SPIRITUALITY AND HEALTH CARE ETHICS

In a pluralistic culture, there is the assumption that there must be a wall between "religious ethics" and "secular ethics" with only the latter variety having a proper role in public bioethics. However, this assumption is not true—it mitigates against a wholistic approach to health care. For the discipline of bioethics to be effective partner in the health care enterprise, matters of the spirit as well as the body and mind/emotions must be addressed.

First, it is important to distinguish between "spirituality" and "religion". With everyone from skinheads to massage therapists appropriating the term spirituality, there is an understandable skepticism that it is a passing fad, nice but not essential to health. "Spirituality" is a slippery term. It can mean almost anything. In the past, the term was confused with "religion" which refers to an organized, concrete form and expression of a particular spirituality experienced and practiced in a particular community of faith with specific scriptures, rituals, and traditions. Despite the confusion and lack of social agreement about what spirituality is, its role in health care cannot be dismissed. A healthy spirituality (whether expressed in religious form or not) is discerned when its fruits are seen in outcomes that produce human respect and dignity, compassion, active listening, and a sense of peace and wholeness (*shalom).*

Spirituality has to do with the human experience of what meaning is in one's life and health, one's health and illness, one's relationship to God or whatever one's Ultimate Concern is (to quote Paul Tillich). Specific religious and spiritual themes and stories play a part in stimulating the moral imagination even among persons and groups with no shared religious tradition.

In the United States, despite a relatively high religious activity in the social fabric, the political culture maintains a fairly strict separation of church and state in order to promote individual liberty and tolerance in our common life. It is feared that religious dogma might be imposed illegitimately, and lead to a suppression of minorities and the right of every person to follow his or her own conscience. Therefore, ethics committees in the secular arena tend to divide religious morality and spiritual morality (often confused together as if it were the same thing) from the "secular reason" that supposedly sets the standard for public policy and biomedical decision-making. Ethics committees exist in this context. They typically bring together persons from diverse personal, moral, and religious backgrounds, which must analyze some

urgent practical problem and attempt to arrive at consensus positions. Ethics committee members rarely use specifically religious or spiritual arguments.

The values of autonomy and privacy that often are assumed to be "rationally self-evident" and thus legitimately "public" and "secular" are in reality themselves traditionally based spiritual values. They are important and relevant to biomedical decision-making. But they are neither neutral nor tradition-free, nor the only values that should govern deliberations of ethics committees. Other important values include human life and health, family relationships, and the common good (including justice in access to health care resources).

Discussion of spiritual values as well as religious perspectives and commitments can help sensitize ethicists and committee members "doing bioethics" to the dimensions of the human experience they are beyond, and yet also help define autonomy. For example, religious doctrines of creation, sin, and salvation, associated with certain faith traditions, represent the finite and fallible nature of human beings, and they remind people that they exists in relation to other beings and to a realm of meaning that transcends merely human projects. Specific religious and spiritual, practical, and moral teachings of faith communities to which patients and their families and the caregivers themselves belong need to be represented and discussed in order to fully value the perspectives of all participants.

There is no community-free zone of moral neutrality into which ethics committee members, for instance, can enter to resolve differences. Bioethical reflection and consultation can only be accomplished through a process of compromise and mutually respectful discussion allowing for the nonjudgmental sharing of all positions and perspectives. The moral insights of all participants, which may or may not be formulated through specific spiritual and/or religious traditions and practices, can be expressed and enhance the educational and consultation work in which the bioethics discipline engages to contribute to a truly wholistic approach to health care. Many of these insights can be expressed in language that speaks across the boundaries of cultural and moral differences, evoking engagement and response. For example, the "image of God" can be expressed as the basic respect for others, "love of neighbor" as an ethos of compassionate service to the sick and suffering, and "the preferential option for the poor" as a social justice that moves first to include the most marginal and vulnerable members of society.

Spirituality in all of its forms that attempt to bring meaning to individuals and communities, including religious faith as an expression of a particular spirituality, is a crucial and essential aspect of bioethical reflection. It cannot be checked at the door of the ethics committee meeting. Nor need these perspectives be the ones that "trumps" all other considerations. The moral discourse comes out of historical communities of identity. Members of these communities can together learn what fulfills moral obligations, respect for human dignity and serve the common good. Moral sensitivities indebted to a specific religious faith can attune ethicists to the special aspects of moral situations and help all engaged in ethical reflection discern where true virtue lies.

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