

Methods and Resources for Teaching Bioethics to Nurses

Barbara Freres

ABSTRACT: In considering methods and resources for teaching bioethics to nurses, I do two things in this article. First, I locate the discipline of bioethics historically and describe what seems to me to be its most common manifestation in colleges and universities presently educating students in the medical professions. Second, I argue that a course in biomedical ethics, though an applied branch of the philosophical discipline of ethics, is enriched and made more effective if its students are encouraged to consider the dignity of the human person in the light of both reason and faith. While considering the diversity of the student populations that many of us face in teaching our courses, I make reference to two works that can enhance an understanding of that dignity with respect to both beginning and end of life issues.

WHEN AND HOW did bioethics – otherwise known as biomedical or health care ethics – come to be?

Some may say that it originated in ancient Greece and that Hippocrates, the father of rational or scientific medicine in the West, was also the father of the ethics of medicine. Since there is some question about whether the man Hippocrates is in fact the author of the Hippocratic Oath,¹ let us simply consider whether the Hippocratic Oath is the first example of an ethics of health care. One who takes the Hippocratic Oath swears, among other things, to teach the art to his instructor's sons, to his own sons, and to those who sign the covenant, but to no one else. This last phrase suggests that the medical art is being entrusted to practitioners who are to protect it from frauds and quacks.

¹ Wesley D. Smith, "Hippocrates," *Encyclopedia Britannica*, <http://www.britannica.com/EBchecked/topic/266627/Hippocrates> (accessed May 25, 2010).

Perhaps they had their share of those in ancient Greece. Further, the oath requires that one swear to apply dietetic measures for the benefit of the sick according to one's ability and judgment, so to keep patients from harm and injustice. He swears that he will not apply a deadly drug, nor make any suggestion to that effect, nor will he perform an abortion. He swears, further, to keep free of all injustice and mischief and that he will not engage in sexual relations with patients, whether male or female, freeman or slave. Essentially he will have professional integrity. Finally, he pledges confidentiality: "Things I may see or hear in the course of the treatment or even outside of treatment regarding the life of human beings, things that one should never divulge outside, I will keep to myself, holding such things unutterable [shameful to be spoken]."²

The Hippocratic Oath is a code, not a discipline. It is not a study of morality as it concerns the medical professions. In fact, a study of the morality of medicine did not appear for many years. Religion, more than philosophy or moral theology, informed the practice of medicine in ancient Greece and Rome and through much of the history of the West. In *Contemporary Catholic Health Care Ethics* David Kelly briefly traces the role that religion has played in health care from the time of Hippocrates, whose oath is directed to Apollo and to all the gods and goddesses, up to the birth of secular bioethics in the 1960s.³

According to Kelly, even the scientifically minded Hippocrates saw medicine as part of his religion. He regarded nature as sacred and saw the laws of natural causality to have their origin in the sacred.⁴ The first

² Hippocrates, "The Hippocratic Oath," trans. Leon Kass, M.D., in *Being Human* (Washington, D.C.: President's Council on Bioethics, 2003), p. 122.

³ David F. Kelly, *Contemporary Catholic Health Care Ethics* (Washington, D.C.: Georgetown Univ. Press, 2004), pp. 5-9.

⁴ *Ibid.*, p. 6. Kelley indicates that the relation between religion and medicine is deeply imbedded in many traditions throughout the world: "The fact that only Catholics and Jews developed, until recently, detailed studies of health care ethics does not mean, however, that only they were interested in larger relationships of religion and medicine. Even though the Roman Catholic tradition was the most detailed and the most influential, even though only this tradition produced a truly systematic and extensive literature in health care ethics, the relationship of medicine and religion is significant within the larger

Christian centuries saw lay physicians realizing the religious significance of their vocation – that as Christ saved by healing, they too were to show *agape* (charity) to others in imitation of Christ. They must care for the poor and for incurable patients, and they must treat the whole person, both body and spirit. Later, after the collapse of the Roman Empire, monks in monasteries began to care for the sick. Priests and religious (women and men) began to take over the role of physician, but the scientific aspects of the role were downplayed. It was not until the eleventh and twelfth centuries, with the recovery of Aristotelianism, that the science of nature and its laws were clearly seen to be compatible with faith, and that laymen again took over the role of doctor. Even then the study of medicine was regarded as a part of the study of God's creation. Kelly says that for many lay doctors of the Middle Ages, the Renaissance, and the Baroque eras, "the care of the sick was a specifically Christian vocation."⁵ Morality was clearly a part of Western medicine throughout the Middle Ages, and morality was for the most part informed by Christian faith. No distinct field of medical ethics yet existed.

It was during the Enlightenment that science attempted to free itself from scholasticism and that medicine tended for the first time, says Kelly, "to separate itself ideologically from religion.... Now medicine was to become secular, unreligious, and sometimes even antireligious."⁶ It was also during the Enlightenment that Christian theologians, responding to this separation, developed a study of the relation between medicine and religion, calling this sub-discipline of pastoral theology, pastoral medicine.⁷ Here, if anywhere, is a precursor to the modern field of biomedical ethics. First there were manuals of first aid for rural

Christian tradition and generally in the religions of our world. Religion deals with the core questions of human existence and is thus interested in issues of healing. The human person is an embodied spirit, an animated body, and so human health involves spiritual and physical aspects in inseparable interaction" (p. 5).

⁵ Ibid, 7.

⁶ Ibid., p. 7.

⁷ Ibid., p. 8.

priests and ministers.⁸ Then, in the nineteenth and twentieth centuries, medical ethics texts that formally incorporated moral theology appeared.

Much as for Christianity, Judaism and Islam also saw medicine as an enterprise with clear religious overtones. According to David Gelernter's essay on the religious character of human dignity, the Talmud was to Jews what the New Testament was to Christians.⁹ When the formal, secular discipline of biomedical ethics came to be in the 1960s, then, it did not come out of nowhere but had religious roots, despite what some may say.¹⁰

Where are we now? I think that in most colleges and universities, biomedical ethics is often taught from a purely philosophical perspective. Tom Beauchamp and James Childress, the originators of Principlism, ushered in a set of principles that still largely shapes ethical discourse as applied to the medical fields: respect for autonomy, beneficence, non-maleficence, and justice. They argue that principles such as these can shape and guide the decision making process when moral uncertainties come to the fore in the practice of medicine and in the area of medical research.

In the seventh edition of the textbook *Contemporary Issues in Bioethics*, the editors (Tom Beauchamp, Leroy Walters, Jeffrey Kahn, and Anna Mastroianni) offer the following explanation as part of their introductory chapter:

⁸ Ibid., p. 8.

⁹ David Gelernter, "The Religious Character of Human Dignity" in *Human Dignity and Bioethics* (Washington, D.C.: President's Commission on Bioethics, 2008), pp. 399-400.

¹⁰ Thomas Mappes and David DeGrazia write: "Although many of the ethical issues falling within the scope of biomedical ethics have historical roots, especially insofar as they are related to various codes of medical ethics, biomedical ethics did not crystallize into a full-fledged discipline until somewhat recently. Only since about 1970 have the various trappings of a relatively autonomous discipline become manifest." Thomas Mappes and David DeGrazia, *Bioethics*, 6th ed. (New York NY: McGraw Hill, 2006), p. 2. While indeed the secular discipline did not emerge until that time, it does not seem that these authors give a full account of the origins of the discipline. They discount the contributions of pastoral medicine, a branch of pastoral theology which centered on issues pertaining to the practice of medicine.

Three general moral principles have proved to be serviceable as a framework of principles for bioethics: respect for autonomy, beneficence, and justice. These three principles should not be construed as jointly forming a complete moral system or theory, but they can provide the beginnings of a framework through which we can begin to reason about problems in bioethics....

One caution is in order about the nature and use of such principles. Moral thinking and judgment must take account of many considerations besides ethical principles and rules, and principles do not contain sufficient content to determine the proper judgments in a great many cases. Often the most prudent course is to search for more information about cases and policies rather than trying to decide prematurely on the basis of either some abstract principles or some general theoretical commitments. More information sometimes will resolve problems, and in other cases it will help identify the principles that are most important in the circumstances.¹¹

What are these starting points? Respect for autonomy is the recognition of one's ability to determine for oneself one's own treatment, to make one's own medical decisions after being properly educated about the risks, the benefits, and the alternatives. The requirement that patients give informed consent for treatment epitomizes this principle, as does the practice of signing an advance directive. Beneficence implies an obligation on the part of health care professionals to benefit the patient, most obviously in curing or caring for the sick under their charge. Non-maleficence is doing no harm and is clearly a duty of medical professionals, but one that can be trumped in the case of chemotherapy, for instance, when one must do some harm to do any good at all. Finally, justice – a principle that calls for the fair distribution of the benefits and burdens of health care and medical research.

Many argue that even if we cannot in this age of pluralism adopt any one ethical theory, we can at least agree on these starting points, for they are so wonderfully open ended. Who could argue with them? However, Beauchamp himself recognizes the limited role that these

¹¹ Tom Beauchamp et al., eds., *Contemporary Issues in Bioethics*, 7th ed. (Belmont CA: Thomson Wadsworth, 2008), p. 22.

“principles” can play. Anyone spending any time working with medical case studies can see what difficulties arise. Consider, for example, the following case taken from a health care ethics textbook:

Rita and Johan are now in their mid-thirties. When they married after college, they decided to postpone having children until they both got established in their careers and had achieved some degree of financial security. Four years ago they decided they were ready to start a family, but their efforts to conceive a child never resulted in a pregnancy. It was discovered that Rita had blocked fallopian tubes that prevented ova from reaching her uterus. She underwent surgical repair of her oviducts but still could not conceive. The Lindens’ physician has suggested they go to the fertility clinic to investigate in vitro fertilization (IVF).¹²

If we are following the model of Principlism, we can see a potential conflict of principles here. Where do the principles lead us? Anywhere and nowhere. If autonomy trumps everything else, as many students like to think, why shouldn’t the couple decide to undergo IVF? If the technology is there, why should one not be free to use it? After all, this married power couple would be better parents than a lot of others, for whom the birth of a child is accidental. Some do not make a real decision to reproduce, whereas this couple would be acting more responsibly, exercising greater autonomy? If one worries about justice, why shouldn’t this couple have what most other married couples have – a baby? Isn’t there a right to reproduce? If beneficence, what is better than a new human being? Yet, we can begin to see a conflict among the principles. Consider non-maleficence: what about the harm done to leftover embryos that will be frozen or discarded? Or, to consider beneficence again, what about the good of the marriage and the marriage bond?

I am pointing to the fact that these principles are not truly principles because, philosophically, they are not truly starting points. They are not really foundational but merely rest upon centuries of ethical theory. Autonomy has its origin in Kant’s imperative that individuals be treated as ends in themselves, as autonomous agents, as

¹² Janine M. Idziak, *Ethical Dilemmas in Allied Health*, 2nd ed. (Dubuque IA: Kendall Hunt Professional, 2009), p. 56.

well as in Mill's discussion of liberty. The principles rest on the presuppositions of these theories – presuppositions that are sometimes in internal conflict with one another. If beneficence is to guide the actions of health care professionals, what place does utilitarianism have in such considerations? Does the good of the individual patient always trump the good of the entire community? What about public health and its potential to utterly dismantle personal autonomy?

In my view, Beauchamp was correct in saying that Principlism is not a sufficient guide for actors within the medical and research contexts. Further, Beauchamp suggests that specification needs to add information to the case if it is to guide decision making. What is required is a deeper and always deepening conception of the dignity of the human person.

In 2002 the President's Council on Bioethics, chaired by Leon Kass, published a report called "Human Cloning and Human Dignity." In a December 2003 edition of the *British Medical Journal*, Ruth Macklin, a professor of medical ethics at the Albert Einstein College of Medicine in New York, penned an editorial called "Dignity is a useless concept." Macklin charged that it means no more than respect for persons and their autonomy, or else it is a mere slogan devoid of content if not actually a subterfuge for inserting religion (namely, Roman Catholicism) into the Council's statements regarding biomedical issues.¹³ The council responded by publishing in 2008 a collection of essays entitled *Human Dignity and Bioethics*.¹⁴

I have been tempted to agree with Macklin that appeals to human dignity should be jettisoned, simply because the phrase means so many different things to different people. It has, for instance, been enlisted in arguments for the legalization of physician-assisted suicide by some people, and in arguments for a pro-life agenda by others. Yet the near ubiquitous appeal to human dignity does mean something important. It

¹³ Ruth Macklin, "Dignity is a useless concept," *British Medical Journal* 327(Dec. 20-27, 2003), ejournal <http://www.bmj.com/cgi/content/extract/327/7429/1419>.

¹⁴ *Human Dignity and Bioethics, Essays Commissioned by the President's Council on Bioethics*. Washington, D.C.: The President's Council on Bioethics, 2008.

signifies that, no matter what one's perspective on the issues, one's understanding of the human person is foundational for medical ethics. Such an appeal pulls one into a philosophical study of the person. If humans have dignity, the assumption is that human beings share in being in a way that other beings do not. There is a special way of being, for the ontological status of a human being is higher than that of other animals. What then is the basis of that dignity? What is the human person?

One excellent treatment of the human person is found in a collection of Robert Sokolowski's writings called *Christian Faith and Human Understanding: Studies on the Eucharist, Trinity, and the Human Person*.¹⁵ In a chapter entitled "Soul and the Transcendence of the Human Person," Sokolowski distinguishes soul from spirit. He explains there that all animals are animated by having a soul that unifies and makes a body an organic whole, but that angels (as spirits) are not animated because they have no body. Only human beings are embodied, animated, and spiritual – this last in virtue of having rational animation (or soul). The following passage presents at length a profound understanding of the human person:

I would like to convey in an intuitive way what we mean by spirit and its life. We should not take spiritual activities to be something ghostly. It is not the case that spiritual things are given to us only through introspection or through self-consciousness or feelings.... Rather, spiritual activity is present whenever we do things that escape the confinements of space, time, and matter. We do this all the time, and we do it in a public way.

For example, when we rationally communicate with one another, we carry on a spiritual activity, because we share a meaning or a thought or a truth with other people at other places and times. The same meaning, the same thought, the same intellectual identity, can be shared by many people, and it can continue as the same truth over centuries of time, when for example, it is written down and read and reread at different times in history. Such a truth transcends both space and time, and it transcends material causality as well, because it is the kind of thing that matter alone does not generate....

Mathematical formulas, recipes for food, machines, furniture, clothing,

¹⁵ Robert Sokolowski, *Christian Faith & Human Understanding: Studies on the Eucharist, Trinity, and the Human Person* (Washington, D.C.: The Catholic Univ. of America Press, 2006).

flags, political actions, all are spiritual things at least in part. A crumbling ancient temple and the ruins of a castle also have a spiritual aspect; they show the presence of reason even while they are being reclaimed by space, time, and matter, and the traces of spirit in them are slowly vanishing. There is something bittersweet about such things, as the signatures of reason in them are gradually extinguished. Human beings saturate the world with spiritual accomplishments and in doing so they transcend their bodily existence.¹⁶

It seems to me that helping students see the spiritual in this light is an important exercise. If one can recognize the spiritual aspect of a play, a piece of furniture, a machine, or a crumbling ancient temple, and appreciate it as the work of the spiritual masterpiece called the human person, perhaps one is better able to appreciate the spiritual (and personal) aspect of an embryo, whose future might also include these spiritual accomplishments. Students sometimes need to be shown that there *is* a spiritual aspect to life, that life itself is *not* a purely physical phenomenon, that the spiritual quality of human existence is evident and that this spiritual quality is what makes for the dignity of a human person. An embryo is not merely a clump of tissue to be disposed of at will or to be manipulated for experimentation, but rather should be treated as having the dignity of a human person. Furthermore, the coming to be of that embryo should not be a mere physical manipulation (as in cloning or in vitro fertilization) but rather the result of a spiritual bond between persons who unite in love. The dignity that persons have calls for such a beginning. This is what it means to be a someone rather than a something¹⁷ and why production demeans the person from the very start.

Sokolowski also discusses the much more intense way in which human spirituality is present in the human body itself. If soul transforms matter by making the body that it animates a whole, so too does rational soul transform the human body in a more particular way. It is not the case that rationality can be explained by material aspects of a person,

¹⁶ Ibid., p. 157.

¹⁷ Robert Spaemann deals with the theme of the human person in an illuminating way. Robert Spaemann, *Persons: The Difference Between Someone and Something* (New York NY: Oxford Univ. Press, 2007).

nor can spirituality be explained away. Rather the brain, the emotions, and the desires are all elevated by reason.¹⁸ Reason transforms them. The spiritual aspect of the human soul seeps into every aspect of human life.

As an aside, let us consider those whose rational capacities are compromised or non-existent? What about the PVS patient, the Alzheimer's patient, the severely mentally disabled, the anencephalic infant? It seems to me that even if the body prevents someone from enjoying fully or enjoying at all the capacities proper to human persons, the spiritual aspect of the soul remains because the individual is by nature, if not by fortune, rational. We should not forget that in speaking of soul and of persons, we are assuming natures and a metaphysics of substance and form.

What all this suggests is that the bodily aspects of human life are transformed by spirit and become particularly human experiences. Although experienced by animals of all kinds, procreation, birth, growth, illness, disease, pain, suffering, and death are for human beings genuinely spiritual experiences. These are the experiences that health care professionals encounter day in and day out, and they are often profoundly spiritual. It is important to make clear the spiritual character of these most physical of experiences.

Daniel Sulmasy, a Franciscan friar who is both a physician and a philosopher, tries to convey this point in his book *A Balm for Gilead: Meditations on Spirituality and the Healing Arts*. This volume is a great resource for a course in bioethics. Illness, he says, "disturbs more than relationships inside the human organism. It disrupts families and workplaces. It shatters pre-existing patterns of coping. It raises questions about one's relationship with God."¹⁹ Perhaps making evident the spiritual quality of human existence opens one up to the possibility of a spiritually transcendent reality. Ultimately, this is a necessary step in coming to a deeper and more comprehensive understanding of the

¹⁸ Ibid., p. 158.

¹⁹ Daniel Sulmasy, O.F.M., M.D., *A Balm for Gilead: Meditations on Spirituality and the Healing Arts* (Washington, D.C.: Georgetown Univ. Press, 2007).

human person.

Sulmasy encourages those in the medical professions to see their work in terms of their own spiritual journeys and to dare to counter the prevailing winds in medicine toward impersonalization and the tyranny of technology with a more spiritual outlook. He offers a Franciscan-inspired Christian spirituality as one way to do this, as is clear in the following passage:

A Franciscan spirituality of health care must be marked by a compassion that is as deeply personal as the Passion of Christ. Every patient's ordeal is the story of a person, and this story must be linked with the story of the person of Christ.

Marked by its incarnational emphasis, Franciscan spirituality will always recognize that illness is a spiritual as well as a physical event. The Word became flesh. Afflictions of the flesh can enlighten spiritual awareness in anyone, just as the early illness of Francis awakened his spiritual life. Human persons are constituted as body and spirit at once, and illness grasps human beings as whole persons.

Marked by its imaginative emphasis, a Franciscan approach to health care can never be mere bioengineering. It must engage patients as persons, endowed not only with the dignity that comes from having been created in the image and likeness of God but also with the alien dignity that comes from having been redeemed by the cross of Christ. A genuinely Franciscan spirituality of health care does not treat patients as mere isolated organs or as mere consumers of health care resources. Rich or poor, young or old, citizen or alien, able or disabled, the personal in every person is boundless and of inestimable work. A practitioner imbued with a Franciscan spirituality will even be imaginative enough to be aware of the embarrassment that patients often feel, just as Francis understood the embarrassment of the poor knight. Practitioners imbued with the Franciscan spirit will recognize how the sick are often shunned. They will move past any initial hesitation or revulsion and reach out to touch their patients personally, as Francis embraced the leper. Practitioners imbued with the Franciscan spirit will understand the essential unity of their own suffering and the suffering of Christ. They will be able to feel the suffering Christ in their own persons. They will find unity with his suffering through active engagement with their own suffering and that of their patients, just as Francis did on Alvernia.... Compassion of this sort can only be shown, not said.²⁰

This last point regarding patient suffering and the suffering of Christ is especially significant. If materialism is one dominant theory of the

²⁰ *Ibid.*, p. 99-100.

universe that stifles a pro-life ethic with respect to beginning of life issues (e.g., in the view that the embryo is merely a clump of human cells), pragmatism or utilitarianism is the dominant view at the other end of life. The move toward physician-assisted suicide is very strong. It is rooted in an overarching autonomy, to be sure. It is also the result of an inability to see any value in suffering. Can one truly see much value in suffering apart from the cross? Isn't medicine's goal, in accordance with the project of modern science, with utilitarianism on the continent, and pragmatism in America, the mastery of nature and the virtual elimination of suffering?

Admittedly, this discussion of bioethics ends with faith, which many people would try to avoid when teaching a course in ethics to the scientifically minded. Yet it seems to me a natural ending point. We began this paper with a brief look at the way in which medicine and morality were originally and throughout history united in the context of faith. Healing has historically been a religious vocation, its practice governed by the morality grounded in faith, whether that faith was pagan or Jewish, Christian or Muslim. In a sense, we are merely returning to the roots of medicine. Birth, health, illness, and death are metaphysically significant aspects of human life. Is it any wonder then that religious faith could have something significant to say about these inherently personal and spiritual experiences? Reason can help us a great deal to understand the dignity of the human person. Faith, however, can do more. One's religious tradition can help one see more fully the dignity of human person.