

Miracles, Scarce Resources and Fairness

Clinical Bioethicists (ethicists) work for hospitals, nursing homes, rehabilitation centres and other healthcare institutions (Fox et al., 1998). They perform various work roles including policy development, ethics education and consulting patients, surrogate decision makers, families, healthcare professionals and administrators about ethical issues (Chidwick et al., 2010). Bibler et al. (this issue) offer practical suggestions to ethicists who are asked to consult patients, or their surrogate decision-makers, when a particular medical intervention or course of care is requested on the grounds that this may enable a miraculous cure to take place. They focus their discussion on Christian patients and surrogates who invoke the possibility of miracles.

Bibler et al. argue that when ethicists counsel patients or surrogates, who invoke the possibility of miracles, ‘the overall interests of the patient should (*ceteris paribus*) take priority’ in shaping the counsel provided (manuscript p. 12). I do not agree that ethicists should prioritize the overall interests of particular patients when counselling those patients or their surrogate decision-makers. Ethicists should be sensitive to the needs of particular patients and should demonstrate respect for the beliefs and values of patients and their surrogates, including belief in the possibility of miraculous cures and the religious values that accompany such beliefs. However, ethicists are not advocates for particular patients. They have a professional duty to help patients and surrogates make, and accept, good all-things-considered ethical decisions. Sometimes such decisions will be ones which go *against* the overall interests of particular patients. This is especially likely when a proposed course of action, which is the interests of a particular patient, will have harmful consequences for other patients.

Healthcare institutions are expensive to run and demand for their services can sometimes exceed supply. Demand for the time of highly trained healthcare professionals as well as for the use of highly specialised medical equipment often exceeds supply. This is especially likely to happen in publicly funded healthcare institutions, many of which are run on very tight budgets. In many healthcare institutions, a decision to treat a patient has the consequence of delaying or denying treatment to another patient. Sometimes, when patients and/or their surrogates request a departure from a recommended medical intervention, or course of care, on the grounds that they are hoping for a miracle to occur, they are asking, in effect, for the treatment of other patients to be delayed or denied.

Consider the example of a surrogate decision maker who proposes that an unconscious patient, who is due to be taken off life support, remain on life support while the patient’s family pray for a miraculous recovery, when received medical opinion has it that the patient has no prospect of regaining consciousness. It may only be possible to maintain a limited number of patients on life support at a time, within a given healthcare institution, and the implementation of a proposal to ignore received medical opinion and allow a patient to remain on life support may have the consequence of denying life support to another patient who requires it. If a surrogate makes such a proposal, in these circumstances, then the ethicist has a professional duty to try to help them to appreciate that a healthcare institution has responsibilities to many patients and that a good all-things-considered ethical judgment will involve taking the interests of all of the patients in the care of that healthcare institution into account. A miracle may or may not happen, but while the family of one patient waits in hope and prays that it does, other patients may be denied access to scarce, needed resources, which they have a *prima facie* entitlement to, and this is unfair to those other patients. It can also be argued that, in such circumstances, a decision to allow a particular patient to remain on life support, while family members pray for a miracle, involves discrimination against atheists, agnostics and followers of faith traditions that do not accept the possibility of miracles. Such a decision involves making additional

resources available to patients who come from faith traditions that allow for the possibility of miracles, while effectively denying such additional resources to others; and this is discriminatory (Savulescu and Clarke 2007).

What counsel should ethicists provide to surrogate decision makers who propose that an unconscious patient with no prospects of regaining consciousness be maintained on life support, while that patient's family members pray for a miracle, in circumstances in which this is not a morally appropriate course of action because it will deny needed life support to other patients? One way in which an ethicist can helpfully counsel such surrogates is to make sure that they are aware that their proposed course of action will result in the denial of treatment to other patients who require it. In many cases a surrogate may not have considered the consequences for other patients of accommodating their proposal. Simply having these consequences pointed out to them may be sufficient to dissuade them from their proposed course of action.

Another way in which an ethicist can assist surrogates who propose to maintain a patient on life support, in defiance of received medical opinion, while the patients family members pray for a miracle, is to ask the surrogate and/or the patient's family members to speak to someone whom they regard as a religious authority and confirm that their faith tradition actually encourages its followers to hope that God might be disposed to intervene in the natural world and miraculously cure patients. While nearly all Christian Churches accept that miracles reported in the Bible occurred, most contemporary mainstream Protestant theologians, and many contemporary Catholic theologians, are opposed to the idea that God might now intervene in the natural world in response to prayers (Keller and Keller 1969, pp. 181-191). The patient's surrogate and/or the patient's family may be mistaken in presuming that their faith tradition encourages them to pray for a miraculous cure; and authority figures within that faith tradition may be instrumental in helping to discourage them from wanting to wait for a miracle to occur.

A third way in which an ethicist can assist surrogates is by challenging them to explain why they suppose that an extended period of prayer might make a difference to God's decision about whether or not to intervene in the natural world and provide a miraculous cure. The Christian God is usually understood as all knowing, all powerful and perfectly good. There is no chance that an all-knowing God could have failed to hear an initial prayer which involves a request for a miraculous cure; and being perfectly good and all powerful, God should have no problem deciding whether or not to miraculously cure a particular patient and no problem implementing that decision whenever He chooses to do so. Under such circumstances it is very hard to see why extended periods of prayer might influence God and lead Him to perform a miracle which He had chosen not to perform earlier, especially if this also involves denying needed treatment to other patients. If a surrogate is challenged in this way then they may decide to put their faith in the prayers that have already been made, forego attempting to delay the cessation of life support, and trust that God knows what is best to do.

It may be, however, that the patient's family do not only intend to use the additional time that is being requested to pray, but also plan to undertake specific activities that, they hope, will make it more likely that divine intervention will occur. They may be planning to cast spells, offer sacrifices, recite incantations and so on. If this is what they intend then they are not proposing to wait and hope for a miracle. A miracle is usually understood as the consequence of a decision made by God to intervene in the natural world and is not usually understood as being subject to human prediction or control. Someone who acted in a way that, they supposed, would make it more likely for supernatural intervention in the natural world to occur than it would be otherwise, would be attempting to perform magic, rather than praying for a miracle (Clarke 1999, pp. 55-56). Even though resorting to magic is not uncommon, especially amongst those who are desperate to see their ill relatives cured, most religious traditions regard attempts to perform magic as incompatible with genuine religious faith (Clarke 2014, pp. 139-140). If all of this is explained to surrogates who propose to

extend life support, in defiance of received medical opinion, then, after discussion with family members, those surrogates may be persuaded to reconsider their proposed course of action.

References

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