EPH - International Journal of Medical and Health Science

ISSN (Online): 2456-6063
Volume 05 Issue 01 January 2019

DOI: https://doi.org/10.53555/eijmhs.v5i2.73

RELIGIOUS CONSIDERATIONS AS AN INTEGRAL PART IN MEDICAL DECISION-MAKING

Saleh Alnahdi, PhD[1*]

*[*1]Head of Healthcare Services and Hospital Management Department College of Business, University of Jeddah, Saudi Arabia Asfan Road 285, P.O. Box: 42801, Jeddah 21551*

Corresponding Author:-
Mob. + 966 (0) 500856136

Abstract:-

As a Muslim, I have a certain belief system that encompasses all of life, including my approach to medical ethics. My belief system is distinctive, as are others. Thus, the approaches of Judaism and Roman Catholicism offer a new perspective on medical ethics. The thesis of this paper is that religious considerations play a large and integral part in medical decision-making. The topics to be discussed include shared values; methodology, along with the related concepts of metaethics and the principle of double effect; and applications of these perspectives in medical ethics, particularly with regard to healthcare decisions involving the end of life. Each area will be explored in this paper in order to give insight into how these religious approaches came to be what they are today and how they present positions in medical ethics which may be at odds with other perspectives not based on any theological doctrines. Specifically, this paper discusses shared values, by referring to human dignity and its concepts, as well as theological principles in health care ethics, and definitions of these principles. In addition, the paper discusses the methodology in Roman Catholicism, in addition to explaining the meaning of natural law. Furthermore, the discussion focuses on metaethics and its theories, as well as a consideration of the principles of double effect (PDE) and its four conditions. Lastly, the discussion considers applications of theologically based medical ethics to the question of forgoing treatment and what are the pillars of ethics with regard to this issue.

Keywords: *Religious, medical decision-making,*

1 Shared Values

Roman Catholicism and Judaism have shared principles and differences as well. Some points that the two share are on the level of general values. Jewish approaches are depended on tradition, especially *halakhah*, which means the path or way and denotes Jewish law. On the other hand, Catholic approaches are based on tradition and natural law. Both believe in the narrative of Creation, as well as God and humanity.[1] their common precepts include human dignity that leads them to have similar principles in health care ethics.

1.1. Human Dignity

Ethics in Catholic moral theology depend on *anthropology,* which attempts to understand who human beings are. Moreover, Catholic theology explains the meaning of the dignity of the human person from two theological bases: creation and redemption.[2] According to Schillebeeckx, *Christology* maintains that God wills things into existence. Contemporary theologians depend on the tradition of Catholic theology and the development of modern philosophy as the means of understanding the meaning of human life as God intends it.[3] Central to the message of Christianity is human dignity, which can be seen in God's human incarnation, Jesus. In addition, the concept of human dignity in Christian theology refers to an alien dignity, which means that people are not inherently special, rather that God either allows or disallows it.[4] Furthermore, the notion of alien dignity suggests one's worth comes from God, not as it may be assessed by other humans. From the concept of human dignity, Christian theology has developed to include many themes such as, the human being is created in the image of God, chosen by God, ordered to God in grace, and alienated from God by sin.[5]

1.1.1. The Concepts of Human Dignity

The human person considers men and women, which are the top of God's creation. Both Jews and Christians believe in the first human as a perfect being, nearly divine. The first theme is that people are made in the image of God. According to David F. Kelly, the Hebrew words *selem* and *Demuth* means image and likeness. The first word would seem to suggest that people look just like God, while the second word corrects any misconception; therefore, together they describe humans as being nearly divine. The second theme is that the human person is chosen by God, implying that God created each human being with a chosen destiny. According to Christian theology, the human person is special, because he or she begins life expecting to develop into something more than he or she already is.[6] the third theme is that the human person is ordered to God by grace. Grace determines the dignity of people, though it cannot be accurately assessed. This state of affairs is because grace may be beyond the limits of human comprehension and seem mysterious as such. Furthermore, its mysterious nature comes not only from it supernatural status, but also because it is human, making it that much more complex.[7] the fourth theme is that the human person is alienated from God by sin. In other words, God wanted us to be supernatural, but sin put that plan in jeopardy. Thus, the fulfillment of God's plan becomes in doubt, but ultimately is not destroyed.[8]

2. Theological Principles in Health Care Ethics

Catholic medical ethics developed prior to the 1960s as a specified set of principles that helped people by providing simple answers to the plethora of medical issues facing health care providers and patients at the time. This system of ethics came through as cause and effect were how many diagnoses came to fruition, as levied by the Catholic medical ethics. Each act of providing medical care was analyzed in and of itself, being subcategorized into a number of causal relationships, and ultimately the evaluation of the act as a whole served as the fundamental determiner by which Catholic moralists judged that action's rightness or wrongness. The final judgment usually depended on the analysis of the physical biological properties of the act itself. Two theological principles dominate the Roman Catholic perspective of health care ethics, namely the principle of divine sovereignty over life and the principle of redemptive suffering.[9]

2.1. Divine Sovereignty and Redemptive Suffering

Divine sovereignty and redemptive suffering play integral parts in this approach to healthcare and healthcare ethics as being based upon the relationship between human beings and their presumed Creator.[10] More than that, these two aspects also bring to light all other possible relationships the creature has with the Creator. These concepts function, not as rules for healthcare, but as a way of understanding the meaning of human life.[11] From this perspective, some scientist and ethicists, unfortunately, fail to consider the dignity of humanity and human life as inherent coming from God as part of His act of creation. Therefore, these scientists and ethicists may be prone to seeing humans as experimental fodder, open to any kind of operation or augmentation, which encourages the notion that anything can be fixed with the right decision making.[12] Those who hold such views feel that theology has no role in providing specific answer as to morality and appropriateness of medical practices and procedures, a view that is significantly at odds with the answer usually given concerning the function of theology in relation to bioethics.[13]

3. Methodology

Roman Catholicism and Judaism both believe that caring for a dying patient involves many considerations, and that prominent among these is being supportive of many theological aspects and values, especially in terms of respect for God's sovereignty.[14] What is less agreed upon is ethical practice in situations in which the implications of these values are unclear or even appear

to point in contradictory directions. A typical question would be whether forgoing a given life sustaining treatment would constitute an infringement on divine sovereignty, or continuing to prolong life artificially in actuality represent the path of infringement.[15] The next section will discuss the methodology of Roman Catholicism, in relation to metaethics and the principles of double effect.

3.1. Methodology in Roman Catholicism

Roman Catholic morality concerns actions, norms, and virtues appropriate to this faith. Moral theology can be called the attempt to answer the question: How should humans, as endowed by God, live. Traditionally, moral theology relies on moral knowledge from various sources to address this question, including Scripture, tradition, reason and experience, and the authority of church teaching, Roman Catholic ethics are often seen appealing to human reasons and experience, usually through natural law, defined by Thomas Aquinas as "the sharing in the Eternal law by intelligent creatures."[16] According to Thomas, all parts of God's creation are given proper ends or purposes; to fulfill them is to flourish, in the divinely prescribed order.

3.2. Natural Law

There are two definitions of natural law used in relation to medical ethics: First, is a theory that answers metaethical questions by asserting that moral judgments can be verified. Second, is a normative approach in which natural law leads to some acts being in accord with nature while others go against it. This approach rests on the assumption that there exists an identifiable nature of the human condition.[17] each of these definitions has its own historical development. The metaethical meaning was proposed by Aristotle, and later Thomas Aquinas. The other, normative meaning was espoused by Ulpian, a third- century Roman jurist. This latter meaning of nature law has been called *physicalism*, implying that it places more importance in the physical properties of actions than in all other aspects.[18] In the 1960s, Catholic moralists shifted focus from the physical or biological properties, physicalism, to *personalism.* Contrary to physicalism, personalism places emphasis on the personal aspects of the act, rather than its physicality.[19]

4. Metaethics

According to David Kelly, *Metaethics* means beyond ethics and refers to the way meaning is developed in ethics and how knowledge is accumulated, as well as existential questions about ethics.[20] Metaethics has developed comparatively recently out of the analytic school of modern philosophy. The radical, reductionist elements in that school see the sole role of philosophy as nothing more than the analysis of statements. Thus, metaethics would merely analyze ethical statements. Furthermore, the use of this approach is extended to evaluate analytic questions not explicitly epistemological. Beauchamp and Childress describe metaethics as extending its analysis to language, concepts, and methods of reasoning. Metaethics encompasses three theories: *Noncognitivism or Emotivism, Metaethical (or Ethical) Relativism, and Meta-ethical Absolutist Positions.*

4.1. Metaethical Theories

The first type of metaethical theory, *noncognitivism or emotivism*, is exemplified by the position that when someone says that euthanasia is wrong, the statement is considered meaningless since it contains nothing verifiable, merely an emotional statement. Therefore, *noncognitivism* is often called *emotivism.* According to David Kelly, the ethical judgments are only emotional reactions that people have. The second type of theory is *metaethical (or ethical) relativism,* in which statements should always be given a metaethical meaning. For example, the above example statement has the meaning that the society of the speaker thinks euthanasia is wrong. There are two subtypes of ethical relativism: individual and social.[21] The third type of theory is *metaethical absolutist positions,* in which ethical judgments have meaning and such meanings can be verified. According to Veatch's typology there are four kinds of metaethical absolutists: *supernatural absolutists, intuitional absolutists, rational absolutists, and empirical absolutists.*[22]

5. The Principle of Double Effect (PDE)

The primary operational principle in Catholic medical ethics emerging from Vatican II was the principle of double effect (PDE), which endeavors to provide guidance for situations in which an action has multiple consequences some of which are desirable on religious and humanitarian grounds creating a duty to be pursued while others are harmful by the same standards and must be eschewed. The principle of double effect (PDE) prescribes that an action causing both good and evil effects must be evaluated according to four conditions: (1) The act must not be inherently morally wrong; (2) the bad effect must not itself cause the good effect; (3) the agent must not intend any negative results; and (4) the negative effects must not outweigh the positive.[23]

5.1. The Four Conditions of the Principle of Double Effect

The principle of double effect (PDE) asserts that an action with both good and bad effects is morally acceptable if and only if all four conditions are met. First, *the act in itself must not be morally wrong*. The PDE is asking whether or not an action with both good and bad effects is itself right or wrong. For example, if a married couple has been unable to give birth to a child, they may go to a physician. The physician may need to obtain the man's sperm sample to check his fertility level, and the best

way to do so is for the man to masturbate. As masturbation is considered one of the evil acts, it is forbidden by Catholic medical ethics. Therefore, the act is considered regardless of the desirability of the consequences or good to be derived.[24] second, *the bad effect must not cause the good effect.* According to David Kelly, a pact with good and bad effects may unfold in three potential ways: (1) the act might cause the good effect, which then in turn causes the bad effect; (2) the act might cause the good effect and the bad effect each independent of the other; or (3) the act might initially cause the bad effect, which then in turn causes the good effect.[25] In this last scenario, the principle of double effect prohibits the act. Third, *the agent must not intend the bad effect,* is a straightforward assertion that any negative consequences although foreseeable, must not be desired as outcomes.[26] Fourth and probably the most difficult to judge in individual cases, *the bad effect must not outweigh the good effect,* meaning that the moral and ethical good must be at least equivalent in importance to the harm or negative consequences.

5.2. Application

Although the issue of deciding to forgo available medical treatment arose in the 1960s and 1970s, by the 1980s no agreement had been reached, and even today many such issues are argued over as fiercely as when they first came to the attention of medical ethicists. In the 1960s and 1970s, the growing field of bioethics in America reacted against what came to be called *medical paternalism*. This instituted change, as an American consensus was reached. The transcripts of a few landmark court trials showed the emergence of this consensus with many previous case files used as evidence in important proceedings. This new consensus seemed to rely on a three-pronged support system. First, it had to be understood that the prolonging of human life is not inherently or necessarily beneficial. Second, it had to be understood that there is a moral difference and should be a legal difference between killing and simply allowing someone to die. Third, these first two moral rules created the third, a legally binding concept that people have the liberty to decide for themselves.[27]

5.2.1. Ordinary and Extraordinary

The first idea the American consensus is based on revolves around understanding that not all medical treatment extending life is necessarily beneficial, and therefore, some treatment can be morally and ethically omitted.[28] the critical point for ethical decision making is the difference between ordinary and extraordinary means of extending life. There is general agreement on defining the two in the following way: Ordinary means have a reasonable prognosis of the patient's gaining significant benefit to his or her experience of human life without incurring a detriment that is disproportionate to the benefit. Providing these measures is moral obligation. Extraordinary means, by contrast, are optional because they offer little prospect of significant human benefit or anticipate disproportionate burdens on the quality of life.[29]

5.2.2. Vitalism and Subjectivism

The distinction between morally ordinary and morally extraordinary measures seems to fit into the middle ground between vitalism and subjectivism. Vitalism contends that life is the most important thing, inherently constituting the greatest worth and should therefore be extended at all costs. Subjectivism holds that people always have the right of choice, even to the extent of killing themselves, on the premise that the subjective choice of a human reigns supreme over any and all considerations.[30] Roman Catholic tradition, and hence the medical ethics growing out of it, rejects both vitalism and subjectivism. This theological position recognized both the sanctity, indeed the sacredness of all life, and although not immediately apparent, the ethical import of this position is that at least some aspects of the quality of life are not held sacred by any and all measures of intervention; therefore life need not be prolonged under all circumstances.[31]

5.2.3. Killing and Allowing to Die

A very important distinction must be made between killing and allowing another to die. The distinction seems to reside in the moralities of the two. Killing someone directly is never morally right, but sometimes, allowing someone to die is. As the Catholic tradition suggests, it is always morally wrong directly to kill an innocent person, but it is sometimes morally right to allow a person to die.[32] Consequently, withholding life sustaining treatment, withdrawing life sustaining treatment, pain relief that hastens death, physician assisted suicide, and euthanasia all have different moral exports and can be viewed differently as interpreted in light of the above
Distinction.

6. Five Types of Killing and Allowing to Die

The first type measure which leads foreseeably to the patient's death involves withholding treatment, where someone may refuse medication. This is not considered killing someone, but rather allowing them to die. The second type is when someone decides to stop a treatment they have already started. This is legally more troublesome as its complex nature creates doubt as to which side of the distinction it falls on. The third type is when someone may try primarily to alleviate suffering but not cause death, though the drug foreseeably may expedite death. The fourth type is assisted suicide, where a patient asks the physician to help them commit suicide, or active euthanasia on the part of the patient. The fifth type is when a physician directly causes the patient's death.[33]

6.1. Forgoing Treatment, Pillar Three: Decisions Making

This section is divided to the sub-sections: *Decision making authority, Surrogate decision making,* and *Advance directives.* The first concept is *decision making authority* and is based on the legal constructs of privacy, autonomy, and liberty. These grant a level of autonomy whereby patients can deny themselves treatment, even against the orders of a physician, with no questioning or possible reversal by healthcare providers.[34] The second concept is *Surrogate decision making,* occurring when patients cannot communication what they want, at which point the decision must be made by someone called a surrogate. A third possibility is the case the patients who, prior to the incapacitation, have explicitly written down what they want to happen in the case of an emergency. The preemptive plan which constitutes their written directives is then exercised.[35]

6.2. Types of Forgoing Treatments

The first premise in forging treatment is to show that patients have the right to decide for themselves whether medical treatment is right for them, as well as the right to refuse it. This is considered the highest law in medical ethics, as far as American law is concerned.[36] there are two exceptions, however, in the case of pregnant women and parents of small children. [37] The second type of forgoing treatment happens when a patient cannot physically make a decision; the decision is then placed on a surrogate.[38] there are three standards for surrogate decision making. The first standard, *the subjective standard,* is based only on subjectively assessing the presumed preferences of the patient.[39] the second standard, *the mixed subjective and objective*, is a case in which some evidence is available to give an idea what the patient would want, but not concrete enough evidence to know with certainty. The third standard, *the pure standard*, is when there is no evidence as to what the patient might want and decision must be made in the best interest.[40]

The third type of forgoing treatment is the *advance directive,* which is a preemptive way of deciding what treatment is to be performed should it come up for consideration, as a competent person lays out a plan ahead of time in the event of inability to make the decision later. There are two kinds of advance directive: first, *the proxy directive*, in which someone is chosen to make the decision that the patient cannot make. Second, the *treatment directive*, usually in the form of a living will in which physical instructions are written down to decide what kind of care the patient would want under certain circumstances.[41]

Conclusion

Medical ethics determines life and death by helping people decide to accept or refuse treatment or terminate life itself. In doing so, it helps to assign responsibility for life and death to medical practitioners as they assist patients either to make decisions regarding care or to help them terminate their lives by providing forms of treatment which constitute physician assisted suicide (PAS). According to available readings, all religions prohibited the latter action. Beyond this consideration, many court cases have arisen in regards to medical ethics in making decisions on behalf of an incompetent patient. This paper has discussed this issue of who is responsible in such situations from the joint perspectives of religious teaching and medical ethics. The teachings of the Roman Catholic Church in particular lead to its interpretations of the medical ethics in ways that are at times contradictory to positions based solely on nonreligious principles. For example, in relation to the principle of double effect some procedures otherwise not even open to ethical question, such as sperm collection for testing, are flatly prohibited. In other situations, such as the determination of killing versus allowing one to die, distinctions between Catholic and non-theologically based ethics may be much more subtle; however, it is still clear that Roman Catholic doctrine pervades its approach to the ethics of healthcare.

End Notes

[1] *Introduction to Jewish and Catholic Bioethics: A Comparative Analysis.* 1,3
[2] *Contemporary Catholic Health Care Ethics*.11
[3] *Contemporary Catholic Health Care Ethics*.11
[4] *Contemporary Catholic Health Care Ethics*.12
[5] *Contemporary Catholic Health Care Ethics*.12
[6] *Contemporary Catholic Health Care Ethics*.15-16
[7] *Contemporary Catholic Health Care Ethics*.18-19
[8] *Contemporary Catholic Health Care Ethics*.21
[9] *Contemporary Catholic Health Care Ethics*.41-42
[10] *Contemporary Catholic Health Care Ethics*.42
[11] *Contemporary Catholic Health Care Ethics*.43
[12] *Contemporary Catholic Health Care Ethics*.44
[13] *Contemporary Catholic Health Care Ethics*.44
[14] *Introduction to Jewish and Catholic Bioethics: A Comparative Analysis.* 25
[15] *Introduction to Jewish and Catholic Bioethics: A Comparative Analysis.*25
[16] *Introduction to Jewish and Catholic Bioethics: A Comparative Analysis.* 26-27
[17] *Contemporary Catholic Health Care Ethics*.88
[18] *Contemporary Catholic Health Care Ethics*.89
[19] *Contemporary Catholic Health Care Ethics*.89

[20] *Contemporary Catholic Health Care Ethics*.77
[21] *Contemporary Catholic Health Care Ethics*.79
[22] *Contemporary Catholic Health Care Ethics*.82-83
[23] *Contemporary Catholic Health Care Ethics*.108
[24] *Contemporary Catholic Health Care Ethics*.109
[25] *Contemporary Catholic Health Care Ethics*.109-110
[26] *Contemporary Catholic Health Care Ethics*.110
[27] *Contemporary Catholic Health Care Ethics*.127-128
[28] *Contemporary Catholic Health Care Ethics*.128
[29] *Contemporary Catholic Health Care Ethics*.133
[30] *Contemporary Catholic Health Care Ethics*.129
[31] *Contemporary Catholic Health Care Ethics*.130
[32] *Contemporary Catholic Health Care Ethics*.134
[33] *Contemporary Catholic Health Care Ethics*.135-139
[34] *Contemporary Catholic Health Care Ethics*.143
[35] *Contemporary Catholic Health Care Ethics*.170
[36] *Contemporary Catholic Health Care Ethics*.151
[37] *Contemporary Catholic Health Care Ethics*.145
[38] *Contemporary Catholic Health Care Ethics*.153
[39] *Contemporary Catholic Health Care Ethics*.154
[40] *Contemporary Catholic Health Care Ethics*.156
[41] *Contemporary Catholic Health Care Ethics*.170
[42]