IACB webinar series on 'What's Love Got to Do with Bioethical Reflection?'

Summary of webinar 1 (Feb. 3, 2024)

1. Dr. Daniel Sulmasy observed that love is central to the Christian mission in health care. Yet love is rarely listed among secular or Catholic principles of bioethical reasoning.

2. He proposed the following questions for the IACB colloquium to consider:

- Is Christian ethics based on love? Derived from love?
- Is natural law really based on love and not human nature, generally considered, or human flourishing, or reason?
- Does love go beyond ethics? Does ethics concern the obligatory and is love supererogatory [beyond what is expected or required]? Or is a Christian called to supererogation? Or is doing one's duty without love insufficient?
- What is the relationship between ethics, love, and spirituality?
- Is love the proper motivation for ethics?
- Is love the soul of ethics?
- Is ethics sufficient for salvation?
- How ought love temper ethics? Is there a role in bioethics for *epikeia* [not following the letter of the law when this exception is reasonable]? A role for mercy? And for forgiveness?
- Can (or must) love and mercy be tempered by prudence? Or is it better to say that prudence is only Christian when it is infused with love?
- Does love concern virtue and ethics principles and rules? Or is this a false dichotomy? How is love related to virtue?
- Is love only a virtue or more than a virtue? Is there both supernatural and natural love?
- If love is a virtue, how is it related to faith and hope (the other supernatural virtues) and, then, in turn, to the cardinal virtues [temperance, fortitude, justice, and prudence]?
- What is the relationship between love and justice? Not just distributive justice but other forms, such as retributive and restorative justice?
- What is the proper relationship between different forms of love (*eros*, *philia,* and *agape)* in Christian ethics?
- In particular settings, like the patient-physician relationship, should we think about *philia* [friendship] rather than *agape*?
- What has any of this to do with biomedical ethics?
- What's love got to do with it?

3. Dr. Anne Dalle Ave addressed the last two of Dr. Sulmasy's questions by suggesting that:
- Bioethics has its roots in relationships;
- because the essence of any relationship is love, then
- the foundation of bioethics is love.

   She acknowledged, however, that the foundation of bioethics is more often related to reason than "feelings or emotions". She later specified that love is more than a feeling. It is a certain "state of being", one characterized by deep joy, a sense of wholeness and abundance, and trust that stills all seeking and displaces sadness, neediness, anxiety, and

fear. Any experience of love is an experience of the divine, and the state of being in unrestricted love is the experience of the presence of fullness of God. Dr. Dalle Ave proposed that one does not so much attain love as *fall* in love; but there might be spiritual practices, such as meditation and prayer, that cultivate love and dispose one to falling in love. Finally, Dr. Dalle Ave suggested that seeking love is something essential to us humans who, throughout our lives, are interposed between "humanity and divinity". We are continually called to be transformed (divinized) by love and, being so transformed, we become more selfless and better able to serve others.

While all of this seems relevant to the *car*e that healthcare providers give, it is not so clear what effects the transformative experience of 'falling in love' or 'being in love' has on the *method* employed in bioethical reflection.

4. Dr. Dalle Ave responded by suggesting that love affects the *goals* of care about which we deliberate in health care. She discussed the case of a dying man who had become progressively frail, but who was on full code in the event of a cardiac arrest (vs a Do Not Resuscitate [DNR] code). The patient's wife prayed daily for him and had "hope and deep faith" in her husband's improvement. This hope presumably was based on her great love of God and love of her husband. When the patient had a cardiac arrest, because his wife had not agreed to a DNR order, the patient underwent excruciating resuscitation attempts for ten minutes before he was declared dead. Dr. Dalle Ave suggested that, without the perspective of love, one might regard this patient's situation only as clinically futile and conclude that the patient underwent needless end-of-life suffering. Such an ethical analysis would, however, lack understanding the importance to the patient's wife of her love of her husband and of God, and miss an opportunity to address her fears that a DNR order would mean 'giving up' on her husband and abandoning trust in God. Here, a 'relational approach' to a clinical ethics consultation involving loving accompaniment and prayerful discernment with the patient's wife would perhaps get at the heart of this ethical dilemma more than a discussion based only on rational principles. This gets us back to some of the questions that Dr. Sulmasy asked in his presentation: Does ethics concern the obligatory and is love supererogatory [beyond what is expected or required]? Or is a Christian called to supererogation? Or is doing one's duty without love insufficient? Is love the proper motivation for ethics? What is the relationship between ethics, love, and spirituality?

5. During the discussion period, Dr. Ursula Sottong responded that being loving towards patients and their family is not separate from the duty of clinicians and ethicists and not supererogatory to ethics. Love, understood as being 'kind' to others who might be different from oneself and open to their different values and perspectives, is fundamental to doing ethics. Dr. Denis Larrivee proposed that love could be formulated as an ethical principle: 'identifying with the patient' (or for Christian clinicians and ethicists, 'seeing Christ in the patient').

6. Dr. Sottong also remarked that being loving cannot be an imposition on clinicians and ethicists by decree. It is learned from others through "modelling" and draws on one's spiritual resources. In this way, ethics and spirituality are deeply connected. Dr. Sottong

suggested that burnout is common among healthcare providers who only approach health care as technicians of the body and, among those, healthcare providers are more likely to experience burnout if they do not engage in practices that restore and renew them spiritually.

7. Dr. Jos Welie asked for clarity on how we are using the term 'ethics'. Does ethics involve critical examination of reasoning? Or does it entail aspiring to lead a morally virtuous life? In response, Dr. Sulmasy suggested that it relates to both and to spirituality.

8. On the connection between reason and love, Fr James McTavish drew attention to these words in Benedict XVI, *Caritas in Veritate*, 30: "Charity does not exclude knowledge, but rather requires, promotes, and animates it from within. Knowledge is never purely the work of the intellect. It can certainly be reduced to calculation and experiment, but if it aspires to be wisdom capable of directing man in the light of his first beginnings and his final ends, it must be 'seasoned' with the 'salt' of charity. Deeds without knowledge are blind, and knowledge without love is sterile. Indeed, 'the individual who is animated by true charity labours skilfully to discover the causes of misery, to find the means to combat it, to overcome it resolutely' [FN: Paul VI, *Populorum Progressio*, 39]. Faced with the phenomena that lie before us, charity in truth requires, first of all, that we know and understand, acknowledging and respecting the specific competence of every level of knowledge. Charity is not an added extra, like an appendix to work already concluded in each of the various disciplines: it engages them in dialogue from the very beginning. The demands of love do not contradict those of reason. Human knowledge is insufficient, and the conclusions of science cannot indicate by themselves the path towards integral human development. There is always a need to push further ahead: this is what is required by charity in truth [FN: Benedict XVI, *Deus Caritas Est*, 28]. Going beyond, however, never means prescinding from the conclusions of reason, nor contradicting its results. Intelligence and love are not in separate compartments: *love is rich in intelligence and intelligence is full of love*."

9. Dr. Christine Jamieson wondered whether love is sufficient as a foundation for bioethics. Can it stand alone? She drew attention to certain North American indigenous cultures that have 'Seven Grandfather Teachings' that connect love, respect, bravery, truth, honesty, humility, and wisdom. Each must be applied along with the others.

10. In summary, our first webinar moved us further along in thinking about 'What's Love Got to Do with Bioethical Reflection?".

- We will interpret 'love' in the title as <u>a verb</u> (*being full; practising virtue; identifying with others*) and not as a noun (the notion or concept of love).
- We intend to focus our discussion on <u>method</u> (*how* we do bioethical reflection) rather than on ethical norms, principles, and rules.
- To love, one must <u>first experience love</u>/be in love. These latter are not personal achievements but <u>gifts</u> (from family, friends, role models in limited ways, and from God unrestrictedly).

- The experience of love/being in love can be transformative and liberating from biases and limited viewpoints.
- Love and reason (practising intellectual virtues) are connected.
- Love and spirituality, likewise, are related.
- Love is not supererogatory but fundamental in ethics (understood relationally).
- Love expands the horizons of our ethical concerns (from self to other, from others to our shared relationship in and with God). In clinical ethics, this shapes especially deliberations regarding goals of care.