term itself. In antiquity, "Hindu" was both a geographical and religious indicator. The term is derived from the Sanskrit term for river, *sindhu,* and gets applied to the Indus river; a river that served as a natural northwest boundary for the subcontinent. Sharma concludes that "Hindu," and derivatives of it, "contain a series of semantic bivalences characterized by unresolved tensions, and further that these tensions help account for the complexities generated by the induction of the world." The word, like the traditions, reveals fluid boundaries between various categories and internal diversity among official, unofficial, orthodox, and popular expressions of Hinduism, such that it defies simple, unequivocal characterization.[59]

Lipner likens Hinduism to a huge "banyan tree that has lost every trace of the original trunk." From the branches of this tree cascade huge aerial roots; they burrow into the earth below and appear as if each were a separate banyan trunk. Lipner's metaphor of the widespread, interlinked tree captures the diversity and multifaceted nature of Hindu traditions. The tree of Hinduism encompasses tribal people, with vastly different belief systems, and orthodox brahminical traditions, preserved in the *Laws of Manu,* the *Mahābhārata,* and other texts.[60] As there is not one trunk, one source, or one foundation for these traditions, so there is not one voice. The complex, polycentric center allows for a multitude of voices to emerge from within the traditions of Hinduism.

According to Radhakrishnan, Hinduism is a conglomeration of movements, not a position; processes, not a result; growing traditions, not a fixed revelation.[61] The traditions themselves do not acknowledge a single authoritative body or voice; they celebrate diversity. According to a passage in the *Mahābhārata,* "The Vedas are varied and the traditions are varied: one is not a sage if his view is not varied."[62] According to Hindu traditions, having the ability to hold a variety of perspectives is a sign of a sage! Consequently, when examining a particular Hindu view, one should always bear in mind that another legitimate, even conflicting, "Hindu" perspective is around the corner. It is true that many Hindus are not bothered by this pluralism. Rather, for a Hindu "it was no less provocative of anxiety to be asked to choose between two incompatible alternatives than it is for us ["Westerners"] to tolerate our own inconsistency."[63]

A defining characteristic of traditions within Hinduism is their multivalent natures. Inevitably, when Hinduism, or Hindu views, are being discussed, one often encounters expressions such as: "Some Hindus believe . . .," "the common people describe these things . . ., the educated Hindus do not share these opinions," "some Hindus say . . ., others have told me . . . ."[64] When asked how

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Hindus might respond to a particular question or issue, my responses usually begin with, "It depends . . ."

In conjunction with not having clear "doctrinal" boundaries and definitions, Hindu daily life is not separated from religious life. While this may lead some, such as John Stratton Hawley, to argue that "Hinduism is not a religion; it is a way of life,"[65] it leads others, such as Radhakrishnan, to say: "Religion is not the acceptance of academic abstractions or the celebration of ceremonies, but a kind of life or experience. It is insight into the nature of reality [. . .], or experience of reality."[66] The daily practice of eating provides a perfect example of this. For many within Hinduism, eating is an activity highly regulated by the religion. The food actually eaten, who cooks it, when and with whom it is eaten are all a part of Hindu ritual activity. Desai also points out how many activities that fall under the category of "hygiene" are often religious for many Hindus.[67]

For many Hindus, religion, philosophy, and the conduct of daily life are all tightly interwoven. There is no formal discipline that presents "an internally consistent rational system in which patterns of human conduct are justified with reference to ultimate norms and values."[68] Nevertheless, this does not mean that Hindus do not know about ethics or that they are immoral. It simply indicates that there is neither a discipline within Indian thought that separates ethics from the activities of daily life nor one that focuses exclusively on it.[69] It is within these mercurial, pluralistic, symbiotic[70] Hindu traditions that we find strands of thought that will benefit contemporary North American conversations regarding assisted reproductive technology. This study engages in an examination of how key elements of Hindu thought might relate, frame, and deal with aspects of bioethics, particularly assisted reproductive medical care.

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