

# BIOETHICS AS MISSIONARY WORK

## *Approach, Example Are Key*

I spent six weeks in early 2012 in Harare, Zimbabwe, where every other year I teach medical ethics to seminarians at Holy Trinity College. I brought along an anthology entitled *Bioethics around the Globe*, reading I thought would be especially pertinent since I was, in fact, teaching bioethics halfway around the globe.<sup>1</sup>



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An essay in the volume that struck particularly close to home compared teaching Western theories of bioethics to those in developing countries with the work of missionaries.<sup>2</sup> Written by Raymond De Vries and Leslie Rott, researchers in bioethics at the University of Michigan, it suggested that “the failures and successes of missionary efforts illuminate (and suggest solutions for) the cultural and social problems encountered by those in the West who wish to share the good news of bioethics.”<sup>3</sup>

The authors explained what they called the “export problem,” which occurs when “bioethics, a creation of Western culture, collides with the systems of ethics found in local, non-Western cultures.”<sup>4</sup> They noted that the desire “to spread the gospel” of bioethics begins nobly, with the goal of genuinely helping people in another part of the world, but “noble intent is not sufficient to bring good results.” Missionaries can often become agents of colonialism.

The authors suggested that the power imbalance between the Western “helper” and those helped can create a situation that “not only diminishes the possibility of mutual enrichment but also creates the possibility of unwitting harm.”<sup>5</sup> They concluded that ethicists need to close the gap in a manner that is helpful to all concerned and suggested that an appropriate way of teaching bioethics in these circumstances “should be judged by the degree to which the conversations it creates enrich the moral practices of both the missionary and the missionized.”<sup>6</sup>

### UNDERSTANDING MISSION

I would like to play a bit with the metaphor of bioethicist as missionary. The understanding of mission that De Vries and Rott developed is based on a 19th-century model of what it meant to be a missionary. This model arose from a particular theology, understanding that the point of view of the missionary contained the truth and distrusting any possibility that other points of view could also reveal truth. This attitude often blinded missionaries to their own ethnocentrism, confusing their cultural appropriation of the Gospel with the Gospel itself. Although this attitude may define some forms of bioethics today, it is no longer as true of mission theology.

Two Catholic missiologists — Stephen Bevans and Roger Schroeder, both Divine Word Missionaries — have shown that during the 20th century there arose several other models of mission.<sup>7</sup> They further suggest that a model appropriate for the 21st century is that of mission as prophetic dialogue. This model explains that the missionary not only proclaims the truth of the Gospel, but also learns from his or her encounter with those of another culture or faith tradition and, in doing so, expands his or her understanding “of the depths of God’s unfathomable riches.”<sup>8</sup>

Prophetic dialogue, as dialogue, demands listening, empathy and respect; as prophetic, it entails honesty, conviction, courage and faith.<sup>9</sup> The authors articulate several characteristics of such dialogue, many of which are very properly theological. There are four areas, however, where their analysis can shed light on how one may engage in bioethics across cultures. These areas are witness, interreligious dialogue, contextualization and reconciliation.

Two further, introductory, points: First, one should be careful in making too facile an analogy between teaching bioethics and missionary work. The principles of biomedical ethics will never be as central to our identity as Catholic health care ethicists as the task of mission is central to what it means to be church. Having said this, bioethics can indeed learn from contemporary mission theology. Second, one does not have to travel to Africa or Asia to experience cross-cultural dialogue in bioethics. Often one need go no further than one's own emergency department or clinic.

If we take the analogy between missionary work and the spread of bioethics seriously, the model suggested by Bevens and Schroeder can help raise important questions for bioethics today, especially as its practitioners encounter people and issues of another culture.

#### WITNESS

Bevens and Schroeder explain that being a missionary today demands that one witness by one's lifestyle and presence the message one is trying to proclaim in words. They emphasize that any attempt to impose the Christian message on less-than-willing hearers is antithetical to what it means to be a missionary.<sup>10</sup> The witness that one gives cannot "contradict the spirit of Christian love, violate the freedom of the human person and diminish trust in the Christian witness of the church."<sup>11</sup>

Witness is the appropriate starting place not only for the missionary but also for the health care ethicist. Unlike some schools of philosophical ethics, our tradition demands that Catholic health care not only explain the church's moral teaching but exemplify it. Following the Catholic social tradition, the outreach of Catholic health care to the poor and marginalized of society says more about the nature of Catholic bioethics than the four principles (autonomy, beneficence, nonmaleficence and justice) articulated in Tom L. Beauchamp and James F. Childress's classic text, *Principles of Biomedical Ethics*.<sup>12</sup> As the *Ethical and Religious Directives for Catholic Health Care Services* urge, Catholic health care — precisely as part of the church's mission — should "distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination."<sup>13</sup> Moral witness remains an extremely powerful characteristic of Catholic health care ethics.

#### DIALOGUE

In missionary circles, interreligious dialogue has become commonplace in recent decades as the major faith traditions have found it increasingly beneficial

to engage in joint activities. There is also a theological reason, however, for such engagement: It is in dialogue with the other that one begins to understand better one's own faith. Dialogue, however, is not the same as argument or debate. Theologian David Tracy speaks of the fact that such dialogue (which he prefers to call conversation) involves risk, the most obvious risk being the possibility that one may have to change one's mind.<sup>14</sup>

Although one obviously does not speak of interreligious dialogue in the realm of bioethics, nevertheless intercultural dialogue may similarly allow one to discover new possibilities in oneself, including the

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possibility of changing one's mind. The exchange envisioned by Bevens and Schroeder cannot remain simply on the level of theory or be divorced from the practices of people making (in the case of bioethics) actual medical decisions, whatever their culture. Learning why people of other cultures have developed their own practices, we are able to understand better our own ethical practices.

#### CONTEXTUALIZATION

Contemporary theologies of mission, learning from the mistakes of colonialism, have emphasized that missionaries are called to bring the faith to others, not to bring them European or North American culture. The Gospel is not part of any one culture but, rather, is at home in many cultures. It is "infinitely translatable."<sup>15</sup> Mission theology, therefore, must be sensitive to the cultural context in which the Gospel is preached and the Christian life interpreted. Acknowledging that the Gospel is also countercultural to every culture, missionaries nevertheless need a healthy respect for the local culture. Bevens and Schroeder remind their readers that missionary work is always "walking in someone else's garden."<sup>16</sup>

Applying this element of the theology of mission to bioethics, we realize that we can never enter another culture with an already-formed bioethics. Our own conceptions of the ethical are more often than we realize overlaid with cultural assumptions and even prejudices.

I have learned the limitations of my own cultural lens when I tried to explain to my students in Zimba-

bwe certain “self-evident” presuppositions of Western bioethics. This not only includes principles such as autonomy (when I discussed “autonomy” with my students, they heard “abandonment by community”), but assumptions that are even more basic. For example, there was a strong spiritual component to my students’ worldview that has forced me to ask myself why we raise so few spiritual questions in our Western bioethics. My students in Zimbabwe were able to integrate the Catholic understanding of sacraments into their bioethics, for example, much more easily than those of us in the West.

### RECONCILIATION

Finally, Bevans and Schroeder suggest that reconciliation is the new model of mission.<sup>17</sup> Reconciliation has become increasingly important as a response to globalization. Globalization has connected the world as never before, but it also threatens to exclude entire peoples and cultures from participation in its benefits. Furthermore, as globalization becomes more widespread, there is also a contravening dynamic of greater particularity. Bevans and Schroeder have described this clash as the confrontation between “jihad and McWorld.”<sup>18</sup>

As globalization affects mission theology, so, too, does it affect bioethics. There remains a need for us Catholic health care ethicists to be clear regarding what we are doing. Can Western bioethics become a tool of globalization and a new colonialism? To the extent that this can occur, bioethicists must engage in reconciliation on multiple levels.

Theologian Robert Schreiter suggests that such an attitude toward reconciliation becomes a spirituality. It involves creating “havens of truth, of care, of concern, of prayer, of genuine concern and solidarity.”<sup>19</sup> Pope Benedict XVI has similarly explained that while globalization can make us neighbors, it cannot make us sisters and brothers.<sup>20</sup> The bioethicist as reconciler can bridge the gap from being neighbor to becoming sister and brother.

What would bioethics look like if we Catholic health care ethicists learned from contemporary mission theology?

It seems to me that we would do more listening than speaking.

We would definitely not provide an answer before we understood what the question is.

We would probably be more humble, being self-critical of our own cultural point of view.

Catholic health care ethics might also become more spiritual, allowing the religiosity of other cultures to challenge our often secular understandings

of health and health care and entering more completely into the spirit of Christian love.

Catholic health care ethics might also become bolder, speaking out with greater honesty, conviction, courage and faith. This is where prophetic dialogue leads.

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### NOTES

1. Catherine Myser, ed., *Bioethics around the Globe* (New York, Oxford University Press, 2011).
2. Raymond De Vries and Leslie Rott, “Bioethics as Missionary Work: The Export of Western Ethics to Developing Countries,” in Myser, *Bioethics around the Globe*, 3-18.
3. De Vries and Rott, 3.
4. De Vries and Rott, 4. I have described my experience of this collision in “Medical Ethics Zimbabwe-Style,” *Health Progress* 91, 4 (July-August 2010), 50-54.
5. De Vries and Rott, 5.
6. De Vries and Rott, 16.
7. Stephen B. Bevans and Roger P. Schroeder, *Constants in Context: A Theology of Mission for Today* (Maryknoll, NY: Orbis Books, 2004).
8. Bevans and Schroeder, 248.
9. Bevans and Schroeder, 384.
10. Bevans and Schroeder, 356.
11. Bevans and Schroeder, 356. The authors quote from the Orthodox Consultation on Mission and Proselytism (Moscow, 1995).
12. Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (New York: Oxford University Press, 2009).
13. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Directive 3.
14. See David Tracy, *Plurality and Ambiguity: Hermeneutics, Religion, Hope* (San Francisco: Harper and Row, 1987): 99.
15. Bevans and Schroeder, 386.
16. Bevans and Schroeder, 387.
17. Bevans and Schroeder, 389.
18. Bevans and Schroeder, 390. See Benjamin R. Barber, *Jihad vs. McWorld: Terrorism’s Challenge to Democracy* (New York: Times Books, 1995).
19. See Robert J. Schreiter, “Globalization and Reconciliation: Challenges to Mission,” in Robert J. Schreiter, *Mission in the Third Millennium* (Maryknoll, NY: Orbis Books, 2001): 121-143.
20. Pope Benedict XVI, *Caritas in Veritate*, no. 19.

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