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Medically Valid Religious Beliefs

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I am submitting herewith a dissertation written by Gregory Lawrence Bock entitled "Medically Valid Religious Beliefs." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Philosophy.

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Medically Valid Religious Beliefs

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DEDICATION

I dedicate this dissertation

to
my loving wife
and best friend,

Heather

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I would like to thank Glenn Graber for the time and energy he has devoted to this project, not only in its final stages, but also in its infancy when I first sat in his office to discuss doing an independent study on the problem of religious beliefs in pediatrics. Without his support, this dissertation would not have been possible.

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ABSTRACT

This dissertation explores conflicts between religion and medicine, cases in which cultural and religious beliefs motivate requests for inappropriate treatment or the cessation of treatment, requests that violate the standard of care. I call such requests M-requests (miracle or martyr requests). I argue that current approaches fail to accord proper respect to patients who make such requests. Sometimes they are too permissive, honoring M-requests when they should not; other times they are too strict.

I propose a *phronesis*-based approach to decide whether to honor an M-request or whether religious beliefs are *medically valid*. This approach is culturally sensitive, takes religious beliefs seriously, and holds them to a high ethical standard. This approach uses a principle of belief evaluation developed by Linda Zagzebski: *The Principle of Rational Belief*, which is founded upon Aristotelian virtue ethics. In addition to the Principle, I propose a concrete set of conditions to assist caregivers in clinical case evaluations.

In the final chapters, I apply the *phronesis*-based approach to well-known adult cases such as the refusal of blood transfusions by Jehovah's Witnesses and requests for continued (futile) care by Orthodox Jews at the end of life. Also, I consider cases involving children such as African female circumcision and cases of faith healing. I argue that *The Principle of Rational Belief* should define the threshold of the kinds of M-requests for children that can be honored, but I allow a lower threshold for M-requests made by competent adult patients.

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CHAPTER ONE
Introducing M-Requests[1]

In the hospital, patients and their families, who come from diverse cultural backgrounds, bring with them their religious beliefs. This is how it should be. The religious beliefs of patients give them great comfort and support, but religious beliefs can also influence their decision-making, which may become a problem if their choices violate the standard of care. I will call such choices *M-requests* (miracle or martyr requests): requests for inappropriate treatment or the inappropriate cessation of treatment based on religious beliefs.

In the *Journal of Medical Ethics*, Michael Wreen argues that the religious beliefs of patients and their families deserve respect. Here he explains how religion serves an important function in our lives:

> Religion has to do with (i) describing and explaining the human condition at its most fundamental level; (ii) providing a person with a unique concept of personal identity, in the fullest sense of the term; and (iii) making sense of ourselves and the world around us in a complete and satisfying way. One of the primary pieces of the business of religion, in short, is to give a sense to the expression 'the meaning of life'. It reconciles us, at a deep existential level, to ourselves, to our world, to each other, and most of all to our limitations and relative importance. Religious beliefs and values are therefore not on a par with other beliefs and values a rational person might have, such as ones regarding red objects, however dear to a person's heart such beliefs and values may be…Not to respect an autonomous person's refusal of treatment when that refusal is religiously based is not to respect him as a person at the deepest level.[2]

Wreen thinks that M-requests should have special standing, that they should be given more consideration than "inappropriate" requests based on patients' idiosyncratic

[1] Parts of this chapter appear in an earlier form in Gregory L. Bock, "Medically Valid Religious Beliefs," *Journal of Medical Ethics* 34 (2008) 437-440.
[2] Michael J. Wreen, "Autonomy, Religious Values, and Refusal of Lifesaving Medical Treatment," *Journal of Medical Ethics* 17 (1991) 128.

choices. Robert Orr and Leigh Genesen defend this point of view in a later article in the same journal.[3]

In response, Julian Savulescu argues that such a point of view is discriminatory against atheists because requests motivated by religion are given preferential treatment.[4] In reply to Savulescu, Orr and Genesen modify their definition of "religion" to include atheism and other non-traditional worldviews.[5] I do not have the space here to explore whether atheism serves the same purposes that traditional religious views do, but I will define "religious belief" broadly, including the beliefs of any worldview that fulfill the functions Wreen describes.

The religious beliefs of patients and families deserve respect, and M-requests should be given special consideration. However, not all such requests should be honored because many of them are morally disturbing, such as when parents prevent their children from getting urgent medical care. Nevertheless, the problem is in drawing the line, in deciding whether M-requests are *medically valid*.

In this dissertation, I propose a *phronesis*-based approach for deciding when to honor M-requests. This approach, I argue, is culturally sensitive and holds M-requests to a high moral standard.

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[3] Robert D. Orr and Leigh B Genesen, "Requests for 'Inappropriate' Treatment Based on Religious Beliefs," *Journal of Medical Ethics* 23 (1997)142-147.

[4] Julian Savulescu, "Two Worlds Apart: Religion and Ethics." *Journal of Medical Ethics* 24 (1993) 382. Savulescu also makes the stronger claim that religious beliefs are less rational than others (implication: they have less standing). Religious requests, he claims, are based on irrational beliefs that are probably false. Ethics, on the other hand, is reasonable and factual. In later chapters, I show that religious beliefs can be rational, but aside from these considerations, I think Michael Wreen (1991) makes a solid argument that religions are special and worthy of consideration; see also Huston Smith, *Why Religion Matters: the Fate of the Human Spirit in an Age of Disbelief* (New York: HarperCollins, 2001).

[5] Robert D. Orr and Leigh B Genesen, "Medicine, Ethics and Religion: Rational or Irrational?" *Journal of Medical Ethics* 24 (1998) 385-387.

In chapter two, I examine religious beliefs and M-requests in the following four cases: (1) Jehovah's Witnesses and the refusal of blood transfusions, (2) African female circumcision, (3) Orthodox Judaism and end-of-life care, and (4) faith healing. I explore how religious beliefs are justified in these cases and communities, how the physical body and medicine are viewed from their perspectives, and what virtues they promote. For each, I explain the cultural background and beliefs involved. All four cases reappear for discussion in subsequent chapters.

In chapter three, I briefly explore the philosophical basis of the liberty of conscience and its limits when it comes to healthcare. Second, I examine the standard of care as described in the medical literature. Third, I consider some approaches to handling M-requests and argue that they are either ineffective or insensitive to patients' religious beliefs, being either too permissive or too strict. They inappropriately allow or deny M-requests at different times. Sometimes the standard of care overrides an M-request without giving it sufficient consideration; other times, M-requests trump the standard of care in the name of patient autonomy and religious tolerance. In both cases, decisions are made without adequately engaging the patient's beliefs. True respect requires taking beliefs seriously, which means that caregivers should attempt to understand the patient's point of view and subject the beliefs to standards that govern all other discourse in the public square: standards of reason.

In chapter four, I propose a *phronesis*-based approach which uses a principle of belief evaluation created by Linda Zagzebski. She calls the principle the *Principle of Rational Belief* (PRB) and develops it from Aristotelian virtue ethics, in which the

phronimos (the virtuous person) is the standard against which belief-formation can be judged. In addition, I provide an analysis of some intellectual virtues such as the love of knowledge, firmness, and humility. Finally, I propose a set of conditions that can be employed in clinical case consultations.

In chapter five, I apply the approach to some of the cases from chapter two: (1) Jehovah's Witnesses and the refusal of blood transfusions and (2) Orthodox Judaism and end-of-life care. I conclude that when the patients in these cases are competent adults, the M-requests should be honored.

In chapter six, I consider Savulescu's conditions for deciding M-requests for children and conclude that his approach is flawed. While his conditions hold M-requests to a high moral standard, they are culturally insensitive, and I suggest an alternative set of conditions to remedy this problem. I apply these to pediatric cases involving Jehovah's Witnesses, African female circumcision, and faith healing.

CHAPTER TWO
Four Cases

With the diversity of religious beliefs on our planet, there are an untold number of examples of M-requests. Some M-requests are common while others are peculiar to individuals. In this dissertation, I have chosen to focus on four relatively common cases, but the approach I develop can be applied to any M-request. The cases are the following: (1) the refusal of blood transfusions by Jehovah's Witnesses, (2) African female circumcision, (3) Orthodox Judaism and futile treatment at the end of life, and (4) faith healing.

Jehovah's Witnesses and Blood Transfusions

Case: Joy

> Joy is a thirteen year old Jehovah's Witness (JW) who developed anemia due to a massive Staphylococcus infection, which affected her blood, bones, and lungs. With antibiotics, her condition improved, but her physicians now believe they must intervene surgically to remove the excess pus and scar tissue in her chest cavity. However, they are unwilling to do so without recourse to a blood transfusion because Joy's anemia makes the procedure very risky. Joy and her parents have stated that they are against the transfusion, and Joy has clearly and intelligently articulated her religious beliefs and the JW position on blood in the absence of her parents. To many, Joy seems to be a mature and competent young woman.[6]

Adult JW patients will often refuse blood transfusions even if a transfusion is medically necessary. It has been estimated that around one thousand Witnesses die each year because of this.[7] In addition, JW parents often refuse medically necessary blood

[6] Adapted from Robert Orr and Debra Craig, "Old Enough" *Hastings Center Report*, (November-December 2007) 15-6.
[7] Phil Wilson, "Jehovah's Witness Children: When Religion and the Law Collide," *Paediatric Nursing* 17 (3) (April 2005) 35.

transfusions for their children, but current medical practice usually overrules such refusals, giving a child's physical well-being precedence over religious beliefs. In such cases, the state will often take temporary custody of JW children in order to transfuse them.

JWs hold a high view of physical life, and they usually seek aggressive medical treatment for sickness and disease. Nevertheless, they believe that this earthly life is not the end, and obedience to the God of the Bible is more important. Osamu Muramoto claims that the following doctrines of the Watchtower (WTS), the organizational body of Jehovah's Witnesses, are important to understanding the teachings about blood:

> 1) Armageddon is near, in which all mankind will be destroyed except faithful JWs who will live forever on earth; 2) The WTS governing body is believed to be the "faithful and discreet slave" referred to in Jesus' parable at Matthew 24:45, divinely appointed by Jesus Christ to lead the JWs; 3) *The Bible* cannot be understood without interpretation by the "faithful and discreet slave"; 4) JWs who openly criticize the leadership and the organization are regarded as apostates, disloyal to Jesus and God; 5) Salvation is contingent on how well they perform as loyal JWs.[8]

JWs believe that they will live forever, either with God or on a new earth, but this future is contingent on their obedience to God's commands in the Bible.

They believe that the Bible prohibits the consumption of blood. This belief is supported by passages such as the following: "Only you shall not eat flesh with its life, that is, its blood" (Genesis 9:4, NASV); "You are not to eat any blood, either of bird or animal, in any of your dwellings. Any person who eats any blood, even that person shall be cut off from his people" (Leviticus 7:26-27, NASV); "I will set my face against that person who eats blood and will cut him off from among his people" (Leviticus 17:10,

[8] Osamu Muramoto, "Bioethics of the Refusal of Blood by Jehovah's Witnesses: Part 1. Should Bioethical Deliberation Consider Dissidents' Views?" *Journal of Medical Ethics* 24 (1998) 224.

NASV); "Only be sure not to eat the blood, for the blood is the life, and you shall not eat the life with the flesh." (Deuteronomy 12:23, NASV); "For it seemed good to the Holy Spirit and to us to lay upon you no greater burden than these essentials: that you abstain from things sacrificed to idols and from blood and from things strangled and from fornication; if you keep yourselves free from such things, you will do well"[9] (Acts 15:28-29, NASV); "But concerning the Gentiles who have believed, we wrote, having decided that they should abstain from meat sacrificed to idols and from blood and from what is strangled and from fornication" (Acts 21:25, NASV).

The WTS teaches that these ancient biblical commands apply to the modern practice of blood transfusion as well, at least to whole blood products. This does not, however, preclude the use of some blood components. In an article that was the standard statement of JW blood policy for many years, Dixon and Smalley state,

> Each Witness must decide individually if he can accept [albumin, immune globulins, and hemophiliac preparations]…Witnesses believe that blood removed from the body should be disposed of, so they do not accept autotransfusion of predeposited blood. Techniques from intraoperative collection or hemodilution that involve blood storage are objectionable to them. However, many Witnesses permit the use of dialysis and heart-lung equipment (non-blood-prime) as well as intraoperative salvage where the extracorporeal circulation is uninterrupted…The Witnesses do not feel that the Bible comments directly on organ transplants."[10]

A more recent article states,

> The religious beliefs of Jehovah's Witnesses prohibit them from accepting homologous or autologous blood products, including packed red blood cells, white blood cells, platelets, and plasma, as a part of even life-saving medical therapy. Therapies such as albumin, cryoprecipitate, and intraoperative salvage represent a gray area. Various groups of Jehovah's Witnesses hold slightly

[9] It is of interest that the consumption of blood is condemned in the same verse that condemns sexual immorality.
[10] J. Lowell Dixon and M. Gene Smalley, "Jehovah's Witnesses: The Surgical/Ethical Challenge," *Journal of American Medical Association* 246 (November 27, 1981) 2471-2472.

> different beliefs and, preferably, the use of these therapies needs to be specified by the individual patient. Fluid replacement with crystalloid and other types of colloid is generally acceptable as are hemostatic agents such as desmopressin, recombinant factor VIIa, aprotinin, and epsilon-amniocaproic acid.[11]

In sum, the WTS teaches that the biblical command concerning blood consumption applies to blood transfusions. However, this only applies to certain blood products; some blood components are acceptable.[12]

JWs believe that blood is symbolic of life and that life is sacred. Although some critics say that the deeper theological reasoning behind the WTS prohibition of blood transfusions is unclear,[13] some have speculated that it has to do with a concept of spiritual purity. Richard Singelenberg, for example, explains that in many cultures blood is essential to group identity and that in Hindu culture blood transfusions are only allowed among kin in order to preserve the purity of the caste. "Pollution of an individual's blood means a stain on the whole caste."[14] He says that JWs have a similar understanding of blood:

> In the Society's blood transfusion doctrine, this consanguinity aspect plays a partial role. As shown above, the Society often stressed the questionable characteristics of the donor category, transferring its evil qualities into the believer's bodily system. The analogy with the Indian caste is obvious: reception meant individual, and accordingly, group pollution. However, a significant flaw emerges: why is transfusion *among* Witnesses not allowed? It should be noted that defection among the Society's adherents is considerable… In the view of the

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[11] May Hua MD, Ronald Munson PhD, Art Lucas, Susan Rovelstad MD, Mary Klingensmith MD, FACS, and Ira J. Kodner MD, FACS, "Medical Treatment of Jehovah's Witnesses," *Surgery* 143 (April 2008) 463-465.

[12] The Witnesses also give medical reasons for refusing blood transfusions and have documented alleged risks from using blood products in the manual: *Family Care and Medical Management for Jehovah's Witnesses* (New York: Watchtower Bible and Tract Society of New York, 1992) 4.1-4.13; however, as far as I can tell, these reasons are secondary to the biblical commands.

[13] Ruth Macklin, "The Inner Workings of an Ethics Committee: Latest Battle over Jehovah's Witnesses," *The Hastings Center Report* 18 (Feb-Mar., 1988) 15.

[14] Richard Singelenberg, "The Blood Transfusion Taboo of Jehovah's Witnesses: Origin, Development and Function of a Controversial Doctrine," *Social Science & Medicine* 31 (1990) 520.

> Society, apostate members belong to the realm of Satan. Though the transfusion might have been life-saving, the thought of a believer who once received blood from someone who is now in the devil's category is almost an obscenity within the Society's ideological schemes. Insiders, thus, can also defile, so an absolute prohibition is the most secure defense for spiritual pollution.[15]

While "pollution" may be the reason behind the requests of many JWs, it is not clear that this is the main reason. For example, some JWs are even against auto-transfusion, in which a patient's own blood is taken out and given back to her. JWs who are against this believe that once the connection to the body is severed, the blood should be thrown out.[16]

Before 1960, JWs who accepted a blood transfusion only had to fear the eternal consequences for accepting a blood transfusion: separation from God (which is no small consequence). However, that soon changed: "In the 'Questions from Readers' part in the 15 January, 1961 edition of *The Watchtower*, it was stated that the taking of a transfusion would be followed by excommunication (in the Society's jargon, 'disfellowshipping'). If the offender would refuse to acknowledge his transgression or would persist in accepting or donating blood, he would be considered 'a rebellious opposer and unfaithful example to fellow members' and therefore should be cut off from them."[17] The practice of disfellowshipping has attracted some attention in the *Journal of Medical Ethics*. Muramoto claims that current WTS practices amount to coercion and argues that the WTS could retain the controversial blood doctrine while instituting a don't-ask-don't-tell policy that would protect individual privacy and autonomy.[18] Donald Ridley, a member of the WTS, responds:

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[15] Singelenberg, 520.
[16] Glenn Graber, from personal correspondence.
[17] Singelenberg, 517.
[18] See Muramoto (1998, 1999, 2000).

> Muramoto essentially advances the anarchic notion that, after freely choosing to join an organisation because they have come to share or identify themselves with the organisation's basic values or objectives and after agreeing to abide by its rules and procedures, individuals should nevertheless be free to abandon those values and objectives and reject the organisation's rules and procedures but still insist that the organisation accept them as full and active members in good standing. This argument is patently absurd.[19]

David Malyon, quoting *The Watchtower*, says, "As free moral agents, each one has personally decided to live by Bible standards. These are decisions that fall within the framework of a way of life *freely chosen*… by potential Witnesses before they ever take the step of Christian [baptism]"[20] Malyon continues: "Never is anyone disfellowshipped if he or she displays a repentant attitude, and happily a large number of those thus censured by this rarely used procedure, are eventually restored to our congregations."[21]

In spite of Ridley and Malyon's defense, Muramoto concerns are still pertinent:

> Ridley ignores hundreds of thousands who are members because they were raised by JW parents and baptised as minors. They were indoctrinated from childhood into the religion with minimal exposure, if any to critical views. It is sufficient to point out that the WTS strongly discouraged JW youths from seeking higher education until 1992, that they are today strongly discouraged from participating in internet forums, and that JW children are trained to recite their position on blood to doctors and judges. Where is the free will and full understanding of doctrine for these next generation JWs?[22]

Muramoto also provides evidence that the WTS encourages the practice of shunning, the cutting off of personal ties with apostate friends or family members so that they will

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[19] Donald T. Ridley, "Jehovah's Witnesses' Refusal of Blood: Obedience to Scripture and Religious Conscience" *Journal of Medical Ethics* 25 (1999) 471.
[20] David Malyon, "Transfusion-free Treatment of Jehovah's Witnesses: Respecting the Autonomous Patient's Motives," *Journal of Medical Ethics* 24 (1998) 377.
[21] Malyon, 377.
[22] Osamu Muramoto, "Medical Confidentiality and the Protection of Jehovah's Witnesses' Autonomous Refusal of Blood," *Journal of Medical Ethics* 26 (2000) 383.

repent.[23] This culture of excommunication may not preclude individual autonomy, but it does seem to hinder it.

African Female Circumcision

Case: Annik

> Mr. G brings his 12-year-old daughter, Annik, to Dr. Jordan's office with the request that he [circumcise] her. Although traditionally [in Africa] the procecdure is performed without anesthesia or antiseptics, Mr. G says that he wants his daughter to have access to these, because he does not want her to suffer and wants her to be safe. Dr. Jordan does not find these concessions satisfactory, however. He believes that the practice, even with anesthesia, reflects an unacceptable disfigurement, repression, and control of women. Mr. G and his daughter insist that they want the procedure carried out; if not, they will seek the traditional method.[24]

Female circumcision (also known as female genital mutilation or FGM) in Africa, occurs in twenty-eight countries and affects roughly 132 million women. In Kenya, for example, "over 50 percent of the population…practices female circumcision, in some communities the percentage is as high as 90 percent."[25] Traditionally, the procedure is performed on girls between the ages of four and sixteen by "trained or untrained midwives, traditional healers, barbers, and occasionally doctors or nurses."[26]

There are three types of female circumcision: (1) clitoridectomy, in which all or part of the clitoris is removed; (2) excision, in which the clitoris and labia minora are

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[23] Muramoto, "Medical Confidentiality," 383-4.
[24] From an in-class reflection assignment in Annette Mendola's bioethics course at the University of Tennessee, Fall 2006.
[25] Mary Nyangweso Wangila, *Female Circumcision: The Interplay of Religion, Culture, and Gender in Kenya* (Maryknoll, New York: Orbis Books, 2007) 8.
[26] Rogaia Mustafa Abusharaf, "Introduction: The Custom in Question," in *Female Circumcision: Multicultural Perspectives,* ed. Rogaia Mustafa Abusharaf (Philadelphia: University of Pennsylvania Press, 2006) 4.

removed; and (3) infibulation, in which all of the genitalia are removed and the labia majora is sown mostly shut.

Rogaia Mustafa Abusharaf describes the serious medical risks: "In addition to the immediate risks of bleeding, shock, and sepsis and the longer-term risks of infertility, infection, and obstructed labor, there is an increasing concern in medical circles that unsterilized instruments may be spreading the AIDS virus, particularly when group circumcisions are performed."[27] Infibulation has some of the most serious complications:

> The most common long-term complication was chronic urinary tract infection caused by the pooling of urine because of tight infibulation…Dysmenorrhoea is also prevalent; most Somali girls suffer lower abdominal pain during their monthly period because the very small opening prevents the normal, easy flow of vaginal secretions and menstrual fluid…In Somaliland and Djibouti, a midwife often does the de-infibulation at the time of marriage. In southern Somalia and in the Sudan, the husband is expected to perform this task by penile penetration. The attempt to deinfibulate the woman in this manner causes great pain, carries a risk of infection, and causes frustration for the couple. Sometimes the bride becomes pregnant while still completely infibulated, preventing vaginal exams and prenatal care and leading to further difficulties at the time of delivery. Many infibulated women experience prolonged labor at the second stage, which increases the risk to the mother and may harm the fetus…Medical personnel dealing with infibulated women indicate that the scarred area obstructs the delivery of the baby and in many cases severe perineal tears take place even if an anterior episiotomy is done. Serious complications include vesico-vaginal and recto-vaginal fistulae, abnormal openings between the vagina and the bladder or the vagina and the rectum that can cause urinary and fecal incontinence.[28]

The following reasons are given to justify the practice: (1) social status, (2) religion, (3) female hyper-sexuality, and (4) marriage.[29] First, social status is a concern because girls who do not get circumcised are often stigmatized and ostracized:

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[27] Abusharaf, 4.
[28] Raqiya D. Abdalla, "'My Grandmother Called It the Three Feminine Sorrows': The Struggle of Women Against Female Circumcision in Somalia" in *Female Circumcision: Multicultural Perspectives,* ed. Rogaia Mustafa Abusharaf (Philadelphia: University of Pennsylvania Press, 2006) 191.
[29] Mary Nyangweso Wangila, *Female Circumcision: The Interplay of Religion, Culture, and Gender in Kenya* (Maryknoll, New York: Orbis Books, 2007) 101.

> Female circumcision is viewed by most circumcising communities as an initiation into womanhood. It ensures female fertility, provides a source of identity, and prescribes a social status; the lack of circumcision can lead to social exclusion and shunning. Circumcision is perceived as a test of courage in preparation for the pain of childbirth, a sign of maturity, a source of respect among peers, and an honor for the girl's family. In some communities it becomes a passport to marriage…The elaborate ceremonies such as songs, dances, chants, and teachings about wifely duties create immense social pressure to conform…Sooner or later [an uncircumcised girl] becomes an object of ridicule by her relatives and neighbors…Ridicule can become ostracism, preventing any communal support at a time when it is most needed.[30]

The cultural ceremonies surrounding circumcision are often deeply entrenched. For example, in Meru, Kenya, circumcision is followed by a week of seclusion, during which time the girl is subjected to moral and ancestral teachings. After that, a large celebration is thrown; the family entertains relatives and friends and the parents show off their daughter and their wealth.[31]

It is often the women of the society who defend the practice of circumcision because they have so much invested in their social status as wife and mother. Circumcision is a rite of passage for women in these cultures, and reaching womanhood is as much a social identity as it is an individual identity. Esther Hicks says, "The social identity of the individual is defined, circumscribed and guaranteed by the authority of the community, and initiated by the relevant group. In the case of females, it is the elder generation of women that initiates and carries out this ritual, and it is this privilege and authority that they decline to relinquish."[32]

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[30] Wangila, 100, 101.
[31] Asha Mohamud, Samson Radeny, and Karin Ringheim, "Community-Based Efforts to End Female Genital Mutilation in Kenya: Raising Awareness and Organizing Alternative Rites of Passage," in *Female Circumcision: Multicultural Perspectives,* ed. Rogaia Mustafa Abusharaf (Philadelphia: University of Pennsylvania Press, 2006) 88.
[32] Esther K. Hicks, *Infibulation: Female Mutilation in Islamic Northeastern Africa* (New Brunswick, New Jersey: Transaction Publishers, 1993) 80.

Second, religion is often cited as a reason. African culture is deeply religious, and Africans often perceive everything that happens in life in religious terms, whether the religion is indigenous religion, Islam, or Christianity. The world is not divided into the secular and the sacred as it is in the West. "In all undertakings – whether it be cultivating, sowing, harvesting, eating, traveling – religion is at work. To be born into the African society is to be born into a culture that is intensely and pervasively religious and that means, and requires, participating in the religious beliefs and rituals of the community."[33] For example, when Kenyans reflect on their behavior, they consider everyone who will be affected: friends, family, and the spirits of the departed.[34] Their worldview includes the supernatural, and they think that a full understanding of human well-being requires a consideration of mystical forces. When a Kenyan suffers from a disease, it is not enough to give a medical explanation. As Mary Nyangweso Wangila says, "Possible actions of witches, sorcerers, ancestral spirits, or gods must be eliminated before normal life can resume. Because reason alone cannot encompass every aspect of truth, arguments about practices such as female circumcision that maintain they are unnecessary or unnatural are doomed to fail."[35] Wangila calls this a belief in double causality; illnesses may have natural and supernatural causes. Even a botched female circumcision that results in the death of the girl may be explained in terms of the victim's moral misconduct. "The circumciser may disclaim responsibility by claiming that the

[33] Kwame Gyekye, *African Cultural Values: An Introduction* (Philadelphia: Sankofa Publishing, 1996) 4.
[34] Wangila, 36, 37.
[35] Wangila, 37.

victim's parents committed adultery or that her grandparents or someone else in the family violated a taboo."[36]

The teachings of Islam are sometimes cited to justify the practice. The Koran does not talk about female circumcision; however, some Muslims refer to the teachings of the Hadith (the collection of Muhammad's teachings) that sanctions Abraham's circumcision (and by extension the circumcision of all males and females) and mentions a discussion held between Muhammad and a female circumciser in which Muhammad allegedly endorsed the practice.[37] Muslims who do not circumcise contest this interpretation. In addition, some *fatwas* (authoritative edicts of Muslim leaders) have been issued endorsing circumcision, but equally other *fatwas* have been issued condemning the practice.[38] Wangila says, "Conflicting opinions on the subject of female circumcision among Muslims explains why some Muslims hold to this practice, while others oppose it; female circumcision has an ambiguous link to religious duty that results from inferences and interpretations of ambiguous scriptural verses to support popular practice."[39]

Christianity is also cited as requiring female circumcision. Although it is not mentioned in the Bible (and Christians have historically been the one religious group most opposed to the practice), some Christians infer that Abraham's circumcision is the model for both males and females. As one of Wangila's female informants says, "Since Abraham was circumcised as a sign of his faith in God, we also should emulate him if we

[36] Wangila, 110.
[37] Wangila, 116.
[38] Wangila, 114.
[39] Wangila, 118.

want to be righteous before God as he was."[40] African Initiated Churches (AICs) emerged as a reaction to Western colonialism, and they taught a form of Christianity that was compatible with traditional African culture (Christianity without European adornments). AICs are syncretistic, and they support a number of traditional practices not found in Christianity elsewhere such as polygamy and female circumcision.

Third, circumcision is thought to be a means to control female sexuality. Uncircumcised girls are thought to be unclean, promiscuous, and hyper-active sexually. The removal of the clitoris especially, but also infibulation, is thought to remove sexual desire and protect a girl's virginity. In one survey in Kenya, males said they would not marry an uncircumcised female because "uncircumcised partners tend to seek divorce more easily since they are more independent."[41] A woman's "oversexed nature" is a threat to her husband, her family and to herself. As one villager said: "A woman is like a plough-animal; she has no honor," and as such, she can dishonor her husband unless strict standards are followed.[42] Although circumcision is not a guaranteed way to preserve a girl's virginity, combined with a strict code of modesty and seclusion, it can provide a "powerful physical and psychological deterrent to illicit sexual activities."[43] In a survey of Kenyan females, all of the respondents (50) shared this sentiment. In other words, the women agreed that circumcision controls female sexuality. "Kenya's Rendile people, for example, believe that circumcision will reduce a wife's sexual desire and help her to

[40] Wangila, 120.
[41] Mohamud, Radeny, and Ringheim, 98.
[42] Hicks, 74.
[43] Hicks, 76.

control her sexual desire during the often long absences of a husband who may be away for months at a time caring for animals in the bush or working in a larger town."[44]

Fourth, circumcision is often justified as a prerequisite for marriage. For one, circumcised girls are thought to make better wives. In one study, men perceived uncircumcised women as "oversexed, unclean, rude, bossy, and disrespectful."[45] Second, finding a good wife for a son (or having an eligible daughter) is highly valuable. One African proverb says, "A good wife is more precious than gold."[46] Another says, "A good wife is wealth."[47] These proverbs speak not only to the honor that a good wife brings her husband, but also to the generous dowry she will bring her parents. Infibulation is thought of as one way to protect a girl until marriage. The hijab (or veil) acts in much the same way, symbolically protecting the female from the world outside. Infibulation is an act of covering, and so protects the area of reproduction from the world. Traditionally, there were two kinds of women: the protected and the unprotected. "Mernissi has pointed out that women in early Islamic society were divided into two categories: those who were free, and protected from violence and those who were slaves, and were not…. Any woman who did not belong to a tribe and have the protection of a well-armed husband was in danger of being captured, raped, or enslaved."[48]

[44] Wangila, 101, 102.
[45] Mohamud, Radeny, and Ringheim, 81.
[46] Gyekye, 82.
[47] Gyekye, 82.
[48] Hicks, 82, 83.

Orthodox Judaism and End of Life Care

Case: Samuel Golubchuk

> Mr. Golubchuck[49] was an elderly Jewish man admitted to [the] hospital with pneumonia and hypertension with a pre-existing brain injury that left him with minimal brain function. His illness was so severe that he was soon transferred to the ICU and intubated. There were few if any signs that he would recover. In horrifying terms Mr. Golubchuck's physicians argued that to keep him on life support was "torture" due to his increasingly complicated care, whereas his family argued that to take him off life support was tantamount to "murder" according to their Orthodox Jewish beliefs….In a striking move, Mr. Golubchuck's attending physician resigned his position at the hospital over the case, followed by two other intensivists who refused shifts in the ICU, arguing that to continue to treat Mr. Golubchuck was a violation of their medical ethics and their prima facie duty to "do no harm." The physician graphically described that keeping Mr. Golubchuck from his natural death required surgical "hacking away" at his bedsores at the bedside in order to keep his infection at bay. Without reasonable hope of benefit the physician characterized this kind of treatment as "assault" and a "grotesque abomination"…Instead, Mr. Golubchuck was cared for by substitute physicians and remained on life support for a total of seven and a half months. All the while his family never stopped pleading the medical duty to act according to his Orthodox Jewish beliefs. Mr. Golubchuck died while expert neurologists representing both sides continued to debate the status of his brain function and prognosis.[50]

Orthodox Judaism emphasizes the sanctity of life and strongly prohibits the shortening of anyone's life. Fred Rosner, an Orthodox Jew, writes: "In Judaism every human being is considered to be of supreme and infinite value. It is the obligation of individuals and society to preserve, hallow, and dignify human life to care for the total needs of all persons so that they can be healthy and productive members of society."[51]

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[49] In some places Samuel's last name is spelled "Golubchuck," in others: "Golubchuk." I believe that "Golubchuk" is the correct spelling.
[50] Robert Mundle, "The Hospital Chaplain as Religious Interpreter in Bioethical Dilemmas," *Scottish Journal of Healthcare Chaplaincy* 12 (2009) 23.
[51] Fred Rosner, *Contemporary Biomedical Issues and Judaism* (Jersey City, New Jersey: KTAV Publishing House, 2007) xiii.

The sanctity of life, he claims, is so important that it virtually trumps all other values.[52] While discussing the Terri Schiavo case, Rosner says, "Euthanasia in any form is condemned as an act of murder; shortening a person's life by even a moment is tantamount to murder. The removal of Terri Schiavo's feeding tube was wrong in that it would inevitably shorten her life and thus constitutes an act of murder."[53]

Rosner cites the following reasons to support his claims. First, the Bible teaches that human beings were created in the image of God, which means that human life has supreme value.[54] Second, the Bible strongly prohibits murder:

> In Exodus 20:13, it is stated: "And if a man come presumptuously upon his neighbor, to slay him with guile; thou shalt take him from Mine altar, that he may die." In Leviticus 24:17, there is the phrase "And he that smiteth any man mortally shall surely be put to death" and four sentences later we find again… "And he that killeth a man shall be put to death." In Numbers 35:30, it is stated, "Whoso killeth any person, the murderer shall be slain at the mouth of witnesses" …Finally in Deuteronomy 5:17, the sixth commandment of the Decalogue is repeated: "Thou shalt not kill." Thus, in every book of the Pentateuch, we find at least one reference to murder or killing.[55]

Third, euthanasia is also prohibited in the Bible. In I Samuel 31:1-6 and II Samuel 1:5-10, the story of Saul's death is told. It says that during a battle that went badly for Israel, Saul was afraid and asked his armor-bearer to kill him with the sword. The armor-bearer refused, so Saul fell upon his own sword. Later, David was asking a witness how he learned of Saul's death, and the witness said he came upon Saul impaled on his spear. Saul asked the man to finish him off, which he proceeded to do. David, then, put the

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[52] The command to preserve human life trumps all but three commands: adultery, murder, and forbidden sexual relations, Rosner, "Contemporary Biomedical Issues," xiv.
[53] Rosner, "Contemporary Biomedical Issues," 115.
[54] Fred Rosner, "Jewish Perspectives on Issues of Death and Dying," *The Journal of Halacha and Contemporary Society* (11) (1986) 60.
[55] Ibid., 52.

witness to death, it is assumed, for an act of unjustified euthanasia.[56] Fourth, euthanasia is also prohibited in the Talmudic sources. For example, Rosner writes:

> The Mishnah states as follows (*Semachot* 1:1): "One who is in a dying condition (gosses) is regarded as a living person in all respects." The Mishnah continues (*Semachot* 1:2 to 4): … "One may not move him nor may one place him on sand nor on salt until he dies. One may not close the eyes of the dying person. He who touches them or moves them is shedding blood because Rabbi Meir used to say: 'This can be compared to a flickering flame. As soon as a person touches it, it becomes extinguished. So too, whosoever closes the eyes of the dying is considered to have taken his soul." The fifth century Babylonian Talmud (*Shabbat* 151b) mentions as follows: "He who closes the eyes of a dying person while the soul is departing is a murderer."[57]

Orthodox Judaism makes a moral distinction between withdrawing and withholding life support to terminally ill patients. The latter is permissible, but the former is not (unless judged "heroic"). The trouble for Jewish patients and family members is that if they start treatment, they are obligated to continue treatment until the "bitter end." One Jewish scholar suggests a work-around for this problem: "connecting the ventilator at the time of intubation for patients with unclear medical conditions to a timer; if after comprehensive workup and clinical observation over the period of the timer the patient does not improve, the timer would not be reset."[58] This solution would allow the patient's condition to end her life without having to withdraw life support. Benjamin Gesundheit, et. al. says that in certain cases withdrawing might be permissible: "There is no obligation to artificially prolong life with heroic intervention in the ongoing process of dying and, under such conditions… even cessation of treatment (but not active induction

[56] Rosner, "Jewish Perspectives," 52-3.
[57] Rosner, "Jewish Perspectives," 53-4.
[58] Benjamin Gesundheit, "Reflections on the Golubchuk Case," *The American Journal of Bioethics* 10 (2010) 73.

of death!) might be approved or even demanded by Jewish law."[59] However, the key term here is "heroic," for it seems that there will be a wide difference of opinion about what counts as heroic when Judaism takes such a strong stand on the sanctity of life.

Recently, *The American Journal of Bioethics* published a target article based on the Golubchuk case: "The Case of Samuel Golubchuk and the Right to Live."[60] The authors, Alan Jotkowitz, Shimon Glick and Ari Z. Zivotofsky, tell how the College of Physicians and Surgeons of Manitoba released a statement at the time of the case (Golubchuk was from Manitoba, Canada). The statement says that physicians have the final say whether to withdraw life support even if the patient and family disagree. According to the statement,

> "The criterion for maintaining life support is the ability of the patients to recover to a level at which they are aware of themselves, their environment, and their existence. If the family disagrees with this decision to terminate life support, the physician must consult with another physician. If the consulted physician agrees, therapy may be withdrawn over the objections of the patient/proxy/representative. Even if the minimum therapeutic goal is achievable, but the physician concludes nevertheless that life-sustaining therapy should be withdrawn, and he or she obtains a consultant's agreement, the physician may withdraw life support over the express opposition of the patient/proxy/representative, if the family is given 96 hours of notice before withdrawal of life support.[61]

Jotkowitz, Glick and Zivotofsky criticize the statement arguing that it (1) violates patient autonomy, (2) lacks cultural sensitivity, (3) promotes the erosion of respect for life, and (4) overlooks the fact that physician predictions are often wrong.

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[59] Benjamin Gesundheit, Avraham Steinberg, Shimon Glick, Reuven Or, Alan Jotkovitz, "Euthanasia: An Overview and the Jewish Perspetive," *Cancer Investigation*, 24 (2006) 626.
[60] Alan Jotkowitz, Shimon Glick, Ari Z. Zivotofsky, "The Case of Samuel Golubchuk and the Right to Live," *The American Journal of Bioethics* 10 (2010) 50-53.
[61] Jotkowitz, Glick, Zivotofsky, 50.

Faith Healing

Case: Pamela Hamilton

> The Church of God of the Union Assembly in Lafollette, Tennessee had as one of their tenets in 1983: "All members of the church are forbidden to use medicine, vaccinations or shots of any kind but are taught by the church to live by faith."[62] This belief led to a confrontation when 12-year-old Pamela Hamilton, a member of this community, was diagnosed with Ewing's Sarcoma that year. Dr. Frank Haraf, an oncologist, became alarmed when Pamela did not return for treatment because he was certain that she would die within three months unless treated. Larry Hamilton, Pamela's father, said, "If you've got a Chevrolet, you wouldn't take it to Ford to get it repaired, would you? Just like your body, God made you. Why take it to an off-brand to get something done to it. Just believe on him to get it done and he'll take care of you."[63] Pamela shared her father's beliefs and refused treatment, but the Court of Appeals invoked *parens patriae* and ordered her to be admitted immediately for treatment, which was effective; however, Pamela died from a relapse in 1985.[64]

Faith healing is a broad category. It could refer to the power of positive thinking, mind over matter, or belief in miracles. It might not preclude standard medical treatment (as when hospital patients are prayed for), or it might mean refusing treatment (as in the case of Pamela Hamilton). For my purpose here, I will limit the scope of *faith healing* to beliefs in miracles that result in refusal to receive standard medical treatment or in demands to continue care deemed futile.

However, this raises another question: what is a miracle? Some use the word "miracle" loosely such as in describing a "miracle drug." Others use the word to describe surprising medical results. As Cindy Hylton Rushton and Kathleen Russell write:

> For example, health care professionals may use the language of miracles to describe events that defy scientific and medical predictions. In this view, miracles are based on care that is accomplished through technology and human

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[62] State of Tennessee Department of Human Services vs. Larry T. Hamilton, Court of Appeals of Tennessee, Eastern Section (1983).
[63] "The Pamela Hamilton Case," an unpublished paper by Glenn Graber.
[64] Ibid.

> engineering. For instance, critical care professionals may label situations where the patient survives when all else fails as the "PICU Save" and claim a miracle has occurred. From their perspective, such situations represent an event where the expertise of the health care professionals and their technology contributed to saving a patient from the jaws of death despite insurmountable odds.[65]

These definitions above do not include a supernatural component, so I will set them aside. David Hume is thought to have given the standard philosophical definition of a "miracle." He says that a miracle is defined as "a violation of a law of nature."[66] However, he is ambiguous on the point because he also says that a miracle is "a violation of a law of nature by a Deity or invisible agent."[67] The presence of these two definitions in the same work have confounded Hume's interpreters, but I think that the second is more applicable here. Nevertheless, I do not think that a miracle should be conceived of as a "violation" of a law of nature because it is not compatible with how many traditional theistic believers conceive of God's relationship with creation, which is as the author and sustainer of the laws of nature, not as *violator*. For this reason, I will define a miracle as divine intervention in the normal course of events (laws of nature).

Pamela Hamilton and her community relied on faith healing and were hoping for a cure, but they also were resigned to it being Pamela's "time" if God so willed. Although it is cases like Pamela's that make the news, it is not only obscure cult-like groups that believe in miracles. Robert Orr describes a case in which a Pentecostal family makes an M-request:

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[65] Cindy Hylton Rushton and Kathleen Russell, "The Language of Miracles: Ethical Challenges," *Pediatric Nursing* 22 (1996) 64.
[66] David Hume, *An Enquiry Concerning Human Understanding*, ed. Tom L. Beauchamp, (Oxford: Oxford University Press, 2000) 87 (*EHU* 10.12).
[67] Hume, 123, in footnote 7.

> Before this four-month-old boy was born with Down's syndrome and complex anomalies of his heart, his devout Pentecostal parents named him after an Old Testament patriarch. He had had four surgical interventions in an effort to prolong his life, but he was now in multi-organ failure with no reasonable likelihood of survival. For the preceding two weeks, his bedside nurses had urged his physicians to persuade his parents to withdraw life support so that his suffering might cease. When the surgeon approached the family with this strong recommendation, they refused to consider withdrawal of life-support. They said that God had spoken to his mother through scripture references which contained the patient's first name, and in this manner had promised her that he would get better as a testimony to the hospital staff and the community of God's power.[68]

Many mainstream Christians, and not just Pentecostals, believe God still speaks and heals today, so it is not uncommon that Christians will make requests based on a personal revelation from God.

Christian Science has received much attention for its hostile stance toward traditional medicine. Its followers are taught to pursue healing through prayer, not through traditional medicine: "For Christian Scientists, the power of prayer is superior to standard medical treatment. The solicitation of medical care demonstrates weakness of faith. Corroborative evidence for the success of spiritual healing is provided through member testimonials by the recently cured and supported by at least three other church members present during the patient's recovery. Since 1900, Christian Scientists have reported over 53,000 healings from many diseases."[69]

Christian Science teaches its followers to acquire a spiritual consciousness like Jesus; it was this spiritual understanding of reality that enabled Jesus to heal illnesses. Followers are taught that reality is spiritual and that once this spiritual awareness is acquired, so-called physical healing will result. Allison W. Phinney, Jr. writes:

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[68] Orr and Genesen, "Requests for 'Inappropriate' Treatment," 144.
[69] Kenneth S. Hickey and Laurie Lyckholm, "Child Welfare versus Parental Autonomy: Medical Ethics, the Law, and Faith-Based Healing," *Theoretical Medicine* 25 (2004) 267.

"Christian Science treatment could not possibly heal as it does if everything were as solidly material as it appears. But since it isn't, and what we see and experience so vividly and sometimes painfully is a subjective mental impression, this fear and false impression about God and His man can be changed by the omnipotence of divine Mind."[70]

Nevertheless, Christian Science treatments do not always work. Kenneth Hickey and Laurie Lyckholm describe the following case:

> In late Fall of 1992, James Andrew Wantland (Andrew), a twelve-year-old seventh grader in La Habra, California began to experience lethargy, weight loss, and frequent urination. Andrew began to complain to his father and paternal grandmother about his symptoms on or about December 14, 1992. His father, a Christian Scientist, felt his son's symptoms were transient and made little attempt to address the issue. By December 17, 1992, Andrew was emaciated, vomiting, and eating little. His father contacted a Christian Science practitioner who provided healing prayer without actually coming to see Andrew. By December 20, 1992, Andrew experienced altered mental status and total exhaustion. A Christian Science nurse was called to the family home. Upon her arrival, Andrew was making no eye contact, was unresponsive, and had rapid, deep respirations. At this time, Andrew's father decided to abandon spiritual healing and called 911. Andrew was transported to the nearest hospital and was pronounced dead. The medical examiner deemed the death to be the result of complications associated with juvenile diabetes.[71]

Christian Science "practitioners" and "nurses" are trained in the ways of their founder, Mary Baker Eddy. These ways do not include the basics of medical science, but they include "bathing, making beds, wound care, and bandaging, and supporting the patient's own prayer."[72] Also, while most forms of medical treatment are opposed, not all forms are. These include: "orthopedic and dental treatments…as well as supportive equipment

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[70] Allison W. Phinney, Jr. "Why does Christian Science Treatment Heal and How does it Work?" *Christian Science Sentinel*, http://christianscience.com/articles-sentinel/2007/10/11/why-does-christian-science-treatment-heal-and-how-does-it-work/ (accessed February 21, 2012).
[71] Hickey and Lyckholm, 266.
[72] Hickey and Lyckholm, 266.

such as eyeglasses, crutches, and hearing aids."[73] In addition, the practice of praying for sick individuals over the phone is common, so Andrew's case is typical even if the outcome is not.

Conclusion

In this chapter, I have examined four common cases: M-requests made by Jehovah's Witnesses, some African communities, Orthodox Jews, and religions that believe in faith healing. In each case, I have explored the practices and traditions of the communities involved and the reasons given to defend the M-requests.

[73] Hickey and Lyckholm, 267.

CHAPTER THREE
Liberty of Conscience and the Standard of Care

In this chapter, I examine the liberty of conscience and its limits, showing that respect for matters of conscience is an important principle. Second, I explore the standard of care, the clinical point of view, to best understand the reasons for the conflict between matters of conscience and the clinic. Next, I consider three unsatisfying or incomplete approaches to handling M-requests, setting the stage for a *phronesis*-based proposal.

The Liberty of Conscience

The human conscience is the faculty that reflects on questions of morality, meaning, and the good life, and decides, for each person, what the answers to these questions are. The liberty of conscience is the notion that the conscience needs to be free from interference to act effectively. This liberty is enshrined in the First Amendment to the U.S. Constitution: "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof." The first part is known as the Establishment Clause, which is interpreted as saying that the government should not show preference to a religion; the second part is known as the Free Exercise Clause, which is interpreted as meaning that citizens are free to believe what they want and free to act on their beliefs.

In *Liberty of Conscience*, Martha Nussbaum describes six normative principles that are recognized by the First Amendment.[74] First, the Equality Principle is the

[74] Martha Nussbaum, *Liberty of Conscience* (New York: Basic Books, 2008).

principle that citizens have equal rights under the law. As Nussbaum says, "we want not just *enough* freedom, but a freedom that is itself *equal*, and that is compatible with all citizens being fully equal and being equally respected by the society in which they live."[75] Because of this principle, the liberty of conscience is sometimes called "the *equal* liberty of conscience," emphasizing the fact that conscience is common to all citizens and needs to be equally protected.

Second, the Respect-Conscience Principle recognizes the important role conscience plays as the faculty that determines life's meaning. Nussbaum, expounding on Roger Williams' defense of religious liberty, says: "Conscience…is the dignity of the person; it is, indeed, the person himself. So: everyone has inside something infinitely precious, something that demands respect from us all, and something in regard to which we are all basically equal."[76] This principle also recognizes that in any society, especially a pluralistic one, there are diverse commitments of conscience and that each one, being infinitely valuable, should be respected.

Third, the Liberty Principle says that if we are to respect conscience, it must be adequately free with respect to constraints so that it can function properly. Nussbaum says, "Understanding what conscience is like and what it needs, we see that it requires substantial (and equal) religious liberty, including liberty of belief and speech, liberty of religious practice (within limits set by the rights of others), and the liberty of religious bodies to organize their own affairs (again within some limits)."[77] In describing the nature of the conscience, John Locke describes how we cannot force someone to believe

[75] Nussbaum, 19.
[76] Nussbaum, 52.
[77] Nussbaum, 24.

something: "[The conscience] cannot be compelled to the belief of any thing by outward force. Confiscation of estate, imprisonment, torments, nothing of that nature can have any such efficacy as to make men change the inward judgment that they have framed of things."[78]

Fourth, the Accommodation Principle says that in some cases, in order to respect conscience, religious citizens should be exempt from generally applicable laws, which means that occasionally the protection of conscience can trump the interests of the state. For example, in time of war, some citizens should be exempt from military service. As George Washington wrote to Quaker conscientious objectors in 1789: "I assure you very explicitly, that in my opinion the conscientious scruples of all men should be treated with great delicacy and tenderness: and it is my wish and desire, that the laws may always be as extensively accommodated to them, as a due regard for the protection and essential interests of the nation may justify and permit."[79] A recent case in Florida challenged this principle: a Muslim woman was not permitted to wear her veil in her driver's license photograph. She took her case to court, but lost. The court ruled that there was a compelling state interest in having uncovered faces on identification cards.[80] While this may have been a reasonable ruling, consider another recent case involving Muslim dress: on April 11, 2011, France outlawed entirely the wearing of the Muslim burqa. French President Sarkozy said, "The veils are an assault on French values of secularism and

[78] John Locke, *A Letter Concerning Toleration* (Buffalo, New York: Prometheus Books, 1990) 20.
[79] Nussbaum, 115.
[80] Case discussed in Nussbaum, *Liberty of Conscience*, 347.

equality of the sexes…the burqa isolate(s) women and take(s) away their humanity."[81] Another French official said, "You can't have things like men and women refusing to shake each other's hands, and separate hours for boys and girls at the public swimming pool. That's just not France."[82] The French ban seems to be based entirely on the values of unity and conformity, but unless it can be shown that essential interests are at stake, it seems that the ban constitutes an unjust infringement of religious liberty.

Fifth, the Nonestablishment Principle says that the state should not show preference to a religion because doing so would violate the Equality Principle and the Respect-Conscience Principle. Nussbaum explains why religious establishment is wrong: (1) It will encourage religious political competition (factionalism), (2) the state will interfere with the internal affairs of religion, (3) it may be difficult for the state to avoid coercing its citizens, and (4) it undermines equality since the establishment suggests that outsiders are not equal members of the community.[83] Many countries do not support this principle, for example, England, which recognizes an official church, and Iran, which recognizes only Shia Islam. This principle was hotly contested in the U.S. in 2001 when Chief Justice Roy Moore was fired for resisting the order to remove a monument of the Ten Commandments from an Alabama judicial building.

Finally, the Separation Principle says that to some degree, church and state must be separate in order to respect most of the principles already listed, especially the Establishment Principle. If the state is to remain neutral with regards to religion, then

[81] Npr.org, France's Burqa Ban Adds to Anti-Muslim Climate http://www.npr.org/2011/04/11/135305409/frances-burqa-ban-adds-to-anti-muslim-climate (accessed February 21, 2012)
[82] Npr.org, France's Burqa Ban, (accessed February 21, 2012)
[83] Nussbaum, 225.

there must be some degree of separation between the two realms. John Locke argues: "The church itself is a thing absolutely separate and distinct from the commonwealth. The boundaries on both sides are fixed and immoveable. He jumbles heaven and earth together, the things most remote and opposite, who mixes these societies, which are in their original, end, business, and in every thing, perfectly distinct, and infinitely different from each other."[84] This is not, as some think, to promote secularism as the state "religion;" this would also be a violation of both the Equality and Establishment Principles, nor is it a total separation. As Nussbaum remarks: "Imagine what it would be like if the fire department refused to aid a burning church, if churches didn't have access to the public water supply or the sewer system, if the police would not investigate crimes on church property, if clergy could not vote or run for office. Such proposals seem horribly unfair, because the state is providing all these forms of support for everyone else."[85] The actual degree of separation is determined by the minimum requirements of the principles above.

Of course, there are limits to the liberty of conscience. Traditionally, those limits have been framed in terms of the avoidance of harm; in other words, conscience should be free unless the exercise of conscience will result in harm to others. Violating the rights of others and disturbing the peace may also be limits to this liberty.

Should liberty of conscience extend to the clinic? Most certainly it should. If citizens should be free to hold beliefs and act on those beliefs, it would be *unnatural* to limit such freedoms to certain areas of public life. It is in the clinic, moreover, where

[84] Locke, 32.
[85] Nussbaum, 11.

citizens, as patients, come face to face with their deepest beliefs, and it would be callous to deprive them of this basic liberty when it matters most. As Christopher Meyers explains: "Hospital stays are rarely good times and religion provides great support and comfort to many patients and their families. Religious beliefs also closely inform patients' and surrrogates' choices; every clinician has repeatedly heard the request, 'Please give Mom just a few more days while we pray for a miracle.'"[86] In addition, religious beliefs are an important part of patient well-being. David B. Larson and Susan S. Larson discuss patient survey data and studies in which patients view their religion as important to coping with illness, depression, and stress. Harold G Koenig et al. write:

> Religious beliefs and practices reduce the sense of loss of control and helplessness that accompanies physical illness. Religious beliefs provide a cognitive framework that can reduce suffering and increase one's purpose and meaning in the face of loss of other previously relied-upon sources of self-esteem. Private religious activities such as prayer reduce the sense of isolation and increase the patient's sense of control over the illness. Praying to God may not only relieve the patient's loneliness, but belief in an all-powerful, loving, and responsive God can give patients the sense that they can influence their own condition by possibly influencing God to act on their behalf. Public religious behaviors that improve coping during times of physical illness include participating in worship services, praying with others (and having others pray for one's health), being visited by clergy at home or in the hospital, and talking with the hospital chaplain.[87]

Caring for patients holistically (their general well-being) requires respecting their religious beliefs. However, some may rightly point out that respecting conscience in the clinic can sometimes conflict with the standard of care.

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[86] Eskew and Meyers, 1.
[87] Harold G. Koenig, David B. Larson, Susan S. Larson, "Religion and Coping with Serious Medical Illness" *The Annals of Pharmacotheraphy* 35 (March 2001) 355.

The Standard of Care

The standard of care is a legal concept that sets the minimum for physician conduct. George J. Annas says, "[the] standard is generally defined simply as what a reasonably prudent physician (or specialist) would do in the same or similar circumstances."[88] Le Puma et al. describe two components of the standard of care: (1) what is medically indicated and (2) what is legally required. Le Puma et al. relate the first component to Aristotle's notion of *techne*, or technical knowledge. They say, "Once clinical practice or clinical trials prove a treatment to be beneficial and better than alternative therapies, it becomes the standard of care. A medical procedure is 'indicated' when it has proved to be efficacious."[89] They relate the second component to Aristotle's notion of *nomos*, or the law: "Mandating similar actions for similar physicians in similar situations."[90]

While Annas' definition above is sufficient for my purposes here, it should be pointed out that the term is subject to debate. As Harvey J. Blumenthal and John R. Woodard explain, the term is not used carefully: "[the standard of care] is a legal concept which increasingly is found in medical writings, often without being defined."[91] They show that authors may use the term for impact, just to give authority to their recommendations. Some articles, they explain, use the term in the title, but offer only "guidelines," which is confusing since "guidelines" sounds much weaker than

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[88] George J. Annas, *Standard of Care: The Law of American Bioethics* (New York: Oxford University Press, 1993) 4.
[89] John La Puma, M.D., David L Schiedermayer, M.D., Stephen Toulmin, Ph.D., Steven H. Miles, M.D., Jane A. McAtee, J.D., "The Standard of Care: A Case Report and Ethical Analysis," *Annals of Internal Medicine* 108 (1988) 122.
[90] La Puma, Schiedermayer, Toulmin, Miles, and McAtee, 121.
[91] Harvey J. Blumenthal, MD, John R. Woodard III, BA, JD, "Standard of Care" *Headache: The Journal of Head and Face Pain* 48 (June 2008) 861.

"standards." Also, the concept varies slightly from state to state. For example, Massachusetts law defines the standard of care as "the care that the average qualified physician would provide,"[92] and Kansas law defines it in terms of best judgment: "Where, under the usual practice of the profession of the defendant, different courses of treatment are available which might reasonably be used, the specialist has a right to use his best judgment in the selection of the choice of treatment. However, the selection must be consistent with the skill and care which other specialists practicing in the same field of expertise would use in similar circumstances."[93]

The standard of care is grounded in evidence-based medicine. Marcia Angell, who was the executive editor of *The New England Journal of Medicine*, describes the evidence-based approach: "Perhaps the most important hallmark of science is its utter reliance on evidence. Furthermore, the evidence must be objectively verifiable. This reliance on concrete evidence distinguishes science from all other human endeavors…Medical conclusions are no different from other scientific matters, because the body is a part of nature."[94]

This approach to medicine has its critics, especially in the supporters of complementary and alternative medicine (CAM). Angell has defended evidence-based medicine against charges of establishment bias from CAM supporters arguing that good evidence "must offer a plausible biological mechanism for effects reported."[95] Such

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[92] Blumenthal and Woodard III, 859.
[93] Blumenthal and Woodard III, 859.
[94] Marcia Angell, *Science on Trial: The Clash of Medical Evidence and the Law in the Breast Implant Case* (New York: W.W. Norton, 1996) 92.
[95] David J. Hufford, "CAM and Cultural Diversity: Ethics and Epistemology Converge," in *The Role of Complementary & Alternative Medicine: Accommodating Pluralism*, ed. Daniel Callahan (Washington D.C.: Georgetown University Press, 2002) 15.

evidence apparently rules out CAM treatments such as homeopathy, moxibustion, and intercessory prayer. David J. Hufford explains that the evidence-based approach is connected to what he calls the theoretical plausibility criterion:

> The theoretical plausibility criterion asserts that (1) all valid knowledge will prove to be coherent (that is, to follow logically without inconsistencies or gaps) with some characteristics of established contemporary science (*known biological mechanisms* in Dr. Angell's instance), and (2) that the likelihood that a claim will eventually have this coherent relation to contemporary science can be judged on the basis of present knowledge.[96]

Hufford's analysis of the theoretical plausibility criterion produces the following components:

(a) Existing conventional scientific knowledge is an adequate measure of whether an unconventional claim is true.

(b) Empirical evidence of an event that is not theoretically plausible can be rejected out of hand.

(c) If a practice lacks theoretical plausibility there is no reason to think that it may work.

(d) Acceptance of theoretically implausible claims would require the abandonment of current scientific knowledge.

(e) There is no such thing as CAM, there is just medicine that is supported by solid research and medicine that is not.[97]

Hufford rightly questions each of these components, claiming that they represent expert paternalism and infringe on the process of free inquiry. However, I do not have the space here to explore his argument.

Grounded, as it is, in evidence-based medicine, the standard of care may, at times, conflict with the liberty of conscience, but it does not follow that the standard of care should run roughshod over commitments of conscience. The liberty of conscience, as a

[96] Hufford, 17.
[97] Hufford, 17.

prima facie right, means that we seriously consider M-requests that violate the standard of care, which is in keeping with the Respect-Conscience and Accommodation principles.

Some might object that this fails to take seriously the consciences of health care providers, who are just as much worthy of respect. There are two parts to this objection: (1) the standard of care is something like a professional conscience, and it would be a violation of this professional conscience to honor an M-request;[98] and (2) caregivers have their own personal convictions, some of which are based on religious beliefs, and it would be insensitive to require them to act contrary to their own consciences (this broaches the topic of conscience clauses in health care). I do not have the space here to respond in depth to these concerns, but to say that in the current patient-centered environment where patient autonomy is heralded as the highest value, the conscience of the patient naturally comes first. Physicians are bearers of conscience too, but they are representatives of a professional institution, one that is meant to serve the public, and the liberty of conscience was meant to protect individual religious convictions, not matters of professional conduct (although those are important too). Also, enough has been said about conscience clauses in the literature to provide, I believe, enough accommodation to professionals who feel conflicted in honoring an M-request.

Macklin's Approach

However, this is not to advocate some kind of moral relativism. Liberty of conscience is not an absolute. If it were an absolute, it could be used to justify atrocious acts such as the Jonestown massacre when, in 1978, Jim Jones instructed his followers to

[98] Thanks to Glenn Graber for this insight.

consume a cyanide-laced drink. Parents were to give it first to their children and then lie down and die next to them in a mass murder-suicide. Religious liberty cannot vindicate such actions. Ruth Macklin argues, "It is one thing to require that cultural, religious, and ethnic groups be treated as equals; that conforms to the principle of justice as equality. It is quite another thing to say that any cultural practice whatsoever of any group is to be tolerated and respected equally. This latter view is a statement of extreme ethical relativism."[99] Macklin is right to want to avoid this type of relativism.

However, Macklin argues against what she calls "respect for tradition," which she considers is simply a "convenient injunction for people in power – usually defenders of the status quo – to keep the system that sustains their power intact."[100] She thinks that such a maxim may serve anthropologists well in the field, but it is not an ethical principle that can justify a cultural practice. She says that it is possible that one might show respect for tradition on utilitarian grounds on occasion, but one need not respect tradition for its own sake. She says,

> It might be argued that respect for tradition could be considered part of respect for autonomy, but that maneuver will not stand up to ethical scrutiny. Application of the principle "respect for autonomy" cannot require that any actions whatever that flow from the capacity for self-determination must be judged ethically acceptable. People who engage in political torture, commit domestic violence, and sterilize people without their consent may all be acting autonomously, but they do not deserve respect. The same is true for traditions that individuals or a cultural group autonomously accept and adhere to. Some traditional practices are harmful, even evil, some are beneficial, and others are ethically neutral. The mere fact that it is a "tradition" says nothing about the moral value that should be

[99] Ruth Macklin, "Ethical relativism in a multicultural society" in *Biomedical Ethics*, ed. TA Mappes and David Degrazia (Boston: McGraw-Hill, 2006) 126. Macklin also says, "Freedom of religion does not include the right to act in a manner that will result in harm or death to another." In "Consent, coercion and conflict of rights" *Perspectives in Biological Medicine* 20 (1977) 365-6.

[100] Ruth Macklin, *Against Relativism: Cultural Diversity and the Search for Ethical Universals in Medicine* (New York: Oxford University Press, 1999) 59.

> attached to it. Just as laws maybe be enacted, criticized, or overturned for ethical reasons, so too may customs and traditions be subjected to ethical scrutiny.[101]

In short, tradition is not valuable in itself, according to Macklin, and respecting tradition is not a normative principle on par with other principles like autonomy, beneficence, nonmaleficence, and justice.

Macklin uses the case of African female circumcision as an example. She notes that anthropologists who defend (or do not adamantly oppose) the practice do so for a number of reasons: (1) out of cultural sensitivity, (2) out of concern that criticism will only more deeply entrench the practice, and (3) out of the desire to avoid appearances of cultural imperialism.[102] She says that the mutilation of female genitals is a brutal violation of women's rights, and the practice violates the principle of nonmaleficence. No appeal to respect for tradition can justify the practice.

While I do agree with Macklin's conclusion about female circumcision, she is mistaken about the way to arrive there. She seems to think that the standard principles of biomedical ethics are sufficient. She tells a story of teaching the principles to a group of cross-cultural workers: "I stated and explicated the principles of nonmaleficence, beneficence, respect for persons, and prominent principles of justice. When I had finished, one participant asked: 'Are these the only fundamental ethical principles?'…Turning the challenge back to them, I asked if they could provide examples of candidates for coequal principles. One person proposed 'respect for tradition.' Never

[101] Macklin, *Against Relativism*, 81.
[102] Macklin, *Against Relativism*, 69.

having heard this proposed as an ethical principle, I wondered whether it should qualify as one."[103]

Macklin concludes that respect for tradition should not qualify as an ethical principle. On the face of it, she seems right, but if tradition is a part of culture, and culture is a part of our identity, then tradition is worthy of respect – if for no other reason than it is derivative from respect for persons. Respect for tradition can also be conceived as a component of the principle "respect for conscience" (or Respect-Conscience Principle), which can also be shown to be closely linked to the principle of respect for persons. To respect people is to respect them as bearers of conscience, as Nussbaum argues above.

Contrary to what some might say, the principle of autonomy is compatible with receiving one's beliefs from tradition, culture, and religion. As Beauchamp and Childress explain, "No fundamental inconsistency exists between autonomy and authority, because individuals can exercise their autonomy in choosing to accept an institution, tradition, or community that they view as a legitimate source of direction. Having welcomed the authority of his or her religious institution, a Jehovah's Witness can refuse a recommended blood transfusion…That we share moral principles in no way prevents them from being *our* principles."[104] There is a philosophical conundrum here that might be expressed in the dilemma: "autonomy today or autonomy tomorrow?" It is not entirely clear how we can protect our autonomy tomorrow if we surrender to authority today. If we second-guess the same authority at every turn, have we really

[103] Macklin, *Against Relativism*: 10.
[104] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics, Fifth Edition* (New York: Oxford University Press, 2001) 60.

accepted that authority?[105] This concern is valid and probably indicates a nonvirtuous epistemic practice that should be avoided (call it total-epistemic-surrender). Nevertheless, I think a middle ground can be staked out. There is an *autonomy* somewhere between total epistemic surrender and absolute independence that is in keeping with proper epistemic functioning. Anyway, a view of autonomy that precludes a patient from adopting the moral views of others in her community is unrealistic; it overemphasizes the value of individualism and overlooks the social nature of belief acquisition.

To reiterate, this respect for conscience does not amount to moral relativism: it is *not* to say that conscience (or autonomy as Macklin recognizes) trumps everything, but the liberty of conscience is a fundamental right. What Macklin overlooks, at a minimum, is the virtue of cultural sensitivity. Even the authors of *Principles of Biomedical Ethics*, the source of the principles she defends, recognize now that the bioethical principles alone are not sufficient as a guide for medical practice. Professionals, they say, need to cultivate moral virtues in their characters in order to cultivate good judgment, and arguably, cultural sensitivity is one of those virtues insofar as it considers patients' background beliefs and respects the patients' commitments of conscience. Macklin's analysis of the female circumcision case omits any serious reflection on the reasons a group might have to engage in such a practice, choosing, instead, to only consider non-religious reasons and factors such as harm, coercion, and sexual misinformation. She jumps to an examination of the practice in terms of the principles of bioethics, but she

[105] Thanks to Glenn Graber for the articulation of this conundrum.

does so without taking the cultural background seriously; hence, I find her approach to be culturally insensitive.

Carter and Klugman's Approach

Macklin's approach avoids moral relativism, but at the cost of being culturally insensitive. Michele A. Carter and Craig M. Klugman propose a model for clinical ethics consultations called "Cultural Engagement," which touts cultural understanding over the resolution of moral conflict.[106] They are committed to multiculturalism, which means "that a person understands, appreciates, and values his or her own culture, but in addition has an informed respect and curiosity about the cultures of others."[107] In addition they base their model on three principles: (1) the principle of mutual respect, which entails a certain degree of respect for every culture; (2) the principle of vulnerability, which means that patients are in a vulnerable situation requiring great care, especially ones from other cultures; and (3) the principle of cultural relevance, which states that ethical conflicts are not solved by "the application of rules, principles, and theories of a dominant medical culture."[108] Instead, the way through conflict, they argue, is by means of the conversational process in which both provider and patient engage each other's cultural and ethical beliefs. To Carter and Klugman, trust is more fundamental than bioethical principles, and their model is an approach that emphasizes learning and understanding over problem-solving.

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[106] Michele A. Carter and Craig M. Klugman, "Cultural Engagement in Clinical Ethics: A Model for Ethics Consultation" *Cambridge Quarterly of Healthcare Ethics* 10 (2001) 16-31.
[107] Carter and Klugman, 21.
[108] Carter and Klugman, 22.

While Carter and Klugman's approach is culturally sensitive and supplies a needed perspective to clinical ethics, they do not intend to supply a decision-making framework to resolve moral conflict. Austin Dacey, in his book *The Secular Conscience: Why Belief Belongs in Public Life*, provides a notion of respect for conscience that lays a foundation for a decision-making framework. He criticizes secular liberalism for similar reasons that Macklin criticizes her opponents, but Dacey's approach avoids cultural insensitivity, while at the same time, providing a guide for proper epistemic functioning.

Dacey begins by identifying two liberal fallacies: the Privacy and Liberty Fallacies:

> The Privacy Fallacy: this fallacy consists in assuming that because matters of conscience are private in the sense of nongovernmental, they are private in the sense of personal preference.
>
> The Liberty Fallacy: this fallacy begins in the core liberal principle that conscience must be left free from coercion. The mistake lies in thinking that because conscience is free from coercion, it must be free from criticism, reason, truth, or independent, objective standards of right and wrong.[109]

These fallacies have influenced the medical profession as well, so when M-requests are made that entail only minor medical risk, caregivers comply out of "respect," citing privacy and liberty. But this is not true respect.

As Dacey explains, this is just blanket acceptance or disregard. True respect takes matters of conscience seriously, considering others' beliefs important and possibly true. True respect means holding such beliefs to the standards of the public square: "honesty, consistency, rationality, evidential support, feasibility, legality, morality, and

[109] Austin Dacey, *The Secular Conscience: Why Belief Belongs in Public Life* (New York: Prometheus Books, 2008) 15.

revisability,"[110] and it is compatible with, even requires, the possibility of disagreement. Dacey says, "Understood correctly, respect is not just compatible with criticism – it entails criticism. To respect someone we must take him seriously, and taking someone seriously sometimes means finding fault with him."[111]

However, this type of critical engagement, or true respect, is rare in the clinic. Religious beliefs are often a conversation stopper, and caregivers feel uncomfortable asking questions that could be perceived as challenging a patient's religious beliefs. For this reason, it is convenient to rationalize the honoring of M-requests as respect for patient autonomy, and in our modern patient-centered era, this is widely practiced.

In pediatrics, this non-engagement of religious beliefs is reinforced in law because some states have legal exemptions for religiously motivated medical neglect: "A total of 32 states provide a defense for felonious child neglect, manslaughter, or murder, where the child's life was sacrificed for religious reasons, as well as a religious defense for misdemeanors arising from physical harm to children resulting from medical neglect."[112] These laws perpetuate the widespread feeling in the clinic, that M-requests are to be, always and in every place, honored.

Nevertheless, pediatrics supplies another example: medical professionals *do* occasionally intervene and even remove children from parental custody when an M-request will result in great risk to a child, but this falls short of critical engagement because such cases are marked by a lack of consideration of the beliefs themselves – only

[110] Dacey, 17.
[111] Dacey, 18.
[112] Marci A. Hamilton, *God vs. the Gavel: Religion and the Rule of Law* (Cambridge: Cambridge University Press, 2005) 32.

a consideration of the medical risks. As such, caregivers operate on the assumption that the family's beliefs are false or irrelevant and that a secular conception of the no-harm principle trumps all competing values. This is because members of the medical community are primarily trained to make decisions as professionals based on the notions of medical harm and benefit.

In short, the status quo fails to adequately respect the religious beliefs of patients. Sometimes, caregivers grant M-requests; sometimes, they do not. But the common theme is that religious beliefs are undervalued. They are undervalued to the extent that they are not critically engaged. One promising solution to this problem is Christopher Meyers' model for handling M-requests. It is that to which I now turn.

Meyers' Approach

Meyers proposes rationality criteria for judging whether a surrogate's M-request should be honored. His standard is internal consistency (a coherence theory of rationality), which he argues for in the following way: (1) on the basis that it is an easily accessible standard, that is, physicians can feel confident in applying it; (2) he thinks that it is generous and culturally sensitive, reinforcing "commitments to the liberal principles of religious tolerance and pluralism;"[113] and (3) it avoids the "insurmountable problems" that plague foundationalist theories of rationality (although he says nothing about what these insurmountable problems are).

[113] Eskew and Meyers, 4.

Meyers preferred version of the coherence theory of rationality is called reflective equilibrium, and he quotes Beauchamp and Childress (who discuss John Rawls) for an explanation:

> The goal of reflective equilibrium is to match, prune, and adjust considered judgments in order to render them coherent with the premises of our most general moral commitments. We start with paradigm judgments of moral rightness and wrongness, and then construct a more general and more specific account that is consistent with these paradigm judgments, rendering them as coherent as possible. We then test the resultant action guides to see if they yield incoherent results. If so, we readjust just these guides or give them up and then renew the process.[114]

According to this theory, all beliefs are open to revision given tension in the system, even religious beliefs.

Meyers says, "There are no external standards of justification; internal consistency is all that is required."[115] Under this view, beliefs are not evaluated on whether they are factual or conform to certain theological or ethical principles, and there need not be any universal conception of human nature. All that is required is that the beliefs not contradict. He gives an example of a pair of conflicting beliefs: (1) God is omnipotent, and (2) God cannot affect human affairs. Religious beliefs, according to Meyers, can be either rational (coherent), irrational (incoherent), or nonrational (when a pair of beliefs neither cohere nor contradict).

Meyers then appeals to Robert Audi's principles to show why religious beliefs should be subject to secular standards. Audi's three principles summarized by Meyers are:

1. The Principle of Secular Rationale: If one must constrain the freedom of others, one ought to have nonreligious reasons.

[114] Beauchamp and Childress, *Principles*, 398.
[115] Eskew and Meyers, 4.

2. The Principle of Secular Motivation: One's nonreligious reasons to constrain the freedom of others should be reason enough, so that if the religious reasons were eliminated, the choice would still be made.

3. The Principle of Theo-Ethical Equilibrium: One's religious and ethical beliefs should be consistent.[116]

Meyers thinks that these principles should be applied to surrogate decision making because a surrogate decision maker's decisions can have a huge impact on the patient – much like public policy has an impact on others in Audi's example. Meyers, however, modifies Audi's principles into a two-part rule to apply to the clinic:

> Part I: When a surrogate's choices directly affect a patient's length or quality of life, decision makers should be sufficiently motivated by secular reasons;
>
> Part II: When religious beliefs are also present, those beliefs must be rational, that is, they must cohere with the decision maker's other religious and moral beliefs.[117]

If an M-request is made that violates either of the two parts of this rule, it should *not* be honored.

Meyers' shows how this might work in two cases. In the first, a 65-year-old woman with end-stage cancer is ventilator-dependent and fully sedated. Her oldest son is not the only family member, but he is making decisions for her. He instructs physicians to do everything in their power, believing that God will save his mother. When he learns that the pain medication she is on may be interfering with her recovery, he demands that it be stopped in spite of being told that it is necessary for her comfort. He says that the pain medication is getting in the way of God's desire to heal her. Using his two-part rule, Meyers says that it is not clear whether the son satisfies the first part, but he clearly fails

[116] Eskew and Meyers, 5.
[117] Eskew and Meyers, 5.

the second (the coherency test). In the first place, the son believes that a person should not be allowed to suffer when there are means available, but he refuses further pain medication for his mother. Second, the son believes that God is omnipotent but also that pain medication can frustrate God's plans to heal. Third, he believes, according to his religion, that he must honor his parents, but he is dismissive of his mother's life plans as communicated through other family members. He is also disrespectful of his father, who is present, but not allowed (by the son) to make decisions about his wife's care. Because of these inconsistencies, Meyers believes that the son's requests should be verbally opposed and probably overruled.

In the second case, an adult child of two JWs has cerebral palsy and needs surgery for a kidney blockage. The parents inform the hospital staff of the patient's firm JW beliefs and demand a bloodless surgery. The hospital seeks to move her to a hospital that specializes in bloodless surgeries, but the transfer is unlikely. The parents take their child home to wait for an opening, but this probably means that the child will die. Meyers thinks that this case satisfies the two-part rule. The first part of the rule is satisfied (the secular reason) because there is good evidence that the patient would have made the same request if she were able. The secular principle is a respect for autonomy. The second part of the rule would also be satisfied, Meyers claims, because while the parents want their child to survive, they simply desire more to protect her eternal life with God. There are no contradictions in their beliefs or behaviors.

Although Meyers' two-part rule seems reasonable on the face of it, it suffers from a number of problems. I am aware that Meyers intends his rule only to apply to surrogate

decision making, but I am interested in the possibility of its solving the larger problem too (M-requests made by surrogates *and patients themselves*). First I will examine the first part of the rule. To require surrogates (or patients if we apply the rule more widely) to provide secular reasons to accompany an M-request is (1) too burdensome and (2) does not take religious beliefs seriously enough. First, it is too burdensome because average religious believers often do not have the level of education or training necessary to speak the language of the public square adequately. Most people, let alone religious believers, are only conversant with their own cultures. What this rule requires is that religious believers learn the dominant culture and language of the clinic (for example, bioethical principles like autonomy), but why should they shoulder this burden? At the time the M-request is made, it is unlikely that a surrogate, assuming the surrogate is closely related to the patient, would be able to take a "crash course in secular reason." Even if the surrogate were not weighed down with other concerns, it is unlikely that enough time would be available for the surrogate to learn how to translate her beliefs into a secular rationale before the patient expires or the situation changes. While some religions may assist surrogates in this (supplying informational pamphlets to give to doctors), it seems unreasonable to expect that every surrogate or religious group be so prepared. Moreover, it seems that society (or the state) should make accommodations for the individual, not the other way around. In *Liberty of Conscience*, Martha Nussbaum, in describing the Accommodation Principle, says that in order to respect matters of conscience, religious citizens should be exempt from generally applicable laws.[118] As mentioned earlier, she

[118] Nussbaum, 24.

quotes from George Washington's letter to the Quakers in 1789, which says: "I assure you very explicitly, that in my opinion the conscientious scruples of all men should be treated with great delicacy and tenderness: and it is my wish and desire, that the laws may always be as extensively accommodated to them, as a due regard for the protection and essential interests of the nation may justify and permit."[119] In Washington's example, it is the state that makes the accommodation (the sacrifice), while the religious group benefits.

In addition, the surrogacy case is significantly disanalogous to Audi's public policy scenario because a surrogate is often related to the patient, unlike those in the public policy arena whose decisions will constrain the liberty of others unrelated to them. To require secular reasons in surrogacy cases is more intrusive because this involves intervening in and sometimes breaking the bonds of a family unit.

Second, the first part of the rule does not take religious beliefs seriously enough. Audi's principle of secular motivation requires that the course of action would still be chosen if the religious reason dropped out. I interpret Audi to mean that religious reasons do not provide a sufficient justification on which to base public policy decisions, and I interpret Meyers' rule to mean that religious reasons do not provide a sufficient justification on which to base surrogate decision making. While such a rule may be appropriate on the public policy level because the decisions being made constrain the liberty of other citizens, it is not appropriate in the clinic where families and patients are suffering. It is at these times that religious beliefs should be given the most accommodation, but Meyers' rule disallows faith when it matters most. Taking religious

[119] Nussbaum, 115.

beliefs seriously entails acknowledging that they might be sufficient justification for actions, even actions that affect others. Of course, there are limits to the type of actions that can be justified this way, but it is far from clear that surrogate decision making is one of those limits, especially when the surrogate is acting on the perceived best interests of the patient.

The second part of Meyers' rule, the coherency requirement, suffers from a couple of problems. First, it may be necessary, but it is not sufficient as a criterion to limit M-requests. As Meyers writes, "Internal consistency is surely the least one can expect of decision makers when their choices potentially harm others."[120] While this is true, certainly much more should be expected; for example, the choices should be compassionate, courageous, and just. Consider Meyers' first case. The problem with the elder son is *not* just that he holds inconsistent theological and ethical beliefs and that his actions do not match up with his stated beliefs; the problem is that the son seems to have a control issue. He oversteps his father's authority and ignores the points of view of everyone else in the family, including his mother's. He also lacks compassion: he seems to care little for his mother's suffering, only caring that God's power be demonstrated in her survival. His theological beliefs are not only inconsistent, but also they are probably aberrant, meaning they depart greatly from the teachings of his religious community. Such a conflict could be resolved by putting the son in conversation with someone from his church or someone who represents his religion such as a chaplain. The son's

[120] Eskew and Meyers, 4.

treatment requests should not be honored, not for the reasons that Meyers' gives, but because his requests are callous and cavalier.

Meyers grants his blessing on the M-request in the second case (The JW case) because it can be shown that the parents' theological and ethical beliefs are coherent. However, just because a surrogate's beliefs are coherent does not mean that they should be honored. The beliefs of the parents of the followers of Jim Jones (of the Jonestown tragedy) may be shown to be coherent, but that hardly means that their beliefs and choices should be tolerated. Instead, it is more likely that the epistemic practices of the Jonestown community were deeply deficient, for example, instead of being open to the views of others outside the community, the people insulated themselves from the outside (which is the reason the People's Temple moved from California to Guyana). They cultivated epistemic vices, not virtues. And it is for this reason we can refuse to tolerate the choices that followed. The JW case is much the same. JW parents may forfeit their surrogacy rights if their beliefs are not formed in a reasonable way, and while consistency is an important aspect of reasonableness, it is not the only one.

If we apply the coherency requirement to the African Female Circumcision case, we encounter a similar problem. The practice of female circumcision does not seem to contradict the beliefs of the parents or communities that practice it. In fact, it appears that the belief coheres well with their religious beliefs. On their view, it is mandated by God (Islam, Christianity, and others have been used to defend the practice). It also coheres well with their belief that female hyper-sexuality is a bad thing. To supporters, what better way to control female sexuality but through a clitoridectomy? It also coheres well

with the traditional view that a virgin bride is a good thing, so parents should "protect" their daughters by sewing them up. It appears that the coherency requirement would condone such a practice, but to many, this is deeply troubling. Female circumcision dehumanizes women. It seems to represent, as Dr. Jordan believes (in the earlier case) an "unacceptable disfigurement, repression, and control of women." But if this is the appropriate conclusion, Meyers' rule will not deliver the goods.

An additional worry with the coherency requirement is that all religions have coherency "problems" (so do scientific theories such as the wave-particle duality theory of light). In other words, there are apparent contradictions in even the most well-established religions, and since this is the case, it is not clear that any religion would pass Meyers' test. To provide a couple of examples: Christianity teaches that God does not want anyone to go to hell (2 Peter 3:9) but also that God is omnipotent, so he could save everyone if he wanted (but apparently does not). Buddhism teaches the doctrine of reincarnation but also the doctrine of *anatta* (no self). If there is no self, then what is reincarnated? For centuries, religious scholars in both traditions have wrestled with these problems and suggested various solutions, but it is unlikely that these problems will be solved anytime soon.

A possible rejoinder is that many so-called "contradictions" are not contradictions at all, but only "paradoxes," the difference being that paradoxes are merely *apparent* contradictions. Religious scholars from both the east and west have argued that religion often seems contradictory on the surface only because of the inadequacy of human language to capture the ultimate mystery. Even if this rejoinder is correct, it is not clear

that Meyers' rule can benefit practically from this distinction, for who is to decide which "contradictions" are only *apparent*? Meyers, having abandoned externalist and foundationalist principles, does not have the tools to accomplish such a task, and from within a believer's worldview all "contradictions" are only apparent.

In addition, there are a number of problems with Meyers' analysis of his first case. The elder son cannot only use this confusion over apparent contradictions to his advantage, he might also provide a sophisticated defense of his beliefs and choices. For example, he can claim that while God is omnipotent and could heal his mother in spite of the pain medication, God chooses not to because he desires human obedience, which, in this case, may include God's prohibition of any treatment that might shorten life (under this view, God would not be a fan of double effect). Moreover, it is possible (at least Meyers does not rule this out) that the family comes from a traditional culture in which elder sons are expected to be the "spiritual heads" of families and make hard decisions even if others in the family disagree with them. If so, then what appears to be contradictory beliefs on the part of the elder son can be understood as coherent.

Conclusion

Internal consistency is not alone sufficient grounds upon which to decide whether to honor an M-request, and to require that a surrogate be sufficiently motivated by secular reasons fails to take religious beliefs seriously enough. Instead, we should (1) allow surrogates to act on religious motivations, (2) require a *reasonable* amount of internal consistency, and (3) determine whether such a request is compatible with moral and epistemic norms. The third point is probably too "foundationalistic" for Meyers, but if

there is any hope in holding surrogate M-requests to a high standard, then we may have to employ a "foundationalistic" normative theory.

Macklin's approach is helpful insofar as it rules out ethical relativism, but it also fails to take religious beliefs seriously enough. Carter and Klugman's approach is instructive and essential for clinical training in patient care and ethics consultations, but it does not offer a decision-making procedure.

What we need is an approach that takes religious beliefs seriously, giving more than lip service to respecting matters of conscience. However, we also need an approach that holds M-requests to a high moral standard. What we need is a *phronesis*-based approach.

CHAPTER FOUR
A *Phronesis*-Based Approach

A *phronesis*-based approach is culturally sensitive and can, at the same time, hold religious beliefs to a high moral standard. In this chapter, I develop such an approach using Linda Zagzebski's *Principle of Rational Belief* and analyzing the intellectual virtues. I also provide a set of conditions that caregivers will find useful in clinical case evaluations.

The Principle of Rational Belief

Linda Zagzebski suggests a principle for evaluating religious beliefs: *The Principle of Rational Belief* (PRB), which evaluates beliefs in reference to the *phronimos*, the person of practical wisdom. Zagzebski defines PRB as follows:

> The Principle of Rational Belief: S's belief p in culture C is rational just in case a person with phronesis outside culture C might believe p if she were in S's circumstances in culture C.[121]

This principle is in the form of a subjunctive, and it works by asking the question of specific beliefs: if a rational person were in S's shoes, is it possible that the rational person would believe S's belief p? Notice some important aspects of the principle: first, the holder of the belief (*S*) need not be fully rational (or virtuous) herself. This would make the principle too strict since most people fall short of full virtue. Second, the *person with phronesis* need not be real; she may merely be an abstract idea. Second, *outside culture C* need not mean *a member of culture D*; again, the virtuous person may

[121] Linda Zagzebski, "Phronesis and Christian Belief," in *The Rationality of Theism*, ed. G. Bruntrup and R. Tacelli (Netherlands: Kluwer Academic Publishers, 1999) 188.

be a conceptual construct. Finally, the principle says that a person with *phronesis* might believe p, not that she *would*. This makes the principle much weaker, meaning that it is enough that the belief does not violate epistemic virtues.

Consider the case of a prehistoric man called Cave Man, a Neanderthal who walked the earth forty thousand years ago (suspend your doubts about whether Neanderthals had sufficiently developed cognitive capacities to be virtuous). Cave Man most certainly would have believed that the earth was flat. PRB would classify this belief as rational if and only if a virtuous person could have arrived at the same belief in the circumstances. Considering the state of scientific knowledge at the time, it is implausible to think that a virtuous person would *not* have believed the earth was flat. A belief in a flat earth is compatible with simple perception, and in the ancient context, it does not violate any epistemic norms even if the belief turns out to be false.

Zagzebski grounds PRB on a theory of moral exemplarism, which is a moral theory in which moral exemplars play a central role. She describes the framework of such a theory: "[It] defines the evaluative properties of persons, acts, and the outcomes of acts by reference to the exemplar or exemplars identified by the theory. Good and bad traits of character are defined in terms of the traits of character of the exemplar. The moral properties of acts are defined in terms of the actual or hypothetical acts of the exemplar. Good and bad outcomes are defined in terms of the states of affairs the exemplar aims to bring about or to prevent."[122]

[122] Linda Zagzebski, *Divine Motivation Theory*, (Cambridge: Cambridge University Press, 2004) 48.

The first step in a theory of exemplarism is to identify the exemplar, and this can be done (and is commonly done) prior to any conceptual analysis of the good.[123] Zagzebski says, "The *phronimos* [moral exemplar or person of practical wisdom] can be defined, roughly, as a person *like that*, where we make a demonstrative reference to a paradigmatically good person."[124] She appeals to Saul Kripke's work on natural kinds, saying that picking out a moral exemplar is like picking out water. We can pick out something in advance, prior to understanding its nature. In the case of water we say, "This is water," and only later learn that water is necessarily H_2O. In the same way, we pick out moral exemplars in the community and only later learn by analysis what character traits they exemplify. Picking out moral exemplars is logically prior to being able to explain why they are moral exemplars; Zagzebski says, "I surmise that the move from "I want to be like R and not like S" to "R is better than S" is not only genetically primitive, but also basic to moral thinking."[125]

She explains that exemplarism, or what she calls an ethics of imitation, fits naturally with what we know about human psychology. Human behavior, she describes, is acquired through imitation. From the very earliest stages of development, we imitate the behavior of others – not only overt behavior, but also attitudes and emotions. In short, we imitate other people. She says, "The psychology of moral learning suggests that person exemplars are more basic than act exemplars, because the former are imitated in more ways than their behavior. Since imitating other persons includes imitating both

[123] Evidence for this is abundant; all we need to do is examine the human propensity to enshrine particular individuals in stories, poems and traditions throughout time and cultures, from the very beginning before moral concepts were carefully developed.
[124] Zagzebski, *Divine Motivation Theory,* 44.
[125] Zagzebski, *Divine Motivation Theory*, 53.

their behavior and their emotions, we have a simpler model for understanding human imitation if we think of the primary objects of imitation as being other persons."[126]

Zagzebski's theory is influenced by Aristotle, who says that the moral mean is "as a man of practical wisdom would determine it."[127] In Aristotelian ethics, the *phronimos* is the archetype of morality. Aristotle says that a *phronimos* is the model of right action *and* right emotions and feels emotions "at the right times, with reference to the right objects, towards the right people, with the right motive, and in the right way."[128] A *phronimos* exemplifies the virtues of the good life such as courage, honesty and compassion, living a well-balanced life, avoiding the extremes of both "too much" and "too little."

There are a couple of common objections to exemplarism. First, one objection is that the exemplars we pick out in the world around us often disagree with one another. However, this problem can be resolved. Zagzebski explains:

> Exemplars change, particularly under the influence of other exemplars, but there would be no reason for them to change if they were perfect. Furthermore, an exemplar does not have to be perfectly virtuous in order to function satisfactorily to fix the reference of 'good.' It is not necessary that our exemplars of water be pure samples of H_2O in order for them to fix the reference of 'water,' either.[129]

These real life exemplars allow us to fix our reference, but it is the later realization that some exemplars have better or more traits than others that drives us to imagine what a fully virtuous moral exemplar would look like. The limitations of moral exemplars simply drive us to look beyond and imagine a being like them, but more virtuous.

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[126] Linda Zagzebski, *Divine Motivation Theory*, 48.
[127] Aristotle, *Nicomachean Ethics*, trans. W. D. Ross, in *The Basic Works of Aristotle*, ed. Richard McKeon (New York: Random House, 1941) NE II.6.1107a1-2.
[128] Aristotle, NE 1106b21.
[129] Zagzebski, *Divine Motivation Theory*, 56.

The second objection is related to the first. Some think that exemplarism suffers from a circularity problem: being able to pick out a good person assumes a conception of the good. Zagzebski's response to this is to say that the circularity objection applies only if moral concepts are basic. Zagzebski writes:

> We cannot define everything in a fixed domain using conceptual analysis. Unless we are willing to accept conceptual circularity, either some moral concept or concepts will be basic, or the foundation of the theory will refer to something outside the domain. That means that either something is good in the most basic way and we cannot expect a defense for its goodness, or the structure of moral theory rests on something (allegedly) outside of ethics…But if reference to exemplars of good persons can be incorporated into the foundation of a theory without going through concepts, then that would permit us to avoid the problems with a purely conceptual foundation. We have a model for constructing a theory of this kind in the theory of direct reference."[130]

Exemplarism begins with "goodness" in a basic way, by direct reference not concepts, so it seems impervious to the circularity charge.

Starting with "goodness" in this way might allow us to identify other concepts by direct reference too, such as a good life. Zagzebski writes: "I have proposed that 'good' is defined by direct reference. If so, it is plausible that 'good life' is defined by direct reference as well. It is a life *like that*, which is to say that we know it when we see it. It is a life we want to imitate."[131] In this way, we may also be able to identify concepts like good belief or good religion.

Some might still respond that Zagzebski's reply to the circularity charge is unsatisfactory because it fails to screen out "exemplars" like Ted Bundy and Adolf Hitler. Someone might mistakenly pick out bad exemplars, thinking they are good, and a moral theory ought to prevent such errors. So, a better answer to the circularity charge is to

[130] Zagzebski, *Divine Motivation Theory*, 42.
[131] Zagzebski, *Divine Motivation Theory*, 117.

base a theory of moral exemplarism on the moral virtues. Under such an approach, a moral exemplar is one who exemplifies the moral virtues, and the moral virtues are widely known.

If there is some confusion about or disagreement among moral exemplars, an analysis or examination of the virtues is required. Rosalind Hursthouse help us understand how we might apply PRB in practice: "If I acknowledge that I am far from perfect, and am quite unclear what a virtuous person would do in the circumstances…the obvious thing to do is to go and ask one, should this be possible."[132] If this is not possible, she says, the virtues of a virtuous person are known (e.g. open-mindedness, conscientiousness, intellectual courage etc.), so determining what a rational person might believe in the circumstances simply requires hypothetical reasoning once the circumstances are understood. For example, one might ask what an open-minded person might believe if she were in *S*'s circumstances. Open-minded people consider other points of view, remain tentative when appropriate, and avoid a head-in-the-sand attitude. Is it possible that a person with such behaviors and attitudes might come to believe *S*'s belief *p* if she were in *S*'s place?

Austin Dacey describes the norms of reason that a rational person would follow: "honesty, consistency, rationality, evidential support, feasibility, legality, morality, and revisability." Dacey unpacks these norms in the following way:

> Honesty means we typically say what we really think; rationality, that we take efficient means to our ends (at least); consistency, that we are prepared to accept the implications of our views as they apply in other instances; evidence, that it matters how our reasons link up with the real world (or don't); feasibility, that the

[132] Rosalind Hursthouse, "Normative Virtue Ethics," in *Virtue Ethics*, ed. S. Darwall (Oxford: Blackwell, 2003) 184-202.

> proposal is realistic; legality and morality, that it is in accord with our laws and ethics; and revisability, that we are prepared to entertain objections, criticisms, and changes.[133]

These norms of reason are illuminating, but I think they are better conceived of as virtues (virtues of the mind), as constituents of a philosophical framework that stretches back to Aristotle's virtue ethics.[134] Reframing these norms in this way would provide the norms with a solid foundation and provide many conceptual resources. In addition, this makes it possible to provide a unifying principle, which should make the standards more accessible to caregivers. I provide an analysis of intellectual virtues below.

Some people might object that the virtues are culturally relative, so employing PRB would be impossible because what a virtue is in one culture might not be the same in another. Take for example "open-mindedness." In many religious communities, it seems that open-mindedness is a vice and dogmatic adherence to doctrine (or faithfulness) is a virtue. This problem is deep and troubling, but not impossible. First, it is important to note that this is not a difficulty unique to this principle; every ethical theory must attempt to handle the divergences in moral judgments across people and cultures. Second, some virtues are essential to the proper functioning and survival of society – honesty, for example. James Rachels argues that truth-telling is essential to any complex society. If a society does not value honesty, then there would be no reason to trust what anyone says; communication and social functioning would break down.[135] Similar arguments can be made for the virtues of fidelity and reverence for life. Third,

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[133] Dacey, 52.
[134] Dacey's norms are an example of what Roberts & Wood describe as a rule-oriented regulative epistemology. In moving to a discussion of intellectual virtues, I will be using a habit-oriented kind of regulative epistemology. See Roberts & Wood, *Intellectual Virtues*, 21.
[135] James Rachels, *Elements of Moral Philosophy 2nd edition,* (New York: McGraw-Hill, 1993) 26.

rationality is an attribute of humanity, not a concept that is restricted to localized traditions. If it were the case that the concept of rationality had no objective sense to it, then it is questionable whether we could discover anything objective in the world – whether we could ever escape our own particular "language games." In arguing for the transcendence of rationality, Zagzebski says,

> Whatever rationality is, it is something all humans share… What is rational is in principle recognizably rational by all rational beings, which means all humans, even those outside one's cultural community. To be rational is to be able to talk to other persons and to make oneself understood, no matter who those persons are. This is the sense in which rationality is transcendent. It is what permits us to communicate with one another and to form a human community that transcends the individual communities we inhabit.[136]

Rationality is an attribute that is deeply connected to our being human – a defining characteristic[38] even if we fail to be fully rational. Therefore, even if background beliefs vary from time and place, moral and intellectual virtues do not.

Another difficulty involves defining a culture for the purposes of employing the Principle. Is a culture to be thought of as a large community such as North America or might it be defined more narrowly such as a group of JWs in North America? I think the concept of culture is flexible here. Adopting a broader definition of culture would complicate PRB because of the sheer number of background beliefs that would need to be considered; nevertheless, the number of virtues remain the same whether the culture is small or large. In some cases, choosing the size of the culture could affect the outcome of the PRB procedure. For example, if the culture is limited to the Yearning For Zion

[136] Zagzebski, "Phronesis and Christian Belief," 179-180.

compound in Texas,[137] then the impoverishment of background beliefs of that community would most certainly affect what a virtuous person would believe. However, if it is doubtful that a *phronimos* would ever lock herself up in such a compound, then it is hard to see how any of the beliefs of the members of that community could ever qualify as rational. Depending on the case, it might be important to employ multiple (broader) conceptions of a patient's culture before reaching a conclusion.

PRB is compatible with what Zagzebski calls *The Culture Sensitivity Principle*, which is one of three principles of rationality she says constrain how diversity should be treated:

> The Culture Sensitivity Principle: Persons should treat the members of other cultures and religions as though they were prima facie as rational as themselves.[138]

The principle constitutes a check against the tendency to conclude that cultural beliefs that are different from one's own are, on the basis of that fact alone, irrational. Nevertheless, the Culture Sensitivity Principle does not rule out a determination that beliefs in other cultures are irrational; in other words, it is possible to be discriminating and remain culturally sensitive. What matters is the procedure one uses to arrive at such a judgment.

In addition, PRB is culturally sensitive because it defines rationality in terms of process, not content. Defining rationality in terms of process means to say that it is the procedure that matters, not the end result. In other words, whatever beliefs are acquired through a rational process are to that extent rational; there is no set of universally-

[137] Yearning For Zion is a sect of fundamentalist Mormons who practice polygamy. They made the news a few years ago when police raided their compound on the belief that underage girls were being married off.
[138] See Zagzebski, "Phronesis and Christian Belief," 181 for her original formulation.

recognized irrational beliefs, the believing of which, apart from any investigation, automatically disqualifies the believer. For example, to the extent to which a belief in reincarnation is the result of an act of intellectual virtue, it is to that extent rational. Also, to the extent to which a belief in the possibility of miracles is the result of an act of intellectual virtue, it is to that extent rational. The alternative – defining rationality in terms of the *content* of the belief – is dangerous because of the tendency to impose on others, as the standard of rationality, the particular beliefs of the dominant culture. For example, a westerner is not likely to believe in the power of deceased ancestors to affect the lives of the living, and she will likely dismiss Chinese ancestral worship as irrational. But this is just a form of cultural imperialism, one that we might call cultural epistemic imperialism. PRB naturally recognizes that *phronimoi* arrive at beliefs via acts of intellectual virtue and that possibly there are *phronimoi* in every culture, so it is ineffective and insensitive to make a list of particular irrational beliefs without first considering whether the beliefs might be acquired through an act of intellectual virtue in a different culture.

Intellectual Virtues

Zagzebski defines *intellectual virtue* as follows: "a deep and enduring acquired excellence of a person, involving a characteristic motivation to produce a certain desired end and reliable success in bringing about that end."[139] The list of intellectual virtues includes intellectual courage, caution, and open-mindedness – traits that are widely desired and recognized as being successful in acquiring truth.

[139] Linda Zagzebski, *Virtues of the Mind: An Inquiry into the Nature of Virtue and the Ethical Foundations of Knowledge* (Cambridge: Cambridge University Press, 1996) 137.

Zagzebski distinguishes between a virtue and an *act of virtue*. Her definition of an act of intellectual virtue is as follows: "An act of intellectual virtue A is an act that arises from the motivational component of A, is something a person with virtue A would (probably) do in the circumstances, is successful in achieving the end of the A motivation, and is such that the agent acquires a true belief (cognitive contact with reality) through these features of the act."[140] According to this definition, an act of intellectual virtue has three components: a motivational, procedural and success component. For example, an act of open-mindedness will have truth acquisition as a motivation, will follow typical procedures (such as listening to the views of others), and will result in the acquisition of a true belief. Distinguishing between a virtue and an act of virtue allows for the possibility that a person's actions might be appraised as virtuous without the person herself having a fully virtuous character.

Zagzebski's "success component" of the definition of an intellectual virtue is problematic, and it is *ad hoc* insofar as it is primarily meant to solve Gettier problems, even though she claims otherwise. In Part III of *Virtues of the Mind*, Linda Zagzebski offers a definition of knowledge that she claims is immune to Gettier problems: "Knowledge is a state of cognitive contact with reality arising from acts of intellectual virtue."[141] She claims that this definition is better than rival analyses of knowledge because it defines knowledge in a way that is not *ad hoc*. For example, she notes that one way to answer Gettier cases and save the traditional analysis of knowledge is by defining

[140] Linda Zagzebski, *Virtues of the Mind*, 270.
[141] Linda Zagzebski, *Virtues of the Mind*, 270.

knowledge as "nonaccidentally true belief."[142] However, she argues that this definition of knowledge falls short because the definition "nonaccidentally true belief" is something only a philosopher would have thought of who was familiar with Gettier cases. She says, "a good definition should be formulated in such a way that it does not contain features whose sole advantage is to answer counterexamples."[143] She says, "What I tried to do with the concept of an act of intellectual virtue was to propose a concept of a kind of act that gets everything right. It is general enough that it applies to overt acts, not just cognitive acts, and it is a concept we would want anyway, even if nobody had ever thought of [Gettier] cases."[144] Every definition of knowledge that is formulated as true belief plus something (where the "something" does not entail truth) is vulnerable to Gettier problems.[145] Zagzebski's success component attempts to close the gap between true belief and knowledge, and her definition of knowledge – cognitive contact with reality arising from acts of intellectual virtue – avoids Gettier problems, she claims, because unlike other "true belief plus something" formulae, it does not leave room for error.

However, while her definition of knowledge seems to have clear advantages, I am not sure it is entirely successful, for it depends on the success component, which seems dubious. An act of intellectual virtue of, say, open-mindedness is still an act of virtue even if it does not succeed in reaching its aim, the truth. Ought we to criticize someone who acts as conscientiously as a fully virtuous agent would, but fails to get the truth? We

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[142] Traditional analysis of knowledge: Knowledge = justified true belief
[143] Linda Zagzebski, *Virtues of the Mind*, 265.
[144] Linda Zagzebski, from a personal e-mail, February 4, 2004.
[145] As Zagzebski cogently argues in the following: Linda Zagzebski, "The Inescapability of Gettier Problems." *The Philosophical Quarterly* 44 (174): 65.

can imagine a situation (one that is fairly common) where the acquisition of knowledge is simply too difficult even for someone who acts thus – the circumstances conspire against our conscientious agent and she simply fails to acquire knowledge. Nevertheless, we would still praise her actions as virtuous.

Zagzebski recognizes this concern, acknowledging that our agent's actions would be praiseworthy but simply not fully virtuous. She writes,

> Even when an act is motivated properly and is what a virtuous person would characteristically do in the circumstances, it may fail in the aim of the act. When this happens the act lacks something morally desirable [namely moral luck] … for example, a person might be motivated by generosity and act in a way characteristic of generous persons in some particular circumstance[s], say by giving money to a beggar on the street, but if it turns out that the beggar is really rich and is playing the part of a beggar to win a bet, we would think that there is something morally lacking in the act…her act would not merit the degree of praise due it if the beggar were really deserving. The same point applies to intellectual acts. A person may be motivated by intellectual virtues and act in a way intellectually virtuous persons characteristically act in attempting to get knowledge, but if she fails to get the truth, her epistemic state is lacking something praiseworthy. This means there is a kind of epistemic luck analogous to moral luck.[146]

I think Zagzebski is partly wrong here. Although it is clear that luck has a part to play, this need not take away from the praiseworthiness of the agent's act. It is unfortunate that our agent's hard work does not pay off, but this is simply *unfortunate*, not something lacking on the agent's part.[147] The virtuousness of the act is independent of the act's outcome. Robert C. Roberts and W. Jay Wood agree: "From the fact that I performed an act of generosity, it does not follow that I actually helped anybody…The same is true of intellectual virtues. A person can perform acts of open-mindedness, of

[146] Linda Zagzebski, "Precis of Virtues of the Mind," *Philosophy and Phenomenological Research* LX, #1 (Jan., 2000) 173.
[147] Assuming that the agent did everything we would expect of a reasonable, virtuous person in her circumstances.

diligence in investigations, of charity in his interpretations of others' views, of honesty with himself and with others, and still not hit on the truth."[148]

Roberts and Wood also suggest that her definition is *ad hoc*. They think that it is artificially tailored to avoid Gettier problems because "the infallibility of acts of virtue presupposed by her definition of knowledge is not a noticeable part of [the history of philosophy], or of ordinary people's use of 'virtue'; her particular twist on the concept of an act of virtue seems specially tailored for closing the gap between justification and truth."[149]

Thus, I propose that Zagzebski abandon the success component of her definition of an act of virtue. Her definition of knowledge would still be formulated as "cognitive contact with reality arising from acts of intellectual virtue (but where acts of virtue do not guarantee truth)." However, if the success component is dropped, then she loses the ability to answer Gettier problems, which may not be so bad anyways. At most, this would put her theory on par with the many others, but would not necessarily undermine it. Zagzebski's definition of knowledge has other strengths that rival theories lack, for example relating the traits of an agent's character to the acquisition of knowledge, and that is commendable.

In *Intellectual Virtues: An Essay in Regulative Epistemology*, Roberts and Wood present a guide for epistemic practice, steering epistemology away from the standard debates, such as the definition of knowledge – debates which they think have ended in

[148] Roberts C. Roberts and W. Jay Wood, *Intellectual Virtues: An Essay in Regulative Epistemology* (Oxford: Oxford University Press, 2007) 13.
[149] Roberts and Wood 14.

paralysis.[150] Regulative epistemology, as they call it, is more fruitful than the standard analytic type. Regulative epistemology "is a response to perceived deficiencies in people's epistemic conduct, and thus is strongly practical and social, rather than just an interesting theoretical challenge for philosophy professors and smart students. This kind of epistemology aims to change the (social) world."[151] Roberts and Wood follow in the footsteps of John Locke, who in his *Of the Conduct of the Understanding* describes the personal dispositions and habits of mind of a rational person. This Lockean kind of virtue analysis is the role that Roberts and Wood take on in Part II of their book, describing in detail a series of intellectual virtues: love of knowledge, firmness, courage and caution, humility, autonomy, generosity, and practical wisdom. In the pages that follow, I will explore and expand on their analysis of these virtues because I think such an examination is necessary in order to apply the Principle of Rational Belief effectively.

The Love of Knowledge

First, the love of knowledge is a virtue that is based on the innate human desire to know. Children come into the world with this desire, but it must mature and grow, becoming a refined, excellent character trait. For one, it is not enough to have an indiscriminate love of knowledge; some kinds of knowledge are more valuable than other kinds. For example, one could memorize random facts in a phone book, or one could set about the more admirable task of learning the properties of the HIV virus in order to find a cure. Roberts and Wood explain that some cases of knowledge are more worthy than others in virtue of their connection to human flourishing (the extent to which they

[150] Roberts and Wood, 20.
[151] Roberts and Wood, 21.

advance human well-being) and that some objects of knowledge have intrinsic importance. Also, some cases of knowledge bear a greater epistemic weight than others by supporting other beliefs. Moreover, some knowledge may not be as important to one agent as it is to another. For example, the knowledge of how to feed *my* family is more relevant to me than it is to you.[152]

Roberts and Wood explain that the love of knowledge should translate to the purveyance of knowledge because knowledge is a social affair. People who love knowledge are motivated to see others love knowledge and acquire it.[153] Roberts and Wood say, "Here the love of knowledge is not just a love of epistemic goods as such, but of other people's having them. So what we would ordinarily call a moral motivation is involved in the structure of the virtue…but the virtue is intellectual inasmuch as the good or the justice that is wished for the other is an epistemic one."[154] The love of knowledge in this sense might be called *intellectual generosity*.

Roberts and Wood describe a number of ways that people can fall short of the love of knowledge. First, they might fail to have a concern for knowledge, otherwise known as epistemic complacency.[155] Consider the following examples: they may decline opportunities to test their beliefs; they may become discouraged with the amount of effort that is required to acquire knowledge; they may shield themselves from hurtful self-knowledge; and academically, they may avoid anomalies that could disconfirm their theories (as in science). The solution for this kind of complacency is an education that

[152] Roberts and Wood, 156-164.
[153] Roberts and Wood, 164.
[154] Roberts and Wood, 165.
[155] Roberts and Wood, 170-172.

treats the truth as an intrinsic good, not just a good useful for passing a course or protecting a religious dogma.

Second, they might have an unvirtuous concern for knowledge. For example, desiring knowledge solely for instrumental reasons can be unvirtuous (but not always). Roberts and Wood explain: "If a piece of knowledge merits a Nobel prize, one who desires that knowledge only for the Prize has a defective epistemic will."[156] An example in which instrumental knowledge could be virtuous is in the case of biological knowledge being used instrumentally for its medical applications. Gossip is another example of a kind of knowledge that only unvirtuous people are concerned with. Even if the gossip is not found to be harmful to someone else, it is by its nature a violation of privacy. Roberts and Wood say, "The gossiper exhibits a deficit of circumspection, of seriousness about the question: Is this something I, in my circumstances, am permitted to learn, or to pass on to this other in his circumstances?"[157]

Third, they might fail to have a concern *not* to know. A gossiper is a straightforward example of this, as seen above; a gossiper fails in this concern. However, we can also see examples of this with cases of higher-order knowledge. For example, a scientist may have the desire to unlock the mysteries of human cloning and may be on the verge of doing so, but she may realize that she herself and modern society would not be able to handle such knowledge.[158] She would be faced with the question of whether the good of the potential knowledge would be outweighed by the potential for evil. This is a difficult question, one that would be best answered by a *phronimos*. Assuming that the

[156] Roberts and Wood, 173.
[157] Roberts and Wood, 175.
[158] Roberts and Wood, 178.

scientist is right about the fact that this knowledge would not be handled correctly, it seems the appropriate concern to have here would be the concern *not* to acquire the cloning knowledge.

Firmness

It is natural and right to hold firmly to beliefs; in fact, having beliefs at all implies a certain amount of firmness about something. If I believe that I see a big truck coming at me, I am committed, in some sense, to the truth of that belief. If I believe that eating fast food every day is unhealthy, then I am committed to the falsehood of the proposition that eating it every day is healthy. It would be impossible to believe anything if a certain amount of firmness were not an essential part of belief. Thomas Kuhn discusses firmness in science, that scientists are justified in holding onto a theory even in the presence of anomalies.[159] In fact, a scientist who worries about every anomaly cannot do good science. Kuhn says, "The scientist who pauses to examine every anomaly he notes will seldom get significant work done."[160]

Roberts and Wood describe firmness as an Aristotelian virtue, as a mean between two extremes. It is not necessarily the midpoint between holding beliefs too loosely or tightly; there are probably a range of possibilities in the middle depending on the circumstances.[161]

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[159] Thomas Kuhn, *The Structure of Scientific Revolutions 2nd edition* (Chicago, University of Chicago Press, 1970) 81-2. Discussed in Roberts and Wood, 193.
[160] Kuhn, 82.
[161] Roberts and Wood, 184.

People who do not hold beliefs firmly are thought to be intellectually flabby.[162] An example of this kind of flabbiness is someone who believes whatever is popular at the moment among her peers. This flabby person changes her mind whenever her peers do, not on the basis of good evidence, but simply because the beliefs she held before are no longer popular. Skeptics are also in violation of the virtue of firmness. Skeptics are worried about being too rigid and about the negative consequences of being mistaken, so they withhold their belief. Roberts and Wood explain: "The skeptic aims to be invulnerable by virtue of flexing with the storm vicissitudes, by going with the flow and riding the waves, like seaweed or fish. So the perfect graduate of skeptical therapy just goes with the flow of his desires as they arise in response to the impressions that he receives from his environment."[163]

Nevertheless, hyper-firmness is also a danger. Roberts and Wood call this "rigidity" or being "too stiff." They describe five kinds of rigidity.[164] First, there is dogmatism, which is "a disposition to *respond* irrationally to *oppositions* to the belief: anomalies, objections, evidence to the contrary, counterexamples, and the like."[165] This irrationality manifests in an unwillingness to listen to other opinions or consider counterarguments. Second, there is doxastic complacency, which is a laziness that manifests in a determination to stick with one's beliefs because doing otherwise would require too much work or research. Third, there is stolid perseverance, which is an overly-tenacious holding onto an epistemic goal when it would be more reasonable to

[162] Roberts and Wood, 185.
[163] Roberts and Wood, 192.
[164] Roberts and Wood, 194-206.
[165] Roberts and Wood, 195.

give it up or modify it. Fourth, there is perceptual rigidity, which is the condition that arises when an individual is so committed to her beliefs that she cannot even recognize things that would count against them. Finally, there is comprehensional rigidity, which is the inability to understand conceptual frameworks other than one's own.

Courage and Caution

The virtues of courage and caution are complementary, related as they are to fear. Roberts and Wood explain: "Both virtues are dispositions with respect to fear, though they are differently related to it. If courage is a disposition to mitigate, circumvent, or transcend fears, caution is a disposition to cultivate, refine, and listen to one's fears."[166] Caution might be called "appropriate fear" in that it considers real problems that might threaten one's epistemic situation. Courage refers to the strength needed to protect or improve one's situation. In some cases, caution will be called for, in others, courage.

Courage is both a moral and epistemic virtue, but as the latter it is related to the love of knowledge. Intellectual cowardice is an inadequate love of knowledge. Knowledge acquisition can often be painful. It might require opening one's most cherished beliefs to criticism, and it might result in a difficult transformation of one's identity. Roberts and Wood show how cowardice can manifest in academic departments. For one, a department might choose not to hire an applicant whose research or intelligence might threaten to upend the prized research or intelligence of others in the department. In such a case, pride or fear is given preference over the love of knowledge. Academicians may give in to fear in other ways too; consider the following example: "A

[166] Roberts and Wood, 219.

philosopher so scrupulous about protecting himself against refutation that he convolutes his formulas with multiple and involved qualifications that render his written and spoken discourse a monstrosity of vacuous and incomprehensible ass-covering."[167]

A person of courage is also a person of caution when appropriate. To lack caution is to be reckless. A reckless love of knowledge is one in which knowledge is pursued relentlessly without concern for the consequences on other individuals, communities, or societies. Roberts and Wood explore this phenomenon in the context of Shakespeare's Othello.[168] Literary critics have speculated as to the motivation Iago might have in arousing Othello's jealousy toward Desdemona. One critic has suggested that Iago may be motivated simply by a desire to know how Othello would react under certain conditions and stresses. Hence, this critic suggests that since knowledge acquisition is good for its own sake, Iago's actions are morally acceptable. Nevertheless, the case of Othello shows that knowledge acquisition can be destructive (destroying both Othello and Desdemona), so it should be pursued with caution.

On the other hand, while caution is good, one can be overly cautious. Roberts and Woods call this "scrupulosity."[169] This vice is present when an individual is afraid of taking risks; she is unable to judge when taking risks are appropriate. Roberts and Wood think that W. K. Clifford's "The Ethics of Belief" essay is an example of scrupulosity.[170] In it, Clifford argues that it is wrong to ever believe something on insufficient evidence lest, as in his ship-owner thought experiment, horrible things happen. Clifford's ship-

[167] Roberts and Wood, 223.
[168] Roberts and Wood, 224-225.
[169] Roberts and Wood, 231.
[170] Roberts and Wood, 231-234.

owner may not have been cautious enough, but Clifford thinks that even drunk drivel in a village alehouse should be held to this high standard lest society "shrinks back into savagery."[171] Roberts and Wood argue that Clifford's high demands are unrealistic. Such a high degree of certainty is impossible and not even desirable. They say, "The person who is virtuously cautious…knows that the ship must eventually sail, and that Cartesian certainty is not available in the case. He knows that religious beliefs are not susceptible to the same kind of testing as a ship's seaworthiness, and that if one is to reap the benefits of religious life one must (with courage) venture out with faith."[172]

Faith requires courage, and religious believers often exemplify such a virtue. However, the most common concern is that believers are not cautious enough (hence, lacking true courage), believing indiscriminately whatever their particular religion teaches. The victims of the Jonestown tragedy might have escaped their fate if they would have showed a little more caution and skepticism about the character of Jim Jones. A properly cautious or courageous religious believer will know when faith is appropriate and when it is better to withhold belief. This virtue is closely connected with the virtue of autonomy, which I will explore below.

Humility

Intellectual humility is the disposition to evaluate one's intelligence or intellectual accomplishments properly. It might seem that humility means to have a low estimation of oneself, but such a definition would make it impossible for unusually intelligent

[171] W. K. Clifford, "Ethics of Belief," http://www.infidels.org/library/historical/w_k_clifford/ethics_of_belief.html (accessed February 21, 2012)
[172] Roberts and Wood, 234.

individuals to be virtuous. Instead, the virtue of humility is better located between the vices of having too high and too low an evaluation of oneself. It is to have in mind one's human and limited epistemic condition, but also to realize one's intellectual accomplishments.

Roberts and Wood show how the virtue of intellectual humility is contrasted with the vices of vanity and arrogance.[173] They describe the intellectually vain person as one who is too concerned with impressing others or looking smart. They say, "The lack of concern to look good frees the intellectually humble person to pursue intellectual goods simply and undistractedly…the humble person will be free to test his ideas against the strongest objections. His humility may also make for intellectual adventure: he will not be afraid to try out ideas that others may ridicule."[174] The intellectually arrogant person is one who thinks his intelligence exempts him from considering other points of view. He feels that he does not need to listen to others because of his "privileged epistemic position," which in fact is an illusion or ought to be tempered by the realization that no person or position (besides God) has a monopoly on knowledge. Roberts and Wood point out that humility is more conducive to knowledge acquisition because "the humble inquirer has more potential teachers than his less humble counterparts."[175]

Intellectual humility may seem to be synonymous with the virtue of open-mindedness, and certainly, the two are connected in some ways. However, as James Spiegel points out, "One can be open-minded about particular issues (e.g. whether the

[173] Roberts and Wood, 252-3
[174] Roberts and Wood, 253.
[175] Roberts and Wood, 253.

salmon season should be extended) while lacking intellectual humility as a general epistemic trait."[176]

Is intellectual humility compatible with religious devotion? Religion often seems to be the very antithesis of humility insofar as it makes claims to specially privileged divine knowledge and authority. While there clearly are examples of arrogance in religion (as there are in any domain), it does not seem to be a necessary ingredient. In fact, there are many religious texts that enjoin their readers to live humbly. For example, James 4:10 (NIV) says, "Humble yourselves before the Lord" and Philippians 2:3 says, "Do nothing out of selfish ambition or vain conceit, but in humility consider others better than yourselves." Nevertheless, some might think that humility entails doubt, and believers are not supposed to doubt, which is the opposite of faith. However, it not clear that doubt and faith are entirely opposed. For example, consider the life of Mother Teresa. In her posthumously published writings, it has become clear that she was plagued by doubts about God.[177] Nevertheless, she still is the model of religious devotion, if there ever was one. No, intellectual humility does not preclude religious convictions. If it did, it would likely preclude the holding of beliefs in any domain. What it does preclude is holding beliefs with such certainty that the believer ceases to listen to others.

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[176] James Spiegel, "The Virtue of Open-Mindedness," unpublished paper presented at the Evangelical Philosophical Society, Atlanta, November 17th 2010, 4.
[177] Mother Teresa, *Mother Teresa: Come Be My Light – the Private Writings of the Saint of Calcutta*, ed. Brian Kolodiejchuk (New York: Doubleday, 2007).

Autonomy

Autonomy means "self-governing," which means being your own person. Beauchamp and Childress describe the moral virtue of autonomy in terms of agents who act "(1) intentionally, (2) with understanding, and (3) without controlling influences that determine their action."[178] The *intellectual* virtue of autonomy is the ability and willingness to think for oneself when appropriate. The corresponding vice is called "heteronomy," which means being regulated by others when one should be regulating oneself.

The virtue of autonomy does not preclude being regulated by others when appropriate; in fact, it is often necessary, but Roberts and Wood describe an example of someone who is hyper-autonomous.[179] Such a person never relies on others, never submits to the teaching of another, and always insists that she discover the truth on her own. Such a person would lack knowledge in important ways, never trusting sources of information that are trustworthy. Roberts and Wood describe when "hetero-regulation" is appropriate such as in learning from experts in a particular field, or submitting one's own thoughts to the criticism of others, or in modeling one's thinking after one's mentors.[180]

On the other hand, it is easy to think of examples of people who are overly regulated by others. Roberts and Wood describe such a thinker in the following way:

> When he follows a rule of inference, he must not only have the rule dictated to him by some authority…but he must have guidance in how to apply the rule to the present case…When he does an experiment, he must be guided at every step by his research director. He never "plays" with vocabulary, but must be able to find exactly the required meaning in a dictionary, and regularly needs confirmation by

[178] Beauchamp and Childress, *Principles*, 59.
[179] Roberts and Wood, 259.
[180] Roberts and Wood, 261-280.

> a teacher that the meaning he thinks he has found is indeed the required meaning…He takes course after course in the university, collecting notebooks full of lecture dictation that he duly memorizes, but never ventures to put any of the ideas together in his own way.[181]

Such a thinker may benefit from the knowledge of others, but he fails to make much use of it. He may be regulated by others out of fear of being wrong, but more likely he is so because he has never learned to think for himself.

Roberts and Wood entertain the question whether religious people can submit themselves to a religious authority, or a hetero-regulator, and still be considered autonomous.[182] For example, Christians believe the Bible is authoritative and submit to its teachings; some would consider this vicious heteronomy. Roberts and Woods explain, as above, that no one is (or should be) completely autonomous. As they put it, "Autonomy is an ability to resist *improper* hetero-regulators,"[183] and they say, "[Autonomy] is a disposition and ability to resist *some* hetero-regulators by virtue of obedience to *another* hetero-regulator."[184] However, autonomy in this sense, say Roberts and Wood, is autonomy in the true sense to the extent that it is a matter of standing on one's own two feet.[185] In other words, autonomous individuals submit to a hetero-regulator, but understand why they are doing so. Autonomy is not blind. In addition, when the pressure from multiple, conflicting hetero-regulators is great, the opportunities to grow in autonomy increase because individuals are faced with choices and are given the chance to reflect on the reasons for choosing one hetero-regulator over another.

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[181] Roberts and Wood, 260.
[182] Roberts and Wood, 276-280.
[183] Roberts and Wood, 282, Italics mine.
[184] Roberts and Wood, 277.
[185] Roberts and Wood, 277.

Submission to a hetero-regulator comes in degrees. Glenn Graber says, "I may trust my priest's interpretation of scripture – but I will still sort through my own reactions to what he says; and if he says something that I find harder to accept, I may at least modulate the strength of my belief to reflect the degree of my doubt. My default position may be to accept what he says, but that default can be overridden."[186]

Autonomous adherence to a hetero-regulator is not merely deference to an authority, but it is also "understanding in terms of the hetero-regulator."[187] This means that the autonomous individual will not only believe what the hetero-regulator believes, but also understand what the conflicting points of views are as understood by his preferred religious authority and as understood by the hetero-regulator being resisted. This requires intellectual courage and critical reflection. Autonomous adherence also requires a deep appropriation of the beliefs of the hetero-regulator so that the beliefs become a part of the self. Roberts and Wood explain: "To think in terms of a hetero-regulator is to love in terms of the hetero-regulator, to care, to be concerned, to be emotionally involved in those terms…Sometimes autonomy has been thought of as disinterested…but on the present analysis, autonomy is not a property of the intellect as a faculty or part of a person, but a property of the thinker, the epistemic agent."[188]

[186] From Glenn Graber, comments on an earlier draft.
[187] Roberts and Wood, 278.
[188] Roberts and Wood, 279-280.

A Set of Conditions for Clinical Case Evaluations[189]

While the PRB and the above analysis of intellectual virtues provide the normative basis for judging which religious beliefs and M-requests should be honored in the clinic, caregivers might find more helpful a set of conditions that are more concrete. James Buryska proposes the following set of principles to determine which M-requests to honor: A request is more defensible if (1) it does not violate a physician's conscience, (2) it is based on negative rights, not positive ones, (3) it is grounded in a community, and (4) it is made by one willing to accept the burden of responsibility.[190] These principles are instructive and illuminating, but some of them are more helpful than others. For example, the community principle – verifying that a belief is based in the teachings of a community – seems to be a necessary condition (I say more about this below), but consideration of a physician's conscience seems less important because such conflict is inevitable if these requests violate the standard of care by definition (if requests are not "inappropriate," then it is a non-issue). Space does not permit me to critique Buryska's principles in detail. Instead, I will propose a different set of conditions that I feel are more useful in the clinic, called MVRB conditions hereafter:[191]

1. The belief is shared by a community.
2. The belief is deeply held.
3. The belief would pass the test of a religious interpreter.
4. The belief does not harm others.

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[189] An earlier version of this subsection appeared as: Gregory L. Bock, "Medically Valid Religious Beliefs," *Journal of Medical Ethics* 34 (2008) 437-440.
[190] James F. Buryska, "Assessing the Ethical Weight of Cultural, Religious and Spiritual Claims in the Clinical Context," *Journal of Medical Ethics* 27 (2001) 118-122.
[191] "Medically Valid Religious Belief" conditions.

These conditions are not simply pass/fail; assessment can fall on a spectrum from "satisfies" or "mostly satisfies" to "fails" or "mostly fails to satisfy." The more conditions satisfied, the more weight ought to be given to the religious belief. The fewer conditions satisfied, the less consideration it receives.

The Conditions

1. The belief is shared by a community

Michael Wreen suggests this condition, saying that values that transcend the individual carry more weight than ones that are based on idiosyncratic choices.[192] He compares a person who refuses lifesaving treatment on the basis of a traditional religious belief and one who does so because he flipped a coin to decide his fate. It seems absurd to assign the same weight to the two requests even if coin-flipping carries deep metaphysical significance to the patient.

Still, one could object that community matters less than existential import; in other words, religious beliefs are as various and unique as the people who hold them, and whether they are peculiar or not does not affect how deeply held they are or nullify the "integrating and reconciling" function they play. This is, I take it, part of the motivation behind Julian Savulescu's criticism of Robert Orr and Leigh Genesen's paper, "Requests for 'Inappropriate' Treatment Based on Religious Beliefs," namely that atheists (whose community may not be clearly defined) are discriminated against.[193]

[192] Wreen, 128.
[193] "Clearly defined" in the sense that their identity is not wrapped up in their community's rituals and practices. See Savulescu, "Two Worlds Apart," 382.

However, religious beliefs that are held by many do seem to have greater weight than beliefs that are held by a lone maverick for the following reasons: first, even though the maverick's personal religious convictions might be carefully thought out and deeply held, this individual does not benefit from the epistemic resources available in the community such as a division of labor, a wealth of experts, and a long tradition. Second, a benefit of community is found in peer accountability, the regular subjection of one's beliefs to scrutiny, which helps to eliminate aberrant and anti-social beliefs.[194] Third, John Hardwig argues that there are many things that we cannot know if we are independent and self-reliant; our knowledge naturally depends on communities of trust relationships.[195] Finally, Buryska explains that a community provides "a supportive structure of psychic and physical resources" that helps individuals make choices that they would otherwise be incapable of.[196]

The size of the community is relevant here too. If the religious belief has few adherents, this should count against the belief; if the belief is a constituent of one of the world's great religions, this counts in its favor. Some would argue that this rules out the beliefs of religious reformers, such as Buddha or Jesus, because their communities have few members at the time the movement begins. However, reformers often identify to some extent with the community they are attempting to reform. The Buddha, in his day, could have been identified as part of Hindu culture; and Jesus was part of the Jewish

[194] Some groups discourage skepticism or questions among their adherents. I am open to the idea that such groups should be given less consideration. Open-mindedness is an intellectual virtue; nevertheless, I don't think that this is a problem for my argument. Adherents of a dogmatic sect, at a bare minimum, share in the epistemic resources of the community (impoverished though it may be). This is more than can be said of the religious maverick, whose ideas have not been tested by the community or have not withstood the test of time and tradition.
[195] John Hardwig, "The Role of Trust in Knowledge," *Journal of Philosophy* 88 (1991) 693-708.
[196] Buryska, 120.

community. To the extent that their beliefs are similar to their background cultures, they would satisfy this criterion. Nevertheless, what makes reformers unique in their contexts is that they hold a number of different beliefs; and if it is these beliefs upon which a medical request is made, then the reformer fares poorly. I see no practical way of avoiding this outcome: a few saints may not get the medical care they deserve. But I am not too concerned about ultimate justice here, nor do I think I should be. What I am suggesting is that sharing a religious belief with a larger community makes the belief, *prima facie*, more virtuous – and thus more relevant to the medical establishment than idiosyncratic beliefs. A few admirable reformers might be left out, but if our medical practice recognizes a large number of mainstream religious beliefs, then I think the cost is worth it. At any rate, scoring low on this condition (having a small community) does not automatically disqualify a treatment request because there are other factors to consider. A figure like the Buddha would likely pass the other conditions below with flying colors, so the reformer objection carries little weight.

This community condition is tied to the virtue of autonomy. As mentioned earlier, proper autonomy does not preclude being regulated by others when appropriate, and hetero-regulation is often necessary; otherwise, we would lack knowledge in important ways.

2. The belief is deeply held

Orr and Genesen argue that it is not enough that the belief in question is widely held; it must also be deeply held: "What makes religious values 'special' is not only that they are shared by a community, but more importantly, that they are incorporated by the

individual into his or her persona. Religious values are thus more intrinsic than [many] other shared values because they deal with the very meaning of life."[197] This would rule out beliefs that are mere cultural baggage. For example, people who think that because they were born in East Tennessee they must be Christian are simply carrying the label, especially if Christian doctrine has little impact on their deeper sense of identity.

As Wreen points out, some people hold the most peculiar and trivial beliefs. Someone might for example have a belief in red objects, that the world would be a better place if these objects were maximized.[198] Nevertheless, Wreen suggests that these beliefs do not carry the same weight because (1) religious values are more important to people, (2) the U.S. Constitution does not provide special protection for red object beliefs, (3) religious beliefs are not clearly true or false while beliefs about red objects are, and (4) religious beliefs fit into a rational person's life in the way beliefs about red objects cannot, namely they describe the human condition, provide a person with a sense of identity, and make sense of the world.[199]

However, it appears as a matter of empirical fact that trivial beliefs are often held in the same manner as traditional religious beliefs. Moreover, some would still say they see no real difference between the merits of deeply believing apparently trivial things and believing in religion. "Whatever does it for you," one might say: "Worshiping God or rebuilding old Mustangs." To the former claim, I concede. Certainly, it is cognitively possible to hold beliefs about trivial things in a deep way, but so what? We should ascribe a certain level of consideration to any belief just because it is deeply held –

[197] Orr and Genesen, "Requests for 'inappropriate' treatment," 145.
[198] Wreen, 127.
[199] Orr and Genesen, "Requests for 'inappropriate' treatment," 127-8.

whether it is in red objects or in restoring old cars – but this does not mean that all deeply held beliefs are equal. To say that there is no real difference between trivial and religious beliefs seems clearly false. Religion – with its literature, rituals and saints – has played a central and sacred role in human society since the beginning, a role that is only poorly fulfilled by ordinary activities. Huston Smith says, "The finitude of mundane existence cannot satisfy the human heart completely. Built into the human makeup is a longing for 'more' that the world of everyday experience cannot requite."[200] So, even if trivial beliefs can be deeply held, there is something about the human experience that such beliefs fail to capture.

Another concern is that it would be too difficult for a caregiver to separate out, in practice, those who hold their religion deeply from those who do not.[201] For example, a patient may profess to be a Christian, but only to satisfy her family. How can we distinguish these patients from other more or less committed Christians? I grant that this is a problem for applying my criteria, but if it is devastating, it is not uniquely destructive to my project alone, for often physicians have no other recourse in making tough medical decisions than to trust the testimony of the patient or make their best judgment. This is the case, for example, in trying to decide whether a surrogate is acting out of the best interest of the patient – the problem is one of judging psychological factors or moral character.

The "deeply held" condition is tied to the virtues of firmness and autonomy. A believer who exemplifies the virtue of firmness will hold her beliefs deeply. She will be

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[200] Huston Smith, *Why Religion Matters: the Fate of the Human Spirit in an Age of Disbelief* (New York: HarperCollins, 2001) 3.
[201] Thanks to John Hardwig for this insight.

firm, but not rigid. She will be firm, but not intellectually flabby. Shallow believers are often dogmatic or too easily swayed. The condition is also tied to autonomy insofar as autonomy involves a deep appropriation of the beliefs in question, a deep appropriation of the beliefs of the hetero-regulator.

3. The belief would pass the test of a religious interpreter

Orr and Genesen suggest involving a religious interpreter when no one on the care-giving team is familiar with the religion of the patient.[202] The interpreter could fulfill many responsibilities including the following: (1) a support for the patient and the family, (2) someone to help articulate the patient's belief to the physician, and (3) someone to help articulate the physician's point of view to the patient.

The responsibilities of a religious interpreter could be fulfilled by a hospital chaplain or social worker, who – in either case – is familiar with the particular religion or a wide variety of traditions. The interpreter might also be the patient's own pastor, priest, or advisor as long as this individual is able and willing to communicate with hospital staff. In rare cases when there are no local representatives of the religion, the caregivers may need to call on a religious studies professor from a local college who has spent time studying sects similar to the patient's.

As an interpreter, the individual would play the mediating role of third party to a conflict, which provides an objective neutral ground from which to facilitate productive communication. This role has already been used successfully in cultural and political contexts and is also employed to solve interpersonal conflicts such as in marriage.

[202] Orr and Genesen, "Requests for 'inappropriate' treatment," 146.

Surely, it would work in this situation as well. In addition, the interpreter might assist in evaluating whether the patient fully understands the situation, whether the belief is shared by a community, and whether it is deeply held (assisting the caregiver in employing the other criteria). Moreover, the interpreter would be in the best position to evaluate whether the patient's belief was recently acquired or whether it is a long-held conviction. Orr and Genesen describe cases of "fox-hole religion," which are similar to deathbed conversions in that they occur under great stress. It is implied that a long-held belief carries more weight than one that is adopted under duress, the former type is one that is more likely to fulfill the functions Wreen describes.

One worry is whether being a practitioner of the religion makes an interpreter better or worse; would religious devotion negatively affect one's ability to fulfill these responsibilities? I think this is a valid concern, but religious devotion (or non-devotion) should not automatically disqualify an interpreter. It is possible that religious commitment might make mediation too difficult, but it is also possible to be too objective, failing to really understand the point of view of the religious believer. Both parties (especially the physicians who are charged with carrying out a treatment request) must evaluate each interpreter anew to decide whether he or she can act effectively. Obviously, the position of a religious interpreter requires a certain amount of objectivity and open-mindedness in order to listen successfully, but simply adhering to a religion does not make this impossible any more than it does for a cultural translator who identifies more closely with one culture and language over another.

The religious interpreter condition is tied to the virtues of the love of knowledge, humility, and autonomy. From the point of view of the caregivers, there should be a desire to know and understand how the patient interprets her situation. The patient must also shoulder some of this responsibility, and an interpreter can help both parties. The condition is also tied to the virtue of humility. The act of bringing in a third party acknowledges the need for help in both understanding and communication. It is also related to autonomy insofar as it is an example of the appropriate submission to a hetero-regulator. For example, if the interpreter is a leader in the patient's community and contradicts the patient's interpretation of her situation, then it may be appropriate to submit to him.

4. The belief does not harm others

A physician's *prima facie* duty is to "do no harm." A request for "inappropriate" treatment may result in harm to the patient and others, so it is necessary to reflect on how much harm we would be willing to permit in the name of autonomy and religious freedom.

First, there is harm to the self, which may make little sense from an outsider's perspective, but we ought to acknowledge the deep role that religion plays in making sense of personal suffering and death. For example, a Jehovah's Witness' refusal of a blood transfusion may look like a needless death from the outside, but to the patient it is an act of obedience to God. The patient views the benefits of the afterlife as more desirable than the goods of this life. However, James Childress raises a relevant point: "when a person is seriously maiming himself…forcible intervention is warranted because

of the heavy burden and costs such injuries impose on others."[203] Childress' point demonstrates that there is often more at stake than the interests of the patient. Although we ought to respect patient autonomy, potential harm to others may be grounds to deny a treatment request.

In some cases, patients may make decisions that ignore the interests of their families and result in great harm financially, emotionally, or physically. This is a matter of great concern and should be discussed with patients and family members prior to approving any such request. Caregivers should consider the harm done to others and whether those affected are willingly affected – they may, in fact, share the religious belief. In addition, a patient's decision might harm other patients, the most obvious case being the problem of scarce medical resources. Such concerns would likely override the patient's autonomy.

The most difficult case, however, is when the religious belief is held by a parent, and the treatment request harms a child. This is difficult because under normal circumstances most feel that parental choices ought to be respected even when they entail a certain amount of risk or danger for the child such as taking children skydiving. However, when it comes to medical care, the law has tended to frown on decisions – religiously motivated or not – that entail great risks for children. In *Prince v. Massachusetts* (1944) the Supreme Court decided that individuals may be free to make martyrs of themselves, but not of their children. I will explore this problem more deeply later.

[203] James Childress, "Must We Always Respect Religious Belief?" *Hastings Center Report* 37 (2007) 3.

In sum, a "no harm" condition is essential if for no other reasons than to reinforce the Hippocratic Oath; this condition is defeasible such as in some cases of self-harm, but it serves as a safeguard against runaway patient autonomy and a prevention of harm done to others. If it can be demonstrated that minimal harm will occur and the belief satisfies the other conditions, then the request may be granted.

The no-harm condition is tied to the virtue of compassion. Beauchamp and Childress define the virtue as "a trait that combines an attitude of active regard for another's welfare with an imaginative awareness and emotional response of deep sympathy, tenderness, and discomfort at another's misfortune or suffering."[204] Both physicians and patients should exemplify this virtue.

Conclusion

Off hand, I can think of two other criteria that might be relevant: (1) that patients understand the medical situation and the consequences related to their requests and (2) that patients show a willingness to reason about or discuss their beliefs with the caregivers of whom they are making the request. I believe that the former criterion is essential, but I have chosen not to address it here because it is a purely epistemic criterion and it is sufficiently addressed by Adrienne M. Martin in "Tales Publicly Allowed: Competence, Capacity, and Religious Belief."[205] The latter criterion is also an epistemic one, but I fear that it would be too limiting, ruling out many religious believers – individuals who are not used to defending their faith and ones who believe that reasons

[204] Beauchamp and Childress, *Principles*, 32.
[205] Adrienne M. Martin, "Tales Publicly Allowed: Competence, Capacity, and Religious Belief," *Hastings Center Report* 37 (2007) 33-40.

cannot be given for faith. One way to include this condition would be to make it subjunctive: if the patient were able or willing to reason about it, could a case be made in its favor? Whether this is a workable criterion is questionable, but even if it is, I believe that the same concerns are addressed by the religious interpreter condition, making this criterion redundant.

Certainly, the MVRB conditions could be further expanded, clarified, or limited; I am sure that they are not yet complete, but my purpose here has been to simply suggest a basic framework within which to separate medically valid religious beliefs from ones not worthy of consideration. It is important to remember that these criteria are not "all or nothing;" some religious beliefs might have more of one and less of another. I take this as a merit of the approach because it does not pretend to draw an absolute line, which separates those on the "inside" from those on the "outside." Each request would need to be evaluated by the criteria independently. Each condition is informed by a principle that is widely accepted as a virtue in the intellectual or moral life. For example, the community and deeply-held conditions are based on the intellectual virtue of autonomy mentioned earlier.

CHAPTER FIVE
Application of the PRB and MVRB Conditions

Jehovah's Witnesses give two main reasons for rejecting blood transfusions: (1) medical risk and (2) the command of God. The Mayo Clinic website says, "Blood transfusion is a common procedure that usually goes without complications. But there are some risks."[206] The website lists the following risks: (1) allergic reactions, (2) fever, (3) lung injury, (4) bloodborne infections like HIV, (5) iron overload, (6) acute immune hemolytic reaction, (7) delayed hemolytic reaction, and (8) graft-versus-host disease.[207] JW literature stresses these risks, so much so that an outsider might get the idea that this is the only reason JWs have to reject transfusions.[208]

While it must be granted that blood transfusions entail some medical risk, the amount of concern shown by JWs is not medically warranted, especially if such worries prevent patients from ever opting for a transfusion. First, it appears to be irrational, based on a logical error. Interpreting JW literature at face value might lead a JW to the following (invalid) logical deduction:

(1) There is a risk of dying from a blood transfusion. (true)

(2) I will require a blood transfusion if I am to have this operation. (true)

(3) Therefore, if I have this operation, I will probably die.[209]

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[206] "Blood Transfusion," Mayo Clinic http://www.mayoclinic.com/health/blood-transfusion/MY01054/DSECTION=risks (accessed February 21, 2012).
[207] Ibid.
[208] See the documentary: *Transfusion Alternatives*, Watch Tower Bible and Tract Society of Pennsylvania, 2004.
[209] This is a modified version of an argument found in Julian Savulescu and Richard W. Momeyer, "Should Informed Consent be Based on Rational Beliefs?" *Journal of Medical Ethics* 23 (1997) 283.

The conclusion does not follow from the premises. Second, if medical risk is the main concern, then it would logically follow that JWs, who say they have a high regard for life, would sometimes accept a transfusion if the risk of rejecting it would amount to certain death.[210] But they do not do so. Therefore, it is obvious that *medical risk* is not playing the role that JWs contend. At best, it is a secondary reason, so I will set it aside for the moment. The main reason for JWs to refuse blood products is that they believe that God prohibits transfusions. Is such a belief rational?

There is nothing inherently irrational about belief in God. In fact, much has been written in defense of the rationality of belief in God; take, for example, the book *The Rationality of Theism* by Paul Copan and Paul Moser.[211] Contributors to the book include William P. Alston, Stephen T. Davis, William Lane Craig, and Charles Taliaferro. Copan and Moser say in the introduction that theism is experiencing a renaissance in intellectual circles, and they refer to atheist philosopher Quentin Smith who laments the return of religious belief:

> Much to Smith's dismay, it became clear that "realist theists were not outmatched by naturalists in terms of the most valued standards of analytic philosophy: conceptual precision, rigor of argumentation, technical erudition, and an in-depth defense of an original world-view." All the while naturalists have "passively watched" as the influence of theistic philosophy has soared: "perhaps one-quarter or one-third of philosophy professors are theists, with most being orthodox Christians." Smith concedes: "God is not 'dead' in academia; he returned to life in the late 1960s and is now alive and well in his last academic stronghold, philosophy departments."[212]

Contributors to the book argue that theism offers the best answers to some of the most difficult philosophical questions such as why something exists rather than nothing. In

[210] Of course, doctors may, in some cases, be overstating the need for a transfusion.
[211] Paul Copan and Paul K Moser, *The Rationality of Theism* (New York: Routledge, 2003).
[212] Copan and Moser, 2

chapter six, "The Cosmological Argument," William Lane Craig describes and defends one argument for the existence of God called the *kalam* cosmological argument, which says, (1) whatever begins to exist has a cause, (2) the universe began to exist, and therefore, (3) the universe has a cause.[213] Philosophical arguments like these demonstrate that theism can be a rational belief.

In addition, there is nothing inherently irrational about belief in a God who gives moral commands. The God of Christian theism has traditionally been conceived as a morally perfect being, one who creates free creatures and desires them to flourish. Divine moral commands are rationally conceivable as a means to the flourishing of free creatures. While divine command theory may be out of vogue these days as a moral philosophy among professional ethicists, it still has its defenders among analytic philosophers.[214] So, if JW beliefs are irrational, then they are irrational for some other reason.

Is it irrational to believe that God would require his people to refuse the medical use of blood products? To answer this question we would need to determine whether the following JW beliefs (mentioned in chapter one) are compatible with PRB:

1. Armageddon is near, in which all mankind will be destroyed except faithful JWs who will live forever on earth;
2. The WTS governing body is believed to be the "faithful and discreet slave" referred to in Jesus' parable at Matthew 24:45, divinely appointed by Jesus Christ to lead JWs;
3. *The Bible* cannot be understood without interpretation by the "faithful and discreet slave";

[213] Copan and Moser, 112-131.
[214] See for example: Robert Adams, "A Modified Divine Command Theory of Ethical Wrongness," in *The Virtue of Faith and Other Essays in Philosophical Theology* (New York: Oxford University Press, 1987) 97-122. Also, Glenn Graber, "In Defense of a Divine Command Theory of Ethics," *Journal of the American Academy of Religion* 43 (1975) 62-69.

4. JWs who openly criticize the leadership and the organization are regarded as apostates, disloyal to Jesus and God;
5. Salvation is contingent on how well they perform as loyal JWs[215]

Some of these beliefs are based on a particular interpretation (hermeneutic) and application of specific Bible passages. To discover whether such beliefs are compatible with PRB, we need to ask what intellectual virtues are relevant in hermeneutics and whether such hermeneutical virtues are compatible with the JW reading of the Bible.

Interpreting the Bible is a practice engaged in by a living tradition, a collection of diverse but related religious communities that see the Bible as authoritative for faith and practice. As Alasdair MacIntyre says, "A living tradition…is an historically extended, socially embodied argument, and an argument precisely in part about the goods which constitute that tradition…What then sustains and strengthens traditions? What weakens and destroys them? …The answer in key part is: the exercise or the lack of exercise of the relevant virtues."[216] As Stephen E. Fowl points out, Christians through the centuries have shown a tendency to rationalize their own evil practices, such as slavery, by ignoring the intellectual virtues in their hermeneutics.[217] He says that a Christian theology of sin (that human beings are fallen and prone to self-justification and rationalization – even while reading Scripture) should inform Christian interpretive practices, encouraging Christians to remain "vigilant over their interpretation."[218]

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[215] Muramoto, "Bioethics of the Refusal of Blood by Jehovah's Witnesses: Part 1," 224.
[216] Alasdair MacIntyre, *After Virtue: A Study in Moral Theory 2nd edition* (Notre Dame: University of Notre Dame, 1984) 222-223.
[217] Stephen E. Fowl, *Engaging Scripture: A Model for Theological Interpretation* (Oxford: Blackwell, 1998) 62-96.
[218] Fowl, 74-75.

The virtues relevant to biblical interpretation are, at least in part, the intellectual virtues mentioned above: the love of knowledge, firmness, courage and caution, humility, and autonomy. If JWs cultivate the love of knowledge, then they would welcome opportunities to test their beliefs and would not reject dialogue and debate with others in the (Christian) tradition regarding the correct interpretation of Scripture. However, it is unclear that this is the case. If Muramoto is correct, "Jehovah's Witnesses have been strongly discouraged from discussing critical religious issues with outsiders, particularly with former members, and can be 'disfellowshiped' (excommunicated) for doing so."[219] It is one thing to require that members of the community adhere to community practices, this conforms to the virtue of community integrity that is alluded to by Donald T. Ridley in response to Muramoto: "Muramoto's suggestion that each individual should be free to disregard the community's scriptural teachings and standards and yet remain a member of the community is preposterous."[220] However, it is quite another thing to prohibit members of the community from discussing or testing their beliefs with those who believe otherwise. The practice of excommunication is, to the extent that it is not coercive, compatible with the love of knowledge; the closed-minded practices that Muramoto refers to is not.

Such an unwillingness to sincerely consider other interpretations is an example of other vices as well, such as being overly cautious. Being overly cautious, in this case, appears to be a manipulative practice based on the fear that members of the community might come to embrace other interpretations or simply abandon ship. This separation

[219] Muramoto, "Bioethics of the Refusal of Blood by Jehovah's Witnesses: Part 1," 223.
[220] Ridley, 471.

from other Christians is also an example of the vice of arrogance. Insofar as The Watchtower enjoins its members not to listen to others, it is commanding them to act in an arrogant manner. Intellectual humility would require JWs to recognize that only God has a monopoly on knowledge and much can be learned in discussion with others, especially with those who disagree with you. In addition, this separation from others appears to be an example of the vice of improper hetero-regulation, which occurs in this case because The Watchtower does not cultivate the virtue of intellectual autonomy, or the ability of its members to think for themselves.

MacIntyre adds to these virtues an additional one: "the virtue of having an adequate sense of the traditions to which one belongs or which confront one."[221] It is unclear whether JWs have an adequate sense of their tradition, especially in light of the beliefs above, in which JWs view themselves as the only beneficiary of God's enlightening and saving grace. Instead, JWs need to view themselves as belonging to a larger tradition of religious groups who hold the Bible to be authoritative.

The JW rejection of blood is based on its unique interpretation and application of particular scriptural passages, as seen in chapter one. The Watchtower asserts that only its interpretations of these passages, no matter how implausible, are valid because The Watchtower is "the faithful and discreet slave" of Matthew 24:45. It is unclear how such authority is supposed to follow logically from this passage even if the "slave" is identified with The Watchtower. No other major Christian group stakes its claim to ecclesiastical authority on this passage, and it seems to be quite a stretch to do so here.

[221] MacIntyre, 223

Since its claim to ecclesiastical and hermeneutical authority starts on such shaky rational footing, any further Watchtower interpretations are suspect.

Julian Savulescu and Richard W. Momeyer argue that JW beliefs are irrational in two ways: they are unresponsive to evidence and inconsistent.[222] First, they argue that their overly literal interpretations are not open to evidence. Such interpretations, they claim, ignore "historical context, the diverse intentions and circumstances of Biblical peoples and authors, oral and written traditions in the Middle East, other religious traditions and interpretations of Biblical texts, and inconsistencies between different canonised works."[223] This failing appears to be an authentic example of a failure to conscientiously do one's research and test one's beliefs against other in the biblical community.

Second, Savulescu and Momeyer argue that JWs ought to recognize that their own beliefs are inconsistent. They explain, as an example, that the JW prohibition against the consumption of blood is incompatible with the practice of communion, in which followers of Jesus drink the "blood" (wine) of Jesus.[224] Another example of inconsistency, they claim, is the teachings of Saint Paul, who taught that believers are not to be slaves to the law, but ought to live by faith.[225]

While Savulescu and Momeyer's first criticism may be valid (that JW interpretations are unresponsive to evidence), it is not clear that their second criticism is successful. The comparison of blood transfusion to the practice of communion may fail

[222] Savulescu and Momeyer, 282-288
[223] Savulescu and Momeyer, 284.
[224] Savulescu and Momeyer, 284.
[225] Galatians 3:10,13,24-25

to take into account what JWs actually believe about the nature of blood consumption. If Richard Singelenberg's analysis is correct, then the underlying reason for not consuming the blood of other human beings is to avoid pollution with apostates.[226] According to JW beliefs, it is possible even for current Jehovah's Witnesses to apostatize, so consuming only the blood of fellow members is no guarantee against pollution. Consuming the blood of Jesus Christ, however, may be safe enough, given his sinless nature. In fact, being united with Christ is a common Christian teaching; however, The Watchtower does not teach the transubstantiation of the communion elements, i.e. the wine becoming blood, like the Catholics. They believe, like many other Protestant denominations, that the elements are only symbols of the body and blood of Jesus, eaten in remembrance.[227] So, the comparison ultimately fails.

The second point about Paul's teaching is also weak. Paul, in this passage, is warning the church in Galatia about the dangers of certain false teachers in their midst (the so-called Judaizers), who were trying to convince the Gentile believers to be circumcised like the Jewish believers. Paul is not teaching antinomianism here, or that all moral rules are bad, for he prescribes other moral practices in his letters. Instead, he is trying to combat the tendency of believers to rely on old Jewish traditions rather than faith. Anyway, Paul himself delivered the "blood" message to the Gentile believers in Acts about the prohibition of consuming blood, so, Savulescu and Momeyer's charge of

[226] Singelenberg, 520.
[227] The Watchtower, http://www.watchtower.org/e/20080401a/article_01.htm (accessed February 21, 2012).

inconsistency fails.[228] Nevertheless, even if the charge of inconsistency fails, the first charge of irrationality may stick.

However, before we decide whether to honor JW M-requests, it will be helpful to determine whether JW M-requests satisfy the MVRB conditions: whether the M-requests are based on religious beliefs that (1) are held by a community, (2) are deeply held, (3) would pass the test of a religious interpreter, and (4) do no harm. The first is the community condition. JWs number close to seven million worldwide, and while the seven million figure does not come close to the number of followers in any of the world's great religions (consider the 1.5 billion followers of Islam[229]), it is not a small religion by any means. In addition, the blood mandate is widely taught and carefully adhered to. The authority of the Watchtower on this issue extends to the JW community worldwide, at least regarding the use of whole blood products. The Watchtower leaves the question of the use of blood components up to local communities.

The second condition is whether the belief is deeply held. Such a condition needs to be applied on a case by case basis – many JWs are sincerely committed to these beliefs, but many are not. Stories abound in the medical community of patients who are relieved to have blood transfusions forced upon them. Such patients feel coerced by their community to refuse blood, but deep inside they want to continue living by whatever means possible. Discerning whether coercion is playing a role is difficult, but it is a challenge that healthcare providers must accept as part of the job, and not just with JW patients. The difficulties of ferreting out coercion can be mitigated if the patient can be

[228] Acts 15:28-29.
[229] http://www.religioustolerance.org/isl_numb.htm (accessed February 21, 2012).

spoken with alone separate from other family or church members. In such a situation, the question can be posed: "We understand what you are asking for, but we would like to know whether you would be relieved if we took the choice out of your hands and simply gave you the transfusion against your will." An affirmative response to this question is often possible because of the understanding that the Watchtower will absolve its followers of any responsibility if the treatment is forced upon them. However, if the Witness is deeply against being transfused, then this counts in favor of honoring the M-request.

The third condition is the religious interpreter test. Would the blood transfusion refusal pass the test of a religious interpreter? It probably would. As mentioned above, such requests are quite common and the beliefs upon which they are based are widely held among JWs. It is also widely known and discussed among medical practitioners, so there is no reason to believe that it would fail this condition. If anything, this M-request represents the best example of when a clear, well-established religious teaching conflicts with the standard of care. Religious interpreters in these cases, then, would fulfill other roles such as mediating between hospital staff and the patient and making sure that both parties understand one another. Even though this M-request is widely discussed among medical practitioners, it is not always honored by medical staff. I recall a story in which a medical resident knew that an unconscious patient was a JW, but proceeded with a blood transfusion anyway "in the patient's interest" and was later reprimanded. An interpreter who is present in the clinic could help prevent such mistakes from occurring

and also inform the caregiver of treatment alternatives that would be compatible with the patient's request.

The fourth condition is the no harm condition. Certainly, harm will occur in many cases if a blood transfusion is refused; however, if the M-request is made by a competent patient and it satisfies the "deeply held" condition, then it must be weighed against the harms perceived by the patient. The patient is making a judgment between physical and spiritual harm where the perceived eternal benefits outweigh the earthly physical costs. When such a death occurs, it may be considered "tragic" by hospital staff, but it probably does not, as James Childress says, inflict a high cost on them. As mentioned in chapter four, Childress makes the point that there is more at stake than just the interests of the patients. The interests of others related to the patient and of the hospital staff need to be taken into consideration.[230] In the balance, the interests of the patient outweigh the interests of others here, so the M-request passes this condition.

In conclusion, JW M-requests satisfy the MVRB conditions but fail PRB. This shows that the MVRB conditions are more liberal than PRB and would allow irrational beliefs. This is acceptable. Until now, I have not said much about the modern emphasis on autonomy, according to which we feel that competent adult patients should make decisions about their own care. Competency is not the same as rationality. Adult patients can be judged competent to make certain decisions about their healthcare while being irrational; for example, a patient might have an aversion to taking medicine and might prefer to seek out alternative therapies to treat her illness before filling her doctor's prescription. The doctor may feel that such an action is irrational, but the patient could

[230] Childress, 3.

still be competent enough to make the decision. Rationality, in terms of PRB, is a higher standard than simple competency.

On the other hand, Julian Savluescu and Richard W. Momeyer explain, "We do not respect autonomy when we encourage people to act on irrational beliefs. Rather, such beliefs limit a person's autonomy."[231] According to this perspective, an autonomous decision is a rational decision, not merely a competent one. If this is the case, then it seems that we must promote rationality with much more vigor. But this may be difficult in a system that has come to view "autonomy" as making decisions about one's own care, whether rational or not.

There are many theories of autonomy, but Beauchamp and Childress define autonomy as "self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice."[232] Under this view, a patient may not be forming beliefs in a fully virtuous manner and may lack many moral virtues such as concern for family members; nevertheless, she may be making the decisions herself and fully understand the consequences. As caregivers, we might encourage her to rethink her decisions, but in the end, I believe that it is right to respect them, which, in other words, is respect for autonomy.

To accommodate patient autonomy in this sense, then, the threshold of honoring M-requests must be lower for competent adults. If such requests pass the MVRB conditions, they should be honored. The more strict PRB should only be applied when

[231] Savulescu and Momeyer, 287.
[232] Beauchamp and Childress, *Principles*, 58.

the stakes are higher such as when the lives of children are at risk, but I will say more about this in the next chapter.

MVRB Conditions and the Golubchuk Case

In a recent article in the *Scottish Journal of Healthcare Chaplaincy*, Robert Mundle applies my MVRB conditions to the Samuel Golubchuk case.[233] He raises some serious questions, especially with the religious interpreter condition.

First, he thinks that the community condition is unhelpful. He says:

> On the one hand, a leading expert in Jewish medical ethics – Rabbi Dr. Edward Reichman – stated that the "overwhelming majority" of rabbinic authorities would prohibit removal of Mr. Golubchuck's ventilator, if doing so would have led to his death…On the other hand, Rabbi Chaim David Halevi, the late Sefardi Orthodox Chief Rabbi of Tel Aviv, once stated that it is prohibited to prolong life artificially when there is no longer any hope for the patient. He said that in such cases it is not only permissible to disconnect the machine, but it is mandatory to do so, in that ventilators can cause the soul to suffer rather than the body by preventing it from departing and going to its rest and peace…And side-stepping the religious debate altogether, yet another rabbi argued that the Golubchuk case was not really a "Jewish" issue at all, but that its scope transcended religious bounds to become a human rights issue.[234]

With such wide disagreement about the Golubchuk case among Orthodox Jews, Mundle thinks that the community condition is indeterminate; moreover, Mundle thinks that community consensus in any religion is "surely elusive if not illusory."[235] While he does not say so explicitly, Mundle suggests that the community condition be dropped from the set of conditions. He says that the decisive factor is "existential confession rather than

[233] Mundle, 21-28.
[234] Mundle, 24.
[235] Mundle, 24.

doctrinal interpretation," which I take to mean that what the individual patient believes is more important than what the community teaches.

While I agree that community consensus might be elusive, I see no reason to think that it is illusory, especially if we define "community" carefully. There are communities within communities, for example, groups of Jews who are more conservative than others, ones who take a more vitalist position than others. This can be seen in Mundle's own words above. Communities and groups can be recognized at many levels within a religion. Jews everywhere share some things in common, so we can identify the religion of Judaism. But within it, there are Orthodox and Reformed Jews, and within those divisions there are even further divisions. The community condition allows for a plurality of views within a tradition as long as a community can be identified whether the community is a "religion" or a "sect." Jewish vitalism may be one view in Orthodox Judaism and may even be in the minority (which is not apparent to me); nevertheless, it is held by a community of believers who have a common identity and literature.

For the community condition, there is a presumption that the larger the community, the more often its M-requests should be honored. So, the beliefs of a group of religious separatists do not count for as much as the mainstream beliefs of one of the larger religions. This is in keeping with the value of community-held beliefs defended earlier.

Second, Mundle thinks that the "deeply held" condition is useful in the Golubchuk case. He says:

> While there is no doubt that the Golubchucks voiced their religious beliefs clearly and strongly, it is unclear what emotions and dynamics might have been fuelling

> their position. From a family systems perspective, for example, the death of a family leader can disrupt a family system and throw it into chaos. A spiritual assessment in end-of-life cases could utilize a genogram to focus on how much a "vitalist" position might actually be driven by fear of a father's death and how that would disorient the family in its wake. Was it fear of their father's death that gripped Mr. Golubchuck's adult children? Or denial? Or long-standing guilt? Was it the burden of uncertainty about what to do that paralyzed their decision-making capacity? Or was it a lack of trust in the medical team? Or was it perhaps something else?[236]

Mundle thinks that the Golubchuks' stated religious beliefs could be masking deeper issues, and asking whether the religious belief is deeply held will help physicians provide better care. He also thinks that chaplains can assist the physician in this endeavor.

Third, Mundle is deeply concerned about the religious interpreter condition. In my original paper, I nominated chaplains for the job of religious interpreter, yet Mundle thinks that this constitutes a conflict of interest for "non-judgmental chaplains."[237] He says, "Hospital chaplains cannot be expected to know with any real depth and accuracy all the details of specific beliefs and practices of multiple religious traditions, and a summary rehearsal of basic fundamental points risks stereotyping otherwise complex belief systems."[238] Mundle thinks that a chaplain is too fallible to provide information about what a patient believes. The religious beliefs of patients are too varied and the systems themselves are too complicated for a chaplain to be authoritative. He says, "The real 'experts' after all are the patients and their families themselves."[239]

Mundle also thinks that asking chaplains to offer judgments in ethically troubling cases conflicts with their "pastoral sensibilities" and that most chaplains would be

[236] Mundle, 24
[237] Mundle, 24.
[238] Mundle, 23.
[239] Mundle, 23.

opposed to their involvement as "interpreters."[240] He is a chaplain by training, and he describes the chaplain's role in a typical fashion:

> Chaplains can help build trust between patients, families, and medical teams in the deadlock of ethical dilemmas in ways that correspond to the main tools of pastoral practice…For example, chaplains provide a ministry of "presence" to patients and to families that enables them to tell their stories freely, ask all their questions without haste and fear of judgment, and contemplate their decisions thoroughly with an attentive and reflective listener…Instead of "religious interpreters" chaplains can be understood more widely as "values interpreters" who engage the treasury of images and symbols in which religious beliefs among other values are expressed.[241]

Mundle argues that chaplains provide comfort and a listening ear and that they are not trained to evaluate religious beliefs. Chaplaincy, he says, "facilitates open communication among equal partners, while it rejects the claim of superiority assumed by the role of the religious interpreter as evaluator and judge of religious validity for others."[242]

I understand Mundle's concerns. Chaplains often perceive themselves in the sole business of providing spiritual care; in fact, they are often asked to do more than this in the clinic, but this frustrates them. For instance, I recall a case where a chaplain was asked by a patient's physician to fix a problem, to convince the family to accept the recommended treatment. This, the chaplain explained to the physician, was not part of his job description, but this is mistaken. The chaplain is part of a team, a team caring for the patient. While chaplains are primarily responsible for spiritual care, such care cannot be easily separated from patient care as a whole. In fact, spiritual care is just one component of patient well-being, and if we are to treat the patient, and not just her

[240] Mundle, 23.
[241] Mundle, 25.
[242] Mundle, 24.

disease, then we must address every component and treat her as a whole person. Anyway, spiritual care is often affected by the other conditions; in other words, how you care for a person spiritually will depend on what the conditions of the disease are, what the medical treatment is, and the communication (or lack thereof) with other caregivers. Also, medical professionals need a complete understanding of the patient to deliver appropriate care, and this often requires communicating with a social worker, psychologist, or chaplain. If one of these other team members is unwilling to assist, patient care is compromised. More than likely, chaplains *are* willing to be a member of the team but simply want to limit their involvement to "spiritual presence," but this is morally unacceptable. If any member of the patient's care team has information that might improve the patient's well-being, it is incumbent on this team member to assist the others even if this means stepping outside one's usual role. This is done for the sake of the patient, and chaplains of all people should be able to recognize this obligation.

When chaplains resist attempts to enlist their assistance in caring for a patient (in ways other than spiritual care), there are alternatives. First, find another chaplain, one willing and able to participate in an ethics consultation. Second, ask the family's minister if she is willing to mediate. Third, consult a professor of religious studies who is familiar with the religion or sect. Also, the hospital could employ a patient advocate whose job description includes familiarizing herself with the religious beliefs of those served by the hospital.

In the Golubchuk case in particular, Orthodox Judaism is not an obscure religion, so finding someone, a chaplain or religious studies professor, who is familiar with its

teachings will not be difficult. An interpreter would confirm that the Golubchuk family's beliefs are in line with traditional Jewish beliefs and could help to determine whether the family is in fact practicing members of that faith. The interpreter could also serve as conflict mediator, which would have been useful in the Golubchuk case. In short, it is likely that this case would pass the religious interpreter condition.

Finally, does the Golubchuk M-request pass the "no harm" condition? Mundle thinks this condition is complicated. He says, "By continuing to treat Mr. Golubchuck his physicians argued that they were inflicting physical harm on him, yet it also could be argued that he did not experience any physical pain due to his minimal brain function."[243] Mundle also points out that some people would argue that the family was harming Mr. Golubchuk because they were not allowing his soul to go free. On the other hand, some would say that the physicians were being harmed emotionally and spiritually because of the great toll this case was taking on them (recall that one physician resigned over it). In spite of these conflicting considerations, it is not clear that continuing to treat Mr. Golubchuk would result in significant harm to anyone other than Mr. Golubchuk, and even in this instance, the harm would be mitigated by his minimal brain function. The "harm" that the physicians experienced is most likely a wounded conscience, which can be mitigated by allowing physicians who have strong moral qualms with a procedure to opt out (a conscience clause).

In short, the Golubchuk M-request should be honored. The Manitoba guidelines that were released in response to this case state that physicians have the final say whether to continue treatment even against the desires of the family. This is unacceptable because

[243] Mundle, 25

it is culturally insensitive and violates Nussbaum's Accommodation Principle discussed in chapter three.

Conclusion

In conclusion, I closely examined two cases. With JW M-requests, I showed that while such a request might fail the PRB condition, it would satisfy the MVRB conditions. Since we are dealing with competent adult JWs and given the high regard for autonomy in the clinic, I argued that these M-requests should be honored in spite of their irrationality. So, when adult patients make M-requests, it is enough simply to apply the MVRB conditions. In the Golubchuk case, I did exactly that, and determined that the requests to continue to treat Samuel should be honored.

CHAPTER SIX
Evaluating M-Requests in Pediatrics[244]

In *Prince v. Massachusetts* (1944), the U.S. Supreme Court ruled that Sarah Prince, a Jehovah's Witness, violated child labor laws. The 9-year-old child entrusted to her care was caught distributing religious literature. The opinion of the court famously stated: "Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves." The child in this case was not in physical danger; nevertheless, this case is often cited when parents make M-requests.

In this chapter, I consider the dominant approach to handling M-requests for children and suggest that it is too insensitive and uncritical for our modern pluralistic society. Until now cultural and religious beliefs have been undervalued (sometimes unintentionally) in this discussion.

In some cases, the standard of care automatically trumps M-requests; medical professionals and courts intervene and remove children from parental custody when an M-request will result in great risk to a child. This falls short of critical engagement because such cases are marked by a lack of consideration of the beliefs themselves – emphasizing only the medical risks. In such cases, caregivers operate (consciously or unconsciously) on the assumption that the family's beliefs are false or irrelevant and that a secular conception of the no-harm principle trumps all competing values.

[244] An earlier version of this chapter appears as Gregory L. Bock "Making Martyrs of Our Children: Religiously Based Requests in Pediatrics" *Ethics & Medicine: An International Journal of Bioethics* (forthcoming).

This is not to say that current medical practice explicitly endorses the view that we ought to be disrespectful of other cultures; nevertheless, the dominant approach is not sensitive enough. It is too permissive in some cases *and* too intolerant in others because *true* respect for matters of conscience has been missing from the clinic. Healthcare needs a new model for dealing with M-requests for children, one that takes the beliefs of parents seriously and avoids Dacey's "Privacy and Liberty Fallacies."[245] I expect that as a result of this move, some M-requests that are currently granted will be denied and some that are currently refused will be allowed.

Julian Savulescu

In this section, I consider Julian Savulescu's approach to handling M-requests for children. His conditions hold parents to a high ethical standard, but, as is common, they undervalue cultural and religious beliefs. He suggests the following standards for limiting the kinds of choices parents can make for their children:

1. It must be *safe* enough, compared to other interventions children are exposed to.
2. The parent's choices must be based on a *plausible conception of well-being* and a better life for the child and not on some idiosyncratic, unjustifiable conception of the good life. In addition, the choice must be based on a good enough expectation of realizing a good life. For this reason, while competent adults can refuse life-saving blood transfusions for themselves, parents cannot refuse life-saving blood transfusions for their children on any grounds.
3. It must be *consistent with development of autonomy and a reasonable range of future life plans for the child*. For example, while adults may be allowed and even have a good reason to have one of their healthy limbs amputated, parents could never have the healthy limb of their child amputated for many reasons, including the fact that it removes a range of possible good futures from the child's grasp. Female circumcision, and the removal of an organ of female sexual pleasure, severely constrain the range of possible good lives for that child, stunting the possibility of full sexual satisfaction. It should not be

[245] Dacey, 15.

> permitted. Male circumcision is different precisely because the possible consequences are more mixed and more uncertain. The reasons for accepting male circumcision include social and cultural considerations, as well as medical considerations such as reduced risk of disease (e.g., penile cancer) and infection (e.g., HIV and HPV).[246]

These conditions are helpful for a number of reasons. First, they establish a strong presumption in favor of protecting the lives of children. Second, they prevent religious liberty from becoming an unqualified absolute. Savulescu's set of conditions hold beliefs to a high ethical standard in order to protect the lives of children, but they suffer from a number of problems.

Safe enough

First, it is not clear *how* safe is "safe enough." It would make a big difference if the basis of comparison includes all of the legitimate risks children are exposed to outside the hospital, like riding in cars or on bikes.[247] This would, I think, make this condition very permissive; on the other hand, if the basis of comparison includes only the risks entailed by other medical interventions such as blood transfusions, then the condition is very strict. Savulescu probably means the latter.

If the basis of comparison only includes medical interventions, then this standard seems indistinguishable from the standard of care, which would mean that *any* conflict between parents and physicians ought to be resolved by ignoring the parents and their beliefs. I find this too paternalistic because it violates *The Principle of Parental Discretion*, defined as the right parents have to make decisions for their children. Allen

[246] Julian Savulescu, "Autonomy, the Good Life, and Controversial Choices" in *The Blackwell Guide to Medical Ethics*, ed. R. Rhodes, L.P. Francis, and A. Silvers (Oxford: Blackwell, 2007) 32.
[247] Thanks to John Hardwig for this insight.

E. Buchanan and Dan W. Brock describe the reasoning given for such a principle: (1) parents do a better job in principle than anyone else; (2) parents bear the consequences of such choices, so they should have some control over the choices; (3) parents have a right to transmit values to their children because they need socialization and development; and (4) the family is an important social institution that requires freedom from oversight and control to work effectively.[248] Mark Sheldon says, "More than any other institution in society, the family…values human beings simply because they *are*, not because of any use to which they can be put. And, for this reason, it is probably in a child's best interest…that the family be maintained to the extent that it is…consistent with this objective of such nurturance."[249] *Parens patriae* – the doctrine that the state has the authority to intervene to protect children's interests – is invoked when parents fail in their responsibilities, and this is as it should be. However, the difficulty with M-requests is in determining when parents have failed their children, and it is not clear that an M-request that entails more risk than other medical interventions necessarily constitutes child neglect or abuse. Hence, to accommodate parental discretion, "safe enough" ought to be given a more permissive interpretation.

Also, "safety" seems to mean mere physical safety to Savulescu, but this ignores other kinds of harms that can occur, for example, psychosocial and spiritual harms. Making children wards of the state may protect them physically but harm them in other ways that have been overlooked. A recent example occurred when more than 460

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[248] A. E. Buchanan and D. W. Brock, *Deciding for Others: The Ethics of Surrogate Decision Making* (Cambridge: Cambridge University Press, 1989) 232-234.
[249] Mark Sheldon, "Ethical Issues in the Forced Transfusion of Jehovah's Witness Children," in *Taking Sides: Clashing Views on Controversial Bioethical Issues 9th edition*, ed. C. Levine (Guilford, Connecticut: McGraw-Hill) 178.

children were taken into state custody when Texas authorities raided the Yearning For Zion compound on a tip that underage girls were being married off to older men. Surprisingly, an appeals court later ruled that Texas authorities had overstepped their bounds: "Evidence that children raised in this particular environment may some day have their physical health and safety threatened is not evidence that the danger is imminent enough to warrant invoking the extreme measure of immediate removal prior to full litigation of the issue."[250] The raid in Texas led top prosecutors in other states to assure the polygamist groups in their states that they would not be raided.[251] The ruling of the appeals court demonstrates this point: the physical safety of children is important, but it is not the only concern.

Psychosocial safety should be a consideration in deciding M-requests because children can suffer psychological trauma as a result of an M-request or from being taken into state custody. Also, they can be harmed socially if the treatment results in their being marginalized in their societies. For example, in some African societies women who do not undergo circumcision find it very difficult to get married. Such a consideration may not ultimately justify the practice of female circumcision, but it is important information and should be given due weight in decision-making.

Children can also be harmed spiritually, which, for example, may occur if the treatment that the M-request was intended to avoid is viewed as sinful by the community. The patient and the patient's family might be ostracized or excommunicated, resulting in

[250] CNN.com, "Court: Texas had no Right to Remove Polygamists' Children," www.cnn.com/2008/CRIME/05/22/flds.ruling/index.html/ (accessed May 22, 2008).
[251] NPR.org, "Utah, Ariz. Prosecutors Vow not to Raid Polygamists," www.npr.org/templates/story.php?storyID=90309590/ (accessed May 21, 2008).

a fracturing of the patient's spiritual development. In addition, there might be eternal consequences that cannot be undone. For example, JWs are convinced that receiving a blood transfusion will result in divine judgment. To ignore or reject such beliefs without first engaging them seriously is an act of disrespect for matters of conscience that is incompatible with a liberal pluralistic society (in fact, the whole focus of the JW blood issue to date has been on the physical risks involved).

An American Academy of Pediatrics (AAP) statement on M-requests seems to support Savulescu's position:

> The AAP opposes religious doctrines that advocate opposition to medical attention for sick children. Adherence to such views precludes appropriate assessment and intervention to protect children. The AAP believes that laws should not encourage or tolerate parental action that prevents implementing appropriate medical treatment, nor should laws exempt parents from criminal or civil liability in the name of religion…The AAP considers failure to seek medical care in such cases to be child neglect, regardless of the motivation.[252]

In this statement, the AAP does not distinguish between different types of harm, focusing entirely on physical safety. In fact, the statement makes it clear that no other conceptions of safety can compete. This is troubling, but I do not think that the AAP is being intentionally insensitive. In fact, a recent policy by the AAP concerning female circumcision demonstrates its cultural sensitivity. The AAP suggests that a compromise might be reached between physicians and immigrant communities who request female circumcision by offering a "ritual knick" instead.[253] The "knick," which has been

[252] American Academy of Pediatrics, "Religious Objections to Medical Care," in Taking Sides: Clashing Views on Controversial Bioethical Issues 9th edition, ed. C. Levine (Guilford, Connecticut: McGraw-Hill, 2001) 169-170.
[253] American Academy of Pediatrics, "Policy statement ritual genital cutting of female minors," www.pediatrics.org (accessed September 2, 2010) 1088-1093.

accepted by some African communities already, is a symbolic practice relating to circumcision and is less harmful (but is currently illegal in the U.S.).

In short, safety should not be analyzed solely in physical terms. Doing so oversimplifies a complex issue, and Savulescu's *safe enough* condition needs to give consideration to all types of harm and be more sensitive to cultural and religious beliefs.

A plausible conception of well-being

Second, the notion of a "plausible conception of well-being" is suspect. Savulescu explains that he wants to rule out idiosyncratic beliefs, but if a particular belief is plausible to seven million people in the world (a conservative estimate of the number of active JWs), then it is not idiosyncratic. He rejects the JW conception of well-being, however, when he gives the example that a parent can never refuse a child a life-saving blood transfusion. Plausibility, to Savulescu, appears to be grounded on an objectivist view of reasons, which he defines as the following: "Whether a person should be offered a treatment turns on the objective values of the *physical* circumstances of that person's situation, such as the chance of prolonging a life in which a person can carry on worthwhile relationships with others, achieve worthwhile goals, and so on."[254] If this is not what Savulescu means by "plausible conception of well-being," then he should make this clear. In the meantime, this interpretation will serve as a useful representation of a widespread assumption. Requiring a physical-health conception of well-being as a condition is problematic because few people would satisfy it.

[254] Julian Savulescu, "Two Worlds Apart: Religion and Ethics," *Journal of Medical Ethics* 24 (1998) 383.

Spiritual well-being is at least as important (if not more) to religious communities across the world. Consider, for example, the Buddha's teaching on the Middle Way: he taught that the path to nirvana was not to be found in the extremes of asceticism or earthly living; rather, it was to be found in the middle. In this way, he affirmed both physical and spiritual well-being. In addition, traditional Christianity rejects the doctrine of medical vitalism – that physical life is the highest good. It teaches that the physical body has value based on the creation and resurrection of the body, but it also stresses the importance of spiritual well-being and eternal life in heaven (I Timothy 4:8).

Even non-religious individuals want more than mere physical well-being. John Hardwig points out that physical health and longevity are not the primary goals of most patients. He says, "Patients usually want much, even most, of what doctors have to offer. But they do not want all of it; they do not always even want very much of it…Indeed, in hindsight it is easy to see that only a very odd person has better health and a longer life as her #1 priority."[255] Individuals, as Hardwig points out, engage in all kinds of risky behaviors on the basis of personal goals and values. For example, many individuals choose academic careers which entail sedentary lifestyles – not the best option if physical health and longevity are the goals. Hence, Savulescu's condition of plausibility should be expanded to be more representative.

Another serious problem with Savulescu's condition is that he appears to define the notion of plausibility by content; in other words, he thinks that there is a set of beliefs that ought to be universally recognized as implausible or irrational, for example, the

[255] John Hardwig, "The Stockholder – A Lesson for Business Ethics from Bioethics," *Journal of Business Ethics* 91 (2010) 330.

belief that God prohibits blood transfusions. If content were used to assess plausibility, the temptation would be much greater to dismiss the beliefs of other cultures too quickly (epistemic imperialism) before investigating how people in those cultures actually arrive at their beliefs. Plausibility as content is not sensitive enough to the diversity of rational beliefs across cultures. A better model would assess plausibility on the basis of intellectual virtues because it would acknowledge that (1) there are rational people in every culture, (2) that rationality is not defined by one's own culture, and (3) it is not the case that one's own culture is *prima facie* more reasonable than others.[256] Rather than deciding that certain beliefs are irrational *a priori*, an intellectual virtue approach would involve an investigation into how particular beliefs were arrived at and how the beliefs are held. For example, what sort of evidence are they based on? What goals do the people hold? How open-minded are they? In short, a plausibility as content approach is too insensitive and needs to be replaced with a model that assesses plausibility (or rationality) on the basis of intellectual virtues.

Future autonomy

Savulescu's third condition represents the most common concern raised against M-requests, namely that parental choices must be consistent with the development of autonomy and a reasonable range of future life plans for the child. The problem with M-requests for children is that their effects may be irreversible and that it is very possible that if the child were old enough to make her own decisions, she would reject the M-request and the belief system it is based on. Many think that autonomy with regards to

[256] For in depth discussion of this, see Zagzebski, "Phronesis and Christian Belief," 177-194.

matters of conscience is preeminent because such beliefs are deeply personal and we just cannot decide such matters for others, even children. Such beliefs are too mysterious, complex or subjective. Sheldon sums up this view:

> While the state does not know truly what is in the child's best interest, neither does anyone else. What the parents believe is in the child's best interest may be mistaken. Given that no one knows what is in the child's best interest, the role of the state is to ensure that children ultimately become adults, able to decide, independently, what is in their own best interest. It is not even that the state assumes that it knows it to be in the child's best interest to become an adult. It may not be. It is simply that no one knows what is in the child's best interest, and the responsibility of the state is to make certain that persons who make decisions which are irrevocable do so when they are competent.[257]

Future autonomy is an important principle, but it is complicated because there are competing values. Adrienne M. Martin points out that religious practices are worthy of some respect apart from considerations of autonomy: "Surely we value such practices and institutions, and individuals' participation in them, for multiple reasons unrelated to autonomy. Religion can be a deep source of meaning in individual and community lives; it can build and maintain communities."[258] Religious liberty is an important value worth protecting, and doing so not only means protecting the rights of the autonomous individual to practice religion, but also the freedom of families and communities to act on faith, even when they impact the lives of their children in ways that would be disagreeable to others.

Moreover, maximizing a child's future autonomy is not always in the child's interests. For example, if a child has a gift for athletics, the parent's decision to enroll her in after-school academic programs instead of athletics may preclude the child from ever

[257] Sheldon, 178.
[258] Martin, 39.

becoming a world class athlete. The child's future autonomy is protected – she can always pick up athletics later – but the option of being a great athlete may have been removed.[259] Parental decision-making limits options one way or another, and it would be unfortunate if parents never nurtured their children's natural gifts because of concerns about maximizing future autonomy.

Female circumcision in Africa poses another problem for Savulescu's notion of autonomy. In some African cultures, as mentioned earlier, refusal to have a girl circumcised may result in social marginalization and the limitation of social options. As Wangila writes, "Female circumcision is viewed by most circumcising communities as an initiation into womanhood. It ensures female fertility, provides a source of identity, and prescribes a social status; the lack of circumcision can lead to social exclusion and shunning."[260] Savulescu is against female circumcision because it limits sexual autonomy and is irreversible (in some of its forms); nevertheless, his view would limit autonomy in another sense: an uncircumcised girl's social opportunities are greatly restricted. Hence, sexual autonomy and social opportunity are in conflict. Which one is more important for young women?

In Joy's case, a pediatric blood transfusion case, Savulescu would stress Joy's future autonomy and reasonable (physical) life plans, so he would recommend invoking *parens patriae*, securing a court order (as is the case in almost every pediatric blood transfusion case), and forcing the transfusion. Some think that at thirteen Joy might be considered a mature minor; if so, autonomy might require that we respect Joy's wishes.

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[259] P. Baines, "Medical Ethics for Children: Applying the Four Principles to Paediatrics," *Journal of Medical Ethics* 34 (2008) 143.
[260] Wangila, 100-112.

Debating the mature minor issue is not within the scope of this chapter, so I will simply stipulate that she is not a mature minor to make her case relevant to the issues being debated here (or we might just change the case so that her age is lowered to ten to ignore the mature minor issue).

If her caregivers invoke *parens patriae* and force the transfusion and she survives, she might face possible expulsion from her community and rejection by her family, which would drastically limit her future autonomy.[261] If she does not survive, then this situation becomes a tragedy upon tragedy because, from the perspective of the family, Joy is physically and eternally separated now.

Some might say that since the Watchtower organization forgives involuntary blood transfusions these worries would evaporate. In fact, for this reason, some JW parents are reportedly relieved when they are informed that a court order will be secured, for their children will live longer on earth and still see eternal life in heaven. Although many Witnesses may feel this way, it is unlikely that all will, so we need to consider those who do not. The fact that many JWs (and physicians) think that God would not hold children responsible for a forced blood transfusion doesn't alone justify our ignoring the protests of parents who disagree. Consider a similar case. I mentioned earlier that traditional Christianity would not support the doctrine of medical vitalism, but that does not keep some Christians from invoking their Christian beliefs in support of keeping patients connected to life support beyond what is thought medically reasonable. The fact that some Christians hold unorthodox beliefs does not mean their beliefs can be ignored. They may hold these beliefs very deeply. Also, a JW recently discussed the transfusion

[261] Thanks to Annette Mendola for this insight.

issue with me, and she compared the command to avoid blood products with the command to refrain from premarital sex. She said that JWs would be forgiven if sex were forced upon them (rape), but that does not make the experience desirable. In the same way, forced blood transfusions may be forgiven, but that does not solve the problem entirely.

Joy's case presents a problem for views like Savulescu's, because without a good reason to prefer an objectivist (non-religious) view of reasons it is not immediately apparent whether this M-request is unreasonable.[262] Sheldon says that the state's only concern should be to protect a child's future autonomy, so all other worries and considerations are irrelevant. It is certainly easier on caregivers to simply have one pair of directives: the future autonomy and physical care of children. Nevertheless, such an approach oversimplifies the issue and is incompatible with the virtue of cultural sensitivity that we expect from modern medical professionals. If and when medical professionals find it necessary to reject M-requests, it ought to be done only after taking a family's values seriously.

[262] Pascal's Wager is an instructive analogy here. Pascal presents a pragmatic justification for believing the traditional Christian God exists because we are not in a good position to evaluate the evidence. The way to decide whether to believe in God is to consider the payoffs: if we choose to believe in God (wager that he exists) and it turns out that he exists, then we are rewarded with endless life in heaven – an infinite value. If he does not exist, we have merely lost some earthly advantages – a finite loss. The prudential person will conclude that she has more to gain by believing in God and more to lose by not, so she will choose to believe in God. In the same way, Joy's choice seems reasonable given her background beliefs. Her choice is between an infinite gain and an infinite loss. Savulescu briefly mentions Pascal's Wager in an endnote (Savulescu, 1997, p. 288).

Three Pediatric Conditions

I have shown that Savulescu's standards suffer from a number of problems, but these problems can be resolved by making the standards more culturally sensitive. I suggest that his standards be reformulated in the following way:

1. *Rational*. Is the request based on a rational conception of well-being? Is it possible that a rational person might hold such beliefs?
2. *Safe*. Is the request safe enough? Is the risk comparable to other legitimate risks the child is exposed to outside the clinic? Here, *safety* is interpreted holistically: physical, psychosocial, and spiritual.
3. *Future-oriented*. Does the request have the child's future autonomy and development in mind? Here, autonomy must be weighed against other values such as social opportunity.

The rationality condition can be unpacked in terms of the *Principle of Rational Belief* (PRB) and an analysis of the intellectual virtues. The other two conditions simply need to be understood in a broader and more careful way than what Savulescu argues for.

Consider these conditions applied to Joy's case. JWs give the following defense for rejecting blood transfusions for their children:

> Protecting children from parental abuse and neglect certainly is not objectionable to [Witness] parents. But child-neglect laws and the Supreme Court statement quoted above often are inappropriately applied to cases involving children of Jehovah's Witnesses. Why? For one thing, Witness parents have no intention of "martyring" their children. If they did, why would they take their children to the hospital in the first place? On the contrary, Witness parents willingly seek medical treatment for their children. They love their children and want them to have good health. But they believe they have a God-given duty to choose responsibly the kind of medical treatment that is best for their children. They want their children's health problems managed without blood. Not only is such alternative non-blood care better and safer than blood but, most important, it keeps their children in the favor of the great Life-Giver, Jehovah God (Watchtower tract, 1992, Safeguarding your children from misuse of blood).

The reasons are two-fold: (1) that blood transfusions are medically risky and (2) that God forbids it.[8] Is it rational to hold these beliefs? As mentioned earlier, medical risk is at best a secondary reason, so I will set it aside. As I concluded earlier, there is a serious doubt about whether JW beliefs about blood are rational, so Joy's M-request would likely fail the first condition. And unlike in the cases of adult M-requests, this result cannot be ignored because the rationality condition carries much more weight in pediatric cases because these are cases of deciding for vulnerable others.

Is Joy's request safe enough? To answer this question, physicians would need to determine the risk/benefit ratio here and how risky the procedure would be if it were attempted with non-blood products. It is possible with the continuing development of such technologies that the risk/benefit ratio entailed in such procedures will become comparable to the risks Joy might face in her everyday activities. If and when it does reach that level, Joy's request would satisfy the *safety* condition. In addition, there might be surgeons in the service area that would be willing to attempt the procedures without blood, a technique that has become more common. Again, if the risk entailed in such a procedure does not exceed the risk Joy would face outside the clinic, then her request satisfies the condition.

Is Joy's request compatible with the development of her future autonomy? As mentioned above, in Savulescu's limited sense of "future autonomy" the answer is a clear "no" because an early death precludes any further development. However, as I mentioned, there is more to autonomy than just the ability to make decisions in the future. We would also need to consider how Joy's community would treat her after learning of

her transfusion. Would she be ostracized or embraced? Would Joy's family members disown her or continue to care for her? Given her geographic location and access to public services, would there be other alternatives for her if she were shunned by her family and community? Moreover, what does her community teach about her eternal destiny? If the physicians force this treatment on her, does the community teach that God will forgive her? Does she believe this as well?

It is impossible to say with certainty without knowing more details whether Joy's M-request should be honored. Failure of the rationality condition is significant, but if the procedure could be safely attempted, then satisfying the safety condition might outweigh the fact that her M-request fails the rationality condition (for the sake of religious accommodation and Joy's future in the community). However, it may come down to how much risk is involved in alternate procedures. If the risk is high and it is likely that her community will forgive her and embrace her after the fact (which is probably the case), then the M-request should be denied.

So, it is possible that an M-request could fail the rationality condition but satisfy the safe and future-oriented conditions. For example, female circumcision in Africa may fail PRB. It is unlikely that a *phronimos* would ever believe that removal of a clitoris would ensure a girl's purity or fidelity (you don't need a functioning clitoris to be unfaithful). Nevertheless, virtuous parents might still choose to circumcise their daughters due to the social opportunities or protection it would secure for the child. As mentioned earlier, sexual autonomy is an important value, but it is not the only value. On the other hand, it is hard to imagine how an M-request for female circumcision would

ever be granted outside a limited number of African communities. For example, all such M-requests made in the U.S. should be denied (even if the patient is African) because there are plenty of social opportunities for uncircumcised women in the larger society. This might entail exclusion from the patient's family or ethnic community, but in a diverse society like the United States, there are other options. This is not to say that such exclusions do not represent serious harms. It is only to say that such harms are outweighed, in this case, by other harms.

Faith Healing and Children

In the Pamela Hamilton case, there is not enough information available about the Church of God of the Union Assembly to know whether its teachings would satisfy PRB. On the other hand, the church appears to identify itself as a Bible believing church on its website, and it mentions a connection with The Church of God of the Mountain Assembly, which has as its first creedal statement: "We believe the Bible to be inspired, the only infallible Word of God."[263] This connects them to the long tradition of biblical interpretation mentioned in the discussion of JW beliefs in chapter five and make it possible to evaluate their beliefs and practices in the context of this tradition. The virtues of this hermeneutical tradition are, as mentioned above: the love of knowledge, firmness, courage and caution, humility, and autonomy. To proceed, we would need to listen to the parents carefully to discern whether they exemplify these virtues. We should discover whether they have considered other biblical interpretations, whether they have truly

[263] Union Assembly: http://www.lookupnlive.com/AboutChurch.html (accessed February 21, 2012), Mountain Assembly: http://www.cgmahdq.org/id4.html (accessed February 21, 2012).

considered the consequences of not seeking medical treatment, and whether they have improperly surrendered their autonomy to the church. We should also investigate the church itself to see whether it cultivates these virtues among its members. We should ask whether the church suppresses dissenting views, whether it engages in dialogue with members of other denominations who read the Bible, and whether it enjoins its followers to think for themselves. Only after careful consideration of these questions will we be able to discover whether their beliefs satisfy PRB.

On the other hand, the Hamilton's M-request appears to do quite poorly under the other conditions. It is not very safe: Pamela will most certainly die if left untreated, which happened anyway, some say, because Pamela's treatment was delayed. And the other risks we might consider – social and spiritual – pale against this fact, especially when considering that this case occurred in Tennessee, where there are plenty of other Christian denominations and opportunities for community engagement. While Pamela's father was a minister for the church, excommunication from the Union Assembly would not be as disastrous for an individual living in Tennessee as it would be for a young uncircumcised girl in Africa to be ostracized from her community, and there are no apparent eternal consequences such as in the JW case. If left untreated, Pamela's safety and future autonomy are clearly threatened, and the benefits of being treated medically outweigh other concerns.

In addition, the size of the community matters here, which is the first of the MVRB conditions. The Union Assembly is a relatively small community, roughly only thirty-five churches found across seven states (as of 2012). While the fact that the M-

request was made on the basis of a belief held by the community will give the M-request some weight, the fact that the community is small will hurt its chances. Moreover, a religious interpreter would connect the Union Assembly with the larger community of biblical interpretation and conclude that the church's beliefs are aberrant. Most churches in the biblical tradition request both medical care and prayer. The failure to satisfy so many conditions would result in the Hamilton's request being denied.

Andrew's case, the Christian Science case in chapter two, is very similar to the Pamela Hamilton case in that Andrew's parents sought religious healing instead of medical treatment. Christian Science teaches its followers to pursue healing through prayer and that reality is fundamentally spiritual. As one Christian Scientist puts it: "The reason that Christian Science treatment, or prayer, heals is that it opens human thought to what is actually there, to God's infinite goodness, which includes no sickness, evil, or fear, and to God's man, who is deserving of all good."[264] Are such beliefs compatible with PRB?

Mary Baker Eddy, the founder of Christian Science, taught a kind of subjective idealism similar to what the English philosopher George Berkeley taught. All being is found in God's mind. As Philip Pecorino describes:

> [God] is and encompasses all aspects of existence as he is referred to as "God is All-in-all." Mrs. Mary Baker Eddy…states that due to God's spiritual nature, humanity…must also appropriately be spiritual and not material…The true universe in its entirety, according to divine metaphysics, or Christian Science, is comprised of ideas that are completely spiritual and fashioned by divine thought, just as Berkeley espouses in his immaterialist views. Therefore, Christian Scientists specify that we as humans are in truth spirits produced by divinity, and

[264] Allison W. Phinney, Jr. "Why does Christian Science Treatment Heal and How does it Work?" *Christian Science Sentinel*, http://christianscience.com/articles-sentinel/2007/10/11/why-does-christian-science-treatment-heal-and-how-does-it-work/ (accessed February 21, 2012).

> in consequence are all incarnations of God. If we ignorantly deny the truth of God's spiritual existence, it is then that we will mistakenly envision the world in the form of material…All ideas hostile to God's infiniteness, permanence, and goodness, such as conceptions of death, hell, and evil, are flawed and wicked hallucinations and are NOT real.[265]

Subjective idealism is not inherently irrational unless we are ready to call George Berkeley irrational, and I see no reason to do that given his impact on the history of philosophy. Also, Hinduism, one of the greatest religious traditions, can be interpreted as a form of idealism,[266] so I'm inclined to think idealism as a philosophy would pass PRB. However, Christian Science derives many of its teachings from the Bible and claims to follow the teachings of Jesus Christ, which would connect it to the long tradition of biblical interpretation like the Union Assembly and JWs above. Hence, we can ask of Christian Science the same questions: does the church cultivate intellectual and interpretive virtues? Does the church encourage its followers to think for themselves? If the answer is no, it may fail PRB.

In addition, Andrew's M-request may do quite poorly under the other conditions. By not seeking locally and easily-available medical care, Andrew's father needlessly put his son's safety and future autonomy in jeopardy. Hickey and Lyckholm argue: "The ethical calculus of benefit/burden is clearly in favor of benefit of medical treatment. It would seem that medical treatment of a Christian Scientist's child does not impose specific or harsh burdens on the child or the parent. Alternatively, the burdens imposed if

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[265] Pecorino, "Metaphysics" http://www.qcc.cuny.edu/socialsciences/ppecorino/intro_text/Chapter%204%20Metaphysics/Idealism.htm (accessed February 21, 2012).

[266] See Pecorino for more on Hinduism: http://www.qcc.cuny.edu/socialsciences/ppecorino/intro_text/Chapter%204%20Metaphysics/Idealism.htm (accessed February 21, 2012).

the child is *not* treated are considerable, including severe morbidity and even mortality."[267] Apparently, there is no banishment from the community and no permanent eternal consequences such as what occurs when a JW requests a blood transfusion. This balance of burdens and benefits leads us to reject the M-requests of Christian Science parents.

Conclusion

Hickey and Lyckholm caution against overriding parental requests too quickly. They cite Beauchamp and Childress in proposing a set of conditions for when to allow the standard of care to override parental M-requests:

(1) Better reasons can be offered to act on the overriding norm than on the infringed norm.

(2) The moral objective justifying the infringement has a realistic prospect of achievement.

(3) No morally preferable alternative actions can be substituted.

(4) The form of infringement selected is the least possible commensurate with achieving the primary goal of the action.

(5) The agent seeks to minimize the negative effects of the infringement.[268]

While these conditions are important and helpful, one could satisfy them without taking the parent's beliefs seriously, which takes us back to the discussion of respect in chapter three.

[267] Hickey and Lyckholm, 271
[268] Hickey and Lyckholm, 272-3.

Parents who make M-requests must be listened to and fully understood before a decision is made, which can occur by putting the parents into dialogue with the caregivers and asking them to explain their beliefs, if possible. However, there may be language and cultural barriers, and the stress of the situation may prevent productive dialogue. In such cases, it may be necessary to consult a religious interpreter – the parents' own minister, a hospital chaplain, or a religious studies professor. An interpreter should be able to open a window into the parents' world and explain to caregivers why the parents hold the beliefs they do.

Taking parents' beliefs seriously also includes examining them under PRB. As I have shown, M-requests for children must be held to a higher standard than M-requests for competent adults, and I believe the conditions I suggest – (1) rational, (2) safe, and (3) future-oriented – accomplish this.

CHAPTER SEVEN
Conclusion

The threshold for honoring M-requests for children must be higher than the threshold for honoring requests made by adult patients because there is more at stake than when competent adults make M-requests for themselves. M-requests in pediatrics must satisfy three conditions: (1) rational, (2) safe, and (3) future-oriented, whereas M-requests for adults only need to satisfy the MVRB conditions: the religious belief (1) is held by a community, (2) is deeply held, (3) would pass the test of a religious interpreter, and (4) does no harm. Applying only the MVRB conditions to adults – a lower threshold – is in keeping with the emphasis on patient autonomy.

I have considered other approaches to dealing with M-requests but have found each to be unsatisfactory. For example, Savulescu's conditions for honoring M-requests in pediatrics are not culturally sensitive enough, and neither are Meyers' conditions for honoring M-requests in proxy decision-making. The conditions I propose, however, are based on a theory of virtue that takes religious beliefs seriously and recognizes the existence of rational beliefs across cultures, while, at the same time, holding M-requests to a high moral standard.

While I have only applied these conditions to a small number of cases here, they can be applied to any M-request, no matter how unusual. This said, it may be asking too much to require doctors to become proficient in applying the conditions. For one, it is impossible to become a religious expert on the religious beliefs of every patient, and there are plenty of others who can act as religious interpreters. Anyway, doctors have plenty of responsibilities already. One solution might be for each hospital to form a

review board (like an IRB) that carefully considers the M-requests and religious beliefs of patients the hospital regularly serves. For example, if the hospital regularly serves JWs, then it would be efficient to have a policy regarding JW M-requests. On the other hand, if a JW has never been treated in their hospital, then a specific policy would be unnecessary.

However, policy-making must be done carefully: M-requests that fail the conditions in one area (or for one kind of patient) might be honored in another. Religious beliefs might be rational for one religious community in one location but may be irrational for adherents of the same religion in a different location. For example, it is possible that a *phronimos* would believe the Watchtower teachings on blood products if she lived in the South American jungle (since contact with other views – theological and medical – might be limited), but it may be equally possible that a *phronimos* would not believe such teachings if she lived in Knoxville, Tennessee. It might take more of a head-in-the-sand attitude to sustain the belief in Knoxville than it would in the jungle. Therefore, two JW patients, each from a different place, could be admitted – even to the same hospital – and make similar M-requests while one request is granted and the other denied. Also, it important to note that ruling out M-requests in advance does not commit Savulescu's error of defining plausibility in terms of content because the PRB condition employs norms of reason in its procedure. It acknowledges that *phronimoi* can be found in many different cultures.

In short, this dissertation represents a new approach for dealing with M-requests that is both culturally-sensitive and morally rigorous, and it is this balance that makes this

approach unique. Grounded in virtue ethics, the PRB condition has the philosophical resources to solve problems and stand up to scrutiny, and the conditions I have offered can be easily applied in clinical case consultations.

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