Signature Religious Virtues in Medical Decision Making
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Abstract

The limitations of principlism have led to a growing interest in the role of the virtues in professionalism and medical decision-making. Although a majority of U.S. physicians report that they try to carry over their religious beliefs into every aspect of life, relatively little attention has been devoted how the virtues embodied in the major religious traditions shape the character, attitudes, and behavior of physicians making bioethical choices. These clearly overlap, but virtues which are especially prominent for Christians include love and grace, for Jews communal responsibility and critical thought, for Muslims reverence and obedience, and for Buddhists equanimity and compassion. Attention to signature virtues could help physicians both in articulating their religious values, and in understanding their implications for practice. Responding to medical dilemmas facing physicians and patients by engaging in dialogue regarding preferred virtues offers a strong complement to principlism.

Of the traditional approaches to ethical decision-making—deontological, situational, casuist, feminist and principle based—the latter came to dominate medical ethics during the latter half of the 20th century. Yet as Vincent Barry (2012) points out, while principlism has provided a valuable, consensual structure for making medical decisions, it has separated individual patients and physicians from social and historical ties which constitute sources of moral meaning. While respecting the autonomy of the self, it fails to ground the self in anything enduring, such as community or God. And while motivated by concern for concrete circumstances of clinical life, it offers abstract principles open to multiple, even opposing interpretations. This may account for the recent finding that individuals’ preferences among the four principles of Beauchamp and Childress failed to predict their choices when faced with ethical dilemmas (Page, 2012).

Partly owing to these limitations of principlism, recent decades have seen a renewed interest in virtue ethics and in the character of the physician making medical decisions. Virtue ethics is primarily concerned with how we live our lives well on a day-to-day basis rather than with formulating criteria for making expert decisions when we are trapped in difficult circumstances (Shuman, 1999). Yet as we suggest here, the character of the physician—her characteristic, habitual responses as a whole person, informed by the specific content of her world view and/or faith tradition—has important implications for medical decision-making. Consider the example of a family who brings an elderly woman with end-stage heart disease for consultation regarding possible surgery. To help the patient and her family to make the best decision, an ethical physician would try to balance the traditional principles of beneficence, non-
malfeasance, self-determination, and justice. But the physician’s values, as well as the patient’s and family’s, play a crucial role in this process. The surgeon’s values reflect his character—as a risk taker, a fatalist, a worshipper of the present life, or a person who views its length as having only relative importance. Put another way, they reflect his preferred virtues.

Or consider a Catholic physician whose patient asks him for help in obtaining the morning after pill. The teachings of the physician’s tradition about the timing of conception will be relevant but may not be decisive. At least as important may be how he understands his role as a physician in helping his patient with her problem. Does he regard the ideal physician as one whose integrity requires him to interfere with his patients’ requests, whose caring encourages him to raise concerns about her choices, or whose respect for her autonomy and suffering would restrain him from interfering with her choices?

A number of factors shape the development of character and virtue, including temperament, family upbringing, formative experiences, key mentors, cultivated practices, and the values which are imparted by culture and shaped by religious and secular views of the world. Religious faith can influence medical decision-making in several ways, such as through the application of sacred texts, established doctrines, and personal beliefs (e.g. in miracles), but also through the particular virtues cultivated by the tradition. Curlin et al. (2005) found that 55% of U.S. physicians surveyed report that their religious beliefs influence their practice of medicine, and 58% say that they try to carry over their religious beliefs into all other dealings in life. In their well known The Virtues in Medical Practice (1993) and The Christian Virtues in Medical Practice (1996), Pellegrino and Thomasma highlight implications of Christian virtues for clinical practice but not how virtues encouraged by Christians compare with those fostered by other traditions. We explore here how the distinctive virtues embodied in four major traditions – Christian, Jewish, Muslim and Buddhist - shape the character, attitudes, and behavior of physicians making medical decisions.

While the virtues of these and other faith traditions overlap, virtues which are especially prominent for Christians include love and grace, for Jews communal responsibility and critical thought, for Muslims reverence and obedience, and for Buddhists equanimity and compassion.

**Christians**

A growing literature describes the implications of the Christian virtues for medical practice. Yet as Denis Hawkins points out, “What is distinctive of the moral teaching of the gospel is not a new code of morality or a new theory of its basis, but the insistence on raising morality to the level of love.” In their book The Christian Virtues in Medical Practice, Pellegrino and Thomasma describe the implications of this love-inspired ethics for ordering the dominant principles of medical ethics under charity, for seeing the physician’s role as a calling involving self-effacement, and for making certain concrete choices in practice. What makes this possible is the experience of God’s grace. St. Francis was repelled by lepers and shunned them like the rest of society until he was impelled to embrace them by the love of Christ. Historically, Christians
have been moved by this love and grace to express hospitality to the poor and suffering in mission hospitals and healing communities such as the L’Arch communities for the mentally disabled, founded by Jean Vanier. In his words, “It is through everyday life in community and the love that must be incarnate in this, that handicapped people can begin to discover that they have a value, that they are loved, and so loveable.” (Vanier, 1979)

**Jews**

The Jewish faith embodies celebration of life and a commitment to give back to the community, as expressed in phrase “tikkun olam” (repairing the world) and in the Prayer of Maimonides: “Thou hast chosen me to watch over the life and health of thy creatures. Enable thy creatures to alleviate their sufferings and to heal their diseases.” Judaism also embodies a long tradition of thinking critically, which favors a practical approach to ethical decision-making over reliance on received authority. This is reflected in the Jewish saying, “arguments among authorities produce wisdom”, and in the value placed by Jews on learning over centuries during which everything else might be taken from them.

**Muslims**

Muslims emphasize submission to the will of Allah in matters of health, as in all of life. Among the many virtues based in the Quran are prayerfulness, moderation, dignity, and obedience. The underlying Islamic virtue of reverence implies respect for received wisdom and acceptance of one’s limitations. This helps to explain the strong connection between Muslim bioethics and jurisprudence. In contrast to a rights-based approach to ethics in Western medicine, Islamic ethics focuses on duties and obligations (e.g. to preserve life, seek treatment). The Quran contains many passages that explicitly refer to human embryological development and the time of “ensoulment,” prompting dialogue regarding the timing and legitimacy of abortion. In this and other areas, many Muslims view the Quran as containing information that precedes, if not predicts, modern scientific developments. Reverence in Islamic bioethics includes respect for the links among the Quran, jurisprudence, and science.

Moreover, there is strong respect for God as the ultimate healer, a virtue that is often in tension with the traditional four-principled model of Western bioethics. One practical implication of this is that decision-making is ideally shared among one’s family, imam, and God (beneficence, as embodied within a community, trumps personal autonomy). Recognizing this, a clinician can sometimes avoid conflict in end-of-life conversations by discussing the issues at stake from the standpoint of Muslim virtues, as opposed to the traditional four-principled model, which emphasizes individual autonomy.

Consider the case described by Westra et al. (2009) of a child with a prognosis of days, attached to a ventilator for incurable lung disease: “The pediatricians may apply the principle of nonmaleficence to justify withdrawing life-sustaining treatment and may be convinced they need an explicit consent for this from the parents in order to respect their autonomy. The
parents, however, do not consider the extra days harm and trust their omnipotent God, which keeps them from making decisions about life and death.” In short, the concept of “autonomy” fails to capture the family’s experience. Instead, their decision rests upon virtues of reverence and obedience, values not easily captured by an approach to ethics which centers around the rational choices of an individual actor.

To avoid an impasse in such a conversation, a pediatrician might explore the application of relevant virtues central to Islamic faith: moderation (avoiding unnecessary medical devices), dignity (what the child may have wanted), obedience (accessing wisdom of religious leaders to ascertain the will of Allah), and freedom (the ability to die a “natural death” on or off of assisted devices). To draw out such virtues opens up a conversation, whereas applying a universal formula for making ethical decisions may hinder discussion and even promote resistance on the part of family members.

Buddhists

Buddhist virtues of compassion, awareness, harmony, and the renunciation of craving as achieved through the practice of mindfulness have increasingly found expression in mainstream psychotherapy, as well as in the self care of clinicians who care for the suffering. For example, Buddhist psychology helpfully distinguishes compassion as empathy with a wish to make the sufferer better from its “near enemies” of pity, horrified anxiety and grief (Halifax, 2011).

Scholarship on ancient Chinese medical ethics traditionally focuses on the relational self versus the individualized self, and hence on the communal nature of medical decision-making. From a contemporary Western perspective, a family who desires to withhold information from a dying loved one out of concern for the patient’s well-being is valuing beneficence over autonomy. However, clinicians can better connect with such a family if they recognize the richness of the virtues embedded within this ethical framework, such as humaneness, compassion, and harmony.

Consider again the scenario of withdrawing a ventilator from a patient. Basic Buddhist concepts of the self as relational and illusory challenge a Western approach to such a case. For instance, whose autonomy are we concerned with - a patient’s, his immediate family’s, or that of the larger community? Furthermore, how is it possible to make an advance directive, to know a patient’s wishes years later, in a different state of consciousness? What is the relationship between the physician’s intent and action? Stonington and Ratankul (2006) point out that in Thailand, physicians avoid withdrawing artificial ventilation because it is spiritually disadvantageous for them: “[i]n a Buddhist ethical framework, it is impossible to withdraw a ventilator with beneficent intent.” Rather, the focus is on exploring the patient’s “knot of problems” (bpom bpan ha in Thai), the gnarled set of worries which are tangling the patient’s [sic] mind and keeping him from achieving mental clarity and letting go of life.” Solving ethical problems involves aiming for decisions which are harmonious to patients, families and physicians.
A Buddhist virtue-based ethical approach would ask questions such as the following: What type of death would achieve a harmonious end? What course of action embodies compassion and reverence for the patient, family, and physician? While these questions do not permit “neat” solutions that can be easily quantified, they can serve to open dialogue in a way that values local difference. The Buddhist virtues of compassion and equanimity have particular relevance for a medical culture that often seems to value protocols, competencies, and checklists over engaged exploration. A Buddhist physician who has a deep understanding of suffering as inevitable will be more likely to speak calmly with his secular patient who is requesting assisted suicide about the sources of his suffering, and thereby help him and his family plan for and compassionately share in the process of dying.

Consider further as a final example the ways that physicians of different religious traditions, each representing a range of perspectives, might approach a patient requesting assisted suicide: A Jewish physician impelled to celebrate life might resist the request, as well feel concerned about the potential threat to the common good for setting such a precedent. At the same time, as a critical thinker he might also identify with the individual’s pursuit of freedom. As one secular Jew’s put it, “I would want the freedom to die this way.” A Muslim, following the teachings of the Prophet that everything including illness comes from Allah and constitutes a test of faith, would see ending life prematurely as forfeiting that test. A Christian feeling gratitude for grace and motivated by love would want the individual to experience God as well in his remaining time. For example, he might want to encourage the believer to prepare for a faithful death in the ancient tradition of ars memori—while also attending to his suffering. And depending on his location within the spectrum of Christian belief about what God most desires, he might resist or support the request for an early death. A Buddhist feeling compassion, and hoping for harmony would want to know whether the individual was at peace, or put another way, in an enlightened state of mind.

Discussion

In practice, these religious virtues are significantly conditioned by culture and need to be accompanied by the virtue of practical wisdom. Love without boundaries can become masochistic and impractical; responsibility and disputation can become rigid and confining; equanimity can become passive; and reverence can become mindless.

Our society is increasingly pluralistic, but religion is still largely privatized and compartmentalized, and Western biomedicine still largely dominated by a secular, immanent frame, which fosters the virtues of self-sufficient reason and individual autonomy. New physicians receive little if any training regarding the connections between spirituality and health. Nor are they offered many opportunities to reflect on how their own religious backgrounds may influence clinical care. Attention to preferred virtues would be
helpful in assisting physicians to articulate their secular or religious values, and to begin this process of investigation.

If religious traditions could articulate and support the expression of their preferred virtues among their own communities, this could serve as a safe foundation for approaching dialogue with other faiths, for appreciating their distinctive virtues and for finding more common ground in the clinical setting. Finally, learning from one another’s religious traditions has the potential to stimulate teaching and research into how to foster virtue. For example, Buddhists encourage compassionate presence and equanimity through meditation. Christian practices include the Jesuit examen, and Twelve Step work. Jewish communal rituals of confession, repentance, and service reinforce virtues developed in the home. And faithful Muslims practice regular prayer and collective fasting.

In conclusion, closer attention to distinctive religious virtues could help physicians to understand both the sources of their own value commitments, and what they have to learn from the traditions of others, as a strong complement to principlism.

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