

Should ministers of religion be on hospital ethics committees?

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In reporting on his research into Australian Ethics Committees, Paul McNeil noted that in the 42 hospitals that responded to his questionnaire, a typical ethics committee consisted of four doctors, two lay members, a minister of religion, a lawyer, a nurse, and one other professional.¹ This, in fact, is consistent with the "Report of the Medical Research Ethics Committee of the NH & MRC" (1985), which states that an ethics committee should include a minister of religion, "Since ministers of religion are widely seen in our society to be privy to the thoughts and concerns of many people from different backgrounds, for this reason alone it is considered that a minister of religion should continue to be one of the specified members of an IEC."² But, as David Muschamp so cogently points out, "taxi drivers and school teachers and bar attendants and opinion poll surveyors also satisfy that condition, and perhaps more fully."³ Muschamp goes on to raise doubts as to the validity of other unidentified qualifications that might recommend ministers to ethics committees, particularly the possibility that they might be placed on committees because of some lingering suspicion that they have access to supernatural information not available to others of a more rational bent.

The question that Muschamp poses is deserving of an answer. Why should ministers of religion be included on nearly every ethics committee? While this paper will not argue that ministers of religion should be on all ethics committees, it will suggest that there are certain things which make them particularly suitable candidates for inclusion. It will first point out that they are experienced in working within ideologically diverse environments; it will demonstrate that they are experienced in applying principles to real life situations in a dynamic way, and finally, the paper will affirm their awareness of the limitations of rule-based systems.

1. MINISTERS ARE EXPERIENCED IN WORKING WITHIN IDEOLOGICALLY DIVERSE ENVIRONMENTS

It is no secret that in both theology and practice Christianity has many competing ideologies. The diversity of ideology reflected in Christian circles also overlaps into their ethical stances. For example, a significant number of academics, churchmen and professional laity urge the adoption of a "Bible Based" ethic, one in which God's will, as revealed in the Bible, is applied rigorously to ethical dilemmas. Yet others argue that there are considerable limitations to using the Bible as the basis for all ethical decision making, not least of which is the fact that modern technology and social changes have meant that many of the dilemmas facing a modern ethics committee are just not discussed in the Bible at all. Yet others argue that social changes since Old Testament and New Testament times means that the Bible is irrelevant to modern ethics, and principles for ethical decision making need to be derived from elsewhere. The debate as to the proper role of Scripture in the formation of Christian ethics has been prolonged and vigorous, and shows no sign of

abating.⁴ This debate as to the proper basis on which to argue ethics is but an indication of the wide diversity within “Christian” approaches to ethical issues.

Diversity is of particular importance to ministers, because they find several of these competing ideologies represented in their congregations. Thus, by its very nature, their work forces them to add to their own perspective an ability to work with others of different ideologies in a way that produces coherent and defensible results. This background should equip a minister to face many of the realities of working on ethics committees, because ethics committees also work with ethical dilemmas where competing cases can be made for mutually exclusive solutions to practical problems.

Since Beauchamp and Childress, bioethics committees have generally worked with the principles of patient autonomy, non-maleficence in patient care, and justice.⁵ But in many of the cases that come before ethics committees, as often as not, one or other of these principles is in direct conflict with another. There is no one system of ethics, or set of ethical principles which will provide comfortable and workable solutions to the whole range of ethical dilemmas faced by an ethics committee. As Carl Elliott has forcefully pointed out, each of us has strong moral intuitions which show that in certain cases our preferred ethical system provides answers which are morally unsatisfactory. While our theories are coherent, our moral sensitivities are unclear, noncomprehensive and incoherent. As he says, “To put it rather bluntly, the conflict here is between tidiness and truth; we want our theories to be simple and elegant, but also true, and the only measure of the “moral truth” of a theory seems to be our own inconsistent, untidy moral intuitions.”⁶

These observations are not a call to abandon the hard won gains of the rationalistic approach to problem solving which has been so successful in improving health care. But they do show how ministers might in fact be able to contribute on a hospital ethics committee. They work in an environment in which cases with conflicting moral imperatives are not uncommon, and work closely with others who resolve them in different directions on the basis of different underlying ideologies. They have had to develop a method of operating in ambiguous environments, and so may be able to contribute helpful perspectives to a group which otherwise draws its membership from amongst those who are trained in a rationalistic thought-universe in which inconsistencies are rigorously eliminated.

2. MINISTERS ARE EXPERIENCED IN APPLYING PRINCIPLES TO REAL-LIFE SITUATIONS IN A DYNAMIC WAY

While they might vary in how they express the relationship, all Christians find the Bible normative in some way. Yet even fundamentalist Christians, who say they base their belief and practice entirely on the Scripture, are forced to take account of the fact that since the time the Bible was written, society has dramatically changed. Take, for example, the laws of Jubilee found in Lev 25. According to this chapter, on every fiftieth year in ancient Israel all slaves were to be freed (vv. 39-46), and all land returned to its rightful owners. These owners had been decided by casting lots to determine which land God desired each family to own (Num 26:55-56; 33:54; 36:2; Josh 14:2). The land could be sold, or lost through bad management and accumulating debt, but at the end of every fifty year period it was to be returned to the family to which it had originally been given (Lev 25:13-17; 25-28).

The laws of jubilee make sense in a rural peasant economy. They express the ideal that every family should have the means to be economically self sufficient, and as in such

economies economic self-sufficiency is based on land ownership, the inability to alienate their land permanently was a strong guarantee of the family's ability to be self-sufficient in the long term. But in a modern western economy these laws are inapplicable, and indeed, there is no evidence that they were ever observed by the ancient Israelites. The principle of the right of all members of a society to have the means of economic self-sufficiency is certainly one which most societies would endorse, but the details of how it is applied are dramatically different, because society has changed dramatically.

This is but one example of the many places in which modern Christians are confronted with the need to take cognisance of the changed circumstances between the times in which the Bible was written and today. Principles may stay constant, but how they are applied to specific circumstances differs over time.

Some of the more difficult challenges facing ethics committees derive from the impact of rapidly changing technology. Change is always difficult to implement, and the large scale nature of medical enterprise, its capital intensive nature, and the fact that it deals with matters of considerable consequence for its clients exacerbates the critical nature of decisions consequent on changing possibilities brought by new technology. While the working environment of ministers of religion is not changing as rapidly as that of the health care system, it is changing significantly. As they struggle to implement suitable changes while preserving underlying principles, ministers of religion develop skills of managing change appropriately. They have before them a rich history of such changes, and for this reason, should be able to bring to their work on ethics committees a certain flexibility of approach, and an openness to changes brought about by new information and circumstances.

3. MINISTERS ARE VERY AWARE OF THE LIMITATIONS OF RULE-BASED SYSTEMS

Public and personal morality has long been an integral part of Christianity, and this morality has been expressed in concrete rules, rules which are based in some way on the law of God. But this stress on rule-based ethics has been tempered by the principle authoritative documents of Christianity, the New Testament, which is replete with warnings against the limitations of such a method of ethics. Jesus himself was often in conflict with the Pharisees over their understanding of how the law should affect their daily lives. In contrast to their rule-based approach, Jesus insisted that internal motivation and attendance to principle should be the basis on which life should be lived (eg. Matt 5:20-48).⁷ Or, to use the language of Paul, Christianity's greatest theologian in its formative years, Christians are to live in the newness of the letter, not the oldness of the letter (Rom 7:6; cf. 2 Cor 3:6). This is not to say that they will have abandoned morality. No. As Jesus insists, a Christian's righteousness must exceed that of the rule-based righteousness of the Pharisees (Matt 5:20; cf. Rom 8:4). Thus, the limitations and dangers of rule-based ethical systems are well known to all ministers of religion.

By their very nature, hospital's work practices revolve around procedures. In other words, their activities are frequently rule-based. Nor is this to be criticised. Rule-based procedures are very effective in ensuring consistency of action and results. Patients are glad when their carers follow the proper procedures for ensuring sterility in the operating theatres, for example. It is not the procedures which are working which come before ethics committees for review, however, but rather those

circumstances in which set procedures are inappropriate or not yet developed. Ministers should be well equipped to deal with those circumstances in which rule-based procedures break down.

CONCLUSIONS

Does the foregoing imply that a minister should be on every ethics committee? By no means. Committees are set up for different purposes, and the contributions listed above may not serve some of these purposes. Nor should what has been said be taken to imply that all ministers of religion would be equally suitable. Ministers are as diverse a group of people as any other segment of society. Just as not all health care professionals make ideal members of ethics committees,⁸ not all ministers of religion would be suitable. Not all would possess the necessary flexibility and patience to function on a committee where much of the discussion revolves around areas only tangential to their primary expertise. But perhaps what has been said might answer the legitimate question raised by Muschamp. In addition to their exposure to the concerns of people of a wide range of backgrounds, ministers bring to their work on ethics committees an ability to work in an ideologically diverse environment, an openness to the changes brought about by changed circumstances, and an awareness of the limitations of rule-based systems. All of these factors make ministers suitable candidates for inclusion on many ethics committees.

NOTES

1. P. McNeill "The Function and Composition of Institutional Research Ethics Committees: Preliminary Research Results." In: Jill Hudson, ed. *Proceedings of the Conference: Can Ethics Be Done by Committee?* Clayton, Vic: Monash Centre for Human Bioethics, 1988:30.
2. P. 8, cited by David Muschamp, in "Who Should Sit on Institutional Research Ethics Committees?" In: Jill Hudson, ed. *Proceedings of the Conference: Can Ethics Be Done by Committee?* Clayton, Vic: Monash Centre for Human Bioethics, 1988:55.
3. Ibid.
4. Some idea of shape of the debate can be gained by perusing Allen Verhey, "The Use of Scripture in Ethics," *Religious Studies Review* 4 (1978) 28-39; John Brunt and Gerald Winslow, "The Bible's Role in Christian Ethics," *Andrews University Seminary Studies* 20 (1982) 3-21; Christopher Wright, "Biblical Ethics: A Survey of the Last Decade," *Themelios* 18/2 (Jan 1993) 15-19.
5. Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* New York: Oxford University Press, 1983.
6. "Where Ethics Comes from and What to Do about it," *Hastings Center Report* 22/4 (July-August 1992) 30.
7. Rudolf Schnackenburg, *The Moral Teachings of the New Testament* New York: Herder, 1971: 56-109; Wolfgang Schrage, *The Ethics of the New Testament* Edinburgh: Clark, 1988: 41-44.
8. "Ethical analysis requires a problem-solving approach that is primarily reflective ... clinical care does not primarily attract persons with that approach to problem solving, for good reason: hospitals are places in which the dominant mode is action ... an exceptional ability to act with certainty and to make decisions quickly, even in the face of necessarily inadequate information, might mark a superb physician but not, necessarily, a good ethics committee member. Ethics committee members need to be open to different ideas...." So Judith Wilson Ross, *Handbook for Hospital Ethics Committees*, American Hospital Publishing, Chicago, 1986:37-38.