MORAL THEOLOGY

Topic:	Lisa Sowle Cahill's *Theological Bioethics*: A Critical Conversation
Coconveners:	Kristin E. Heyer, Loyola Marymount University
	Thomas B. Leininger, Regis University
Moderator:	Kristin E. Heyer, Loyola Marymount University
Panelists:	Lisa Sowle Cahill, Boston College
	James Walter, Loyola Marymount University
	Teresia Mbari Hinga, Santa Clara University
	Bryan Massingale, Marquette University

In the first of three assessments of Lisa Sowle Cahill's *Theological Bioethics: Participation, Justice, and Change* (Washington, D.C.: Georgetown University Press, 2005), James Walter showed how his clinical experience as a bioethicist validates trends in medical practice set forth by Cahill toward a) an increasingly scientific and market-driven rather than humanistic approach, and b) a dominant focus of the principles of autonomy and informed consent. At the bedside, medical practitioners focus exclusively on the patient and the scientific aspects of treatment without much attention to distributive justice or the common good. Yet, bioethics at the bedside is public discourse and should be open to public argument. While medical care requires us to abandon the detached observer perspective and show empathy, discourse on distributive justice at the organizational policy level should inform what happens at the bedside.

Methodologically, Walter finds most bioethical discourse too abstract to speak to real experience at the bedside. He asked Cahill "What relationship does the public discourse of theological bioethics have to lived experience via middle axioms?" "How do you get to the level of middle axioms?" Even if theological bioethics effectively translates religious symbols into middle axioms, "How does one methodologically adjudicate if secular bioethics comes up with different middle axioms?"

Teresia Hinga pointed out first that the "flow" in the global participatory process concerning justice in healthcare tends to be in one direction: from the North to the South. Bioethics in the global North, with its emphasis upon autonomy, has unjustly silenced voices from the South. Second, while Cahill argues that theological bioethics should maintain its own distinctive theological voice in public discourse, Hinga pointed out that, at any give time, multiple theologies are operating. We must ask "Which theologies are supportive or subversive of life and justice?" "How can we balance religious pluralism with the need to be self-critical of existing theologies?" Third, extreme economic disparities as well as cultural differences between North and South mean that bioethical issues look radically different in the global North vs. the South. While the North focuses on the propriety of "pulling the plug," in Africa many deaths occur due to lack of medical care. The profit motive drives medical research and pharmaceutical patents in a way that too often leaves the poor worse off and deepens global economic disparities.

Bryan Massingale argued first that if we take seriously Cahill's call to revision the discipline of bioethics around "justice in access to healthcare" as its controlling

question, then the identity of the theologian becomes that of a "scholar-advocate" for the poor. Tenured professors should work to revise the tenure and promotion process so that it recognizes such advocacy as scholarship. Cahill's revisioning of bioethics also helps us to see that the medical well-being and health of the privileged are purchased at the price of threat and violence. A greater integration of the global perspective would force us to ask: "Is our ethical discourse collusion with privilege, or worse, complicity in the destruction of the lives of the poor?" Second, Cahill gives insufficient attention to the reality of conflict as endemic to social change. She calls for socially transformative practices, yet she draws upon a Catholic Social Teaching tradition that naively minimizes the inevitability of social conflict—including coercion, pressure, and force—in social change. Third, Cahill needs a clearer *telos* for the social order implied by her argument. Cahill invokes principles of the common good, distributive justice, and the option for the poor without articulating: "To what end?" The "Beloved Community" articulated by Martin Luther King, Jr. offers the kind of vision that would complement Cahill's work.

In her response, Lisa Sowle Cahill noted that her key concerns were to not let theological bioethics discard theological language in public and limit itself to the autonomy of the individual patient and bedside issues. In response to James Walter, she pointed out that caregivers cannot entirely avoid cooperation with the very conditions that need to be changed. Moreover, they can't simply use individual patients to solve our larger problems. However, they should ask "Who are we serving?" and "What are our real concerns?" In response to Hinga, Cahill agreed that theological bioethics would be improved by including more voices from Africa and Asia. She wrote her book in part because people writing about bioethics were not attending adequately to the poor. Cahill also agreed with Massingale's characterization of social change as conflictual but suggested that it also involves persuasion and conversion of the imagination of the public so that we commit to different practices.

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