

# Shalom and Justice in Health Care

E. David Cook

**E. David Cook** is professor of Christian Ethics at The Southern Baptist Theological Seminary. Dr. Cook is also a member of the faculty at Oxford University and serves as clinical ethicist at John Radcliffe Hospital. He has authored numerous articles and books, and has often appeared in radio and television broadcasts produced by the BBC, Radio Oxford.

## Introduction

It is now almost a truism to state that the Christian lives in the tension between the now and the not yet. The glories of the coming kingdom in all its fullness stand in tension with the harsh realities of living and dying in a fallen world. Such tension provides the framework for Christian living. We are in the world and yet not of the world, for our citizenship is in heaven, and yet we must live concretely in the here and now.

This means that there will always be a tension between proclaiming the ideal and working in a setting that falls short of that ideal. We continue to preach the ideal, but inevitably fall short of that glory until the whole of creation is redeemed and our bodies partake of the resurrected life. In the interim God invites us to grow up into the full manhood and womanhood intended for us in and through Christ. It is the challenge to be changed from one degree of glory to the next and fuller degree of glory. It means the death of human pride and self-satisfaction in our achievements. It stresses our utter dependence on the grace of God, his mercy and power to enable us, like Paul, to claim, "It is no longer I that live, but Christ who lives in me" (Phil 1:21).

If we now apply this framework to the theme of *just health* we see that there must be two elements in any move towards shalom. There must be the proclamation and description of the ideal of shalom and just health. But that ideal must be matched by a realistic strategy for dealing with the issues of justice and health as they actually face our world and us in the twenty

first century.

Living in a pluralistic society creates a major challenge for Christianity. The challenge is no different today from the time of the birth and spread of Christianity recorded in the Acts of the Apostles. That is why the Bible is so relevant to today's world and today's situation. Today we experience what the early Christians did, a variety of competing worldviews and the minority role of Christianity. The main difference is that in our setting Christianity has played an important role in the development of society, particularly in its moral and ethical standards.

In any approach to health care issues, we must retain a keen sense of our context and a clear historical perspective. How we arrived at where we now are is crucial if we are to build on and improve rather than jettison and destroy. This is especially the case as we look at the intertwining of moral values in a society that is increasingly secularized. Part of our approach should be to learn the lessons of history and to look at, on the positive side, things to be retained and emulated, and, on the negative side, to ensure that pitfalls and mistakes are avoided. But it is more than this, in the sense that we must uncover the basic assumptions and presuppositions that are at work in our society and in its competing value systems. The way forward in so many of our moral disagreements is to go back to the basic assumptions and to explore how we can criticize, change and adapt these basic beliefs and attitudes.

In Christian terms, this drives us back to consider carefully what our basis for

involvement in society must be and the theological framework within which we are to operate. Two themes form the twin pillars for our dealings with society and our involvement as citizens not only of our nation, but also of the world. The first theme is creation. It is the fact, nature, and content of creation that provides us with the theological framework for our relationships with our common humanity and with our world. But it is redemption and the Kingdom of Christ that provides the ultimate goal and the means of transforming that creation pattern into conformity with the original creation intention and pattern and with God's glorious strategy and purpose in eternity.

### The Role of Creation

In a sense it is possible to suggest that creation provides us with a minimal set of standards for social life and well being. Redemption and Christ's Kingdom provides us with a maximum set of standards for well being. Obviously there is a flaw in such a separation, for the creation pattern was intended to lead to shalom. If humanity had lived as God intended, then perfect shalom and wholeness would have been the order of the day and its result. Sin marred creation, and the basic standards set out in the Old Testament provide us with the means of fallen society and humanity living together. It is in the laws of God and his standards for human life together that we discover what is necessary for social life at all.

In practice this means that I cannot expect non-Christians to accept or live by the standards embodied and taught by Jesus. The Sermon on the Mount is certainly the ideal for Christians and for human beings as they are meant to live, but without a living relationship with

Christ and the power of the Holy Spirit, Christian ethics is and can be nothing but a worthy set of ideals. In contrast, if we take the fact of creation seriously we have a basis for dealing with all of humanity. We can discover standards of living that are genuinely human and for all. Thus in proclaiming the ideal in our world we must inevitably begin or be driven back to our understanding of creation and the Old Testament's account of God's desires and pattern for human life.

### *Created for Relationships*

By creating humanity, God revealed his intention for human beings and the pattern he desires. It is *life in relationship*. The primary relationship is with the Creator God who loves us with an everlasting love and whose desire for us is that we have shalom, wholeness and harmony. These stem from a proper relationship with God. That relationship is marked by dependency and interdependency. We are to be dependent on God. All of our living is to be done with reference to God and in deference to his will and his ways. We are to obey his laws and to live as he wants us to live. Without him we ought to do nothing. Every aspect of our life is to be lived in relationship to God. This is why the Old Testament laws cover every aspect of human life. The Mosaic law deals not only with moral, religious and social rules, but also with health and justice standards and rules. Timothy Inglis draws out the role of the laws of cleanliness as effective means for controlling the spread of communicable disease. These cleanliness laws covered food suitable for human consumption, human discharges, and skin diseases. As Inglis puts it, "Observation of these regulations and the Ten Commandments would result in less commu-

nal risk from infected meat, skin infection, gastro-intestinal disease and sexually transmitted disease.”<sup>1</sup>

These rules highlight the interdependency that is set in human relationships from the start. In the Genesis account it is clear that it is because man on his own is inadequate that womankind is created. It was not good for man to be alone. Human community and interdependency are fundamental. This is why the killing of Abel by Cain is so serious and why there are strict rules against the shedding of human blood. Murder destroys the human community and breaks that pattern of interdependency. This must force us to ask: How does legalized murder, whether of embryos, fetuses or of consenting adults in euthanasia, affect our community and destroy our inter-dependency?

#### ***Created as Whole Persons***

Creation also reveals that we are *whole persons*. The Biblical language does not attempt a neat reductionist account of the full content of human being. The Bible talks of soul, body, flesh, loins, mind, heart, breath, spirit and bowels. The mind, will, emotions and spiritual dimensions of human beings are not neatly divided off from one another. Rather, they are presented as different aspects of one whole person. To have shalom and true health we must be in harmony both in terms of each aspect of our being fulfilling its proper role and in terms of our relationships with each other. Shalom comes from proper relationships with God, with ourselves, with each other and with the world around us. Holistic medicine is correct when it stresses that we need to be whole as persons and in relationship with other people and with our environment and

world. Thus the good health of others and of our environment are as important for us as our own health and well being. Without harmony in the whole of our life and in and through all our relationships, disease will result.

#### ***Created in God's Image***

Another aspect of creation is the fact that we are all made in the image of God (Gen 1:26-27). Much debate exists about the content of “image,” especially in any Christian view of health. It is enough to stress that this is the ground of our value, dignity and worth as human beings. It is that God made us like himself. It is that he breathed his life into us. It is that he formed us for himself and has destined us for relationship with him and for glory. Again it is relationship, especially the relationship of the image to the image maker and original that gives value to our human life and being. This again reminds us that human life in and of itself is not what matters. It is life in relationship and life as it is intended to be that counts. It is when our actions conform to God’s plan that we are whole and have shalom.

Part of the content of being made in the image of God is the idea of answerability and responsibility. Being made in the image of God carries with it certain responsibilities whether we like it or not. We are made by God and answerable to him for all that we are and do. This is obedience. The proper answer to God is that we have been his good and faithful servants. It is to be able to affirm that we have done his will and tried always to do the things that please our loving heavenly Father. But we must note that responsibility in relationships is a fundamental aspect of humanity and of relationship. It is part and parcel of what it means to be

in relationship. Shalom comes when we live according to the image of God and when our relationships are marked by proper responses whether to God, to ourselves, to each other or to our world and environment.

Of course, our accountability to God is not only a challenge to our own life-style and behavior but it also ought to affect our attitudes and relationships with others. I am intrigued how often someone recognizes my College tie. Their attitude towards me changes fundamentally. If they are an old member of the College, then we have a common link. I am now considered one of them. For them, I have worth and value now in a way that I did not seem to have before. It all stems from their recognition that I bear a common mark with them. So it is with human beings who share the common mark of being made in the image of God. Therefore, we should treat each other with respect because we recognize in each other the mark of God and that mark accords us all equal dignity and worth.

But the Old Testament is a realistic book and gives a graphic account of how human beings made in God's image failed to live up to the call and challenge of that image. Humanity fell from God's standards by sinning. That sin affected every aspect of human life and every kind and level of relationship from that with God to those with oneself, others and the created world. In a way, the rest of the Bible is the story of the recovery of that image. But before the perfect image of the invisible God (Christ) redeems and restores humanity to our original ideal, there are a series of covenants between God and humanity. These covenants are two way relationships in which God promises and undertakes certain responsibilities—to be

their God and to bless—and the Israelites also undertake responsibilities to obey God, to walk in his ways and to do his will. If they will be his people, then he will be their God. That pattern of mutuality and reciprocity is fundamental to relationships in our fallen and twisted world. It is our means of grace in dealing and coping with the less than ideal. We can enter into covenantal relationships with God and with each other, and these are ways of restraining evil and achieving good. The *covenant pattern* is God's way of enabling human flourishing and shalom in a fallen world. Covenant relationships are the key to proper human life together.

### ***Justice, Mercy, and Love***

There are two further aspects that lie at the heart of creation but are also keystones in redemption and life in the Kingdom of God. They are themes that run throughout the Old and New Testaments. They are justice and mercy and love. Reading the prophets is rather like listening to someone who has swallowed a gramophone needle but claims, "It hasn't affected me, affected me, affected me, affected me . . ." The prophets seem stuck in the groove of "Justice and mercy . . . justice and mercy . . . justice and mercy." This is to be the standard that marks our dealings in relationships with each other. We are to treat each other with justice and with mercy. We are to be fair with each other and to be merciful with each other. It seems that both qualities of justice and mercy are calls for us to regard and treat others properly. My attitude to others is to act justly in all that I do with and to them. My attitude towards other people is to be merciful. This is not what I am to demand from others. God demands this from all human beings. In other words, in

the call for justice and mercy, the prophet is not giving us a charter for human rights, but rather is giving us the ground for human responsibilities. The call is directed to how we treat other people. It is not what we are to claim from others. God does that claiming. Of course, we have come to expect that kind of treatment and to enshrine that expectation in terms of human rights. But in essence the coin has been reversed from God's demand on me to act responsibly in justice and mercy. Instead, justice and mercy are to be characteristics of my relationships, attitudes and dealings with others.

Human beings made in the image of God and destined for glory are to be lovers. This is not just a New Testament theme. It lies at the heart of the Old Testament. God made us to be lovers. We are to love God with all our mind, our heart, our soul and our strength. We are to love our neighbor. We are called to be lovers. We are responsible for loving God and other people.

Jesus embodied and taught us what that love must mean in the end. His call is that we are to love one another as he loved us and that we are to love our neighbors as we love ourselves. All of this is set in the context of a relationship with God in which we love him because he first loved us. Our proper response to the love of God is to love him and everyone else. Love is our responsibility before God. We are to be lovers.

I have here concentrated on the ideal of how we are to live in a fallen world. It is marked by relationships. Those relationships with God, ourselves, others and our world are to be characterized by dependency on God and interdependency with each other. We realize that our worth and value depends upon our being made in

the image of God. God calls us to exercise proper responsibility to God and to each other, by living in covenant relationships and by showing justice, mercy and love in all our dealings with each other.

These are to be the standards shown and expected in all our relationships ranging from the family, to schools, neighborhoods and the global community. They are also to be embodied in our health relationships. They must be translated into our health services and the relationships that lie at the heart of health care.

### **Some Principles for Medical Care *Interdependency***

Medical and nursing care are to be characterized by *interdependency* and not a wrong kind of dependency. Both doctors and patients have often conspired with each other to produce the wrong kind of dependency often marked by paternalism. There must be mutual dependency and the recognition that doctors and nurses need their patients' co-operation as much as patients need doctors and nurses. Our health relationships should be judged by the test of interdependency and the rejection of a false and inappropriate dependency. The rider is crucial. There are times when all of us are and will be dependent on others. Birth and childhood, handicap and old age as well as illness and disease show the reality of dependency. But it is all too easy to institutionalize that dependency and to reduce human beings to a slavish dependency rather than create the setting, capacity and reality of as much interdependency as possible. Sadly, what we rather hear in response to overdependency are calls for independence. This overreaction simply reinforces the lie of individualism and fails to realize that human beings are created for and in

interdependency. Appropriate dependency among us should be our aim and our motive.

### ***Holistic***

We should also aim and desire to be *whole* in ourselves and in our family, social, communal and global relationships. We must resist the reductionism of modern technological medicine and practice. Human beings are to be seen and treated in holistic ways. This is why the role of the family and the community is so important in health matters. We have already seen how social, environmental, industrial, political, financial and a whole host of other factors affect our health and well being. We cannot and dare not isolate one aspect from the other or end up treating people merely as medical cases. Here the role of health education and an overall strategy for health care that deals with the issues of inequalities, poverty and social problems and factors that are central to shalom and good health are vital. Preventative medicine in all its variety, needs to be high on our agenda not just in our own land, but globally where "More than half a million women, nearly all of them in the developing world, die each year in pregnancy or childbirth. This amounts to one every minute. Millions more suffer serious, sometimes permanent injuries. Much of this suffering and death could be prevented."<sup>2</sup> In the two thirds world, on average, one child dies from diahorrea every six seconds. In this sense our responsibility for others is clearly defined in Paul's second letter to the Corinthians, where he sets out the Christian response to those in need: "But as a matter of equality your abundance at the present time should supply their want, so that their abundance may supply your

want, that there may be equality" (2 Cor 8:14).

It is when others have enough that we can talk of having more than enough. Enough is defined, not by what we think we need, but by the needs of others. When they have enough, then we shall have enough too. Equality means that we are to ensure the basics for all, rather than insisting on the high tech, extraordinary for the few.

At the heart of the practice of medicine is the value and worth of the patient. Why are patients to be treated? How are they to be treated not merely in a medical way, but in a humane way? The doctrine of humanity made in the image of God undergirds our treating other human beings with dignity, not because of what they have achieved or how much they contribute to society or to their own health care but simply by the fact of their bearing the mark of God. Because we are equally created we have equal worth and dignity, and this is the way that our relationship with those in need should be conducted. They are to be treated with respect. Their confidences are to be treated appropriately. Their fears and anxieties are to be dealt with properly. They are to be talked with and communicated with in constructive, open, and honest ways rather than in a peremptory fashion.

### ***Covenantal Responsibility***

*Responsibility* lies at the heart of human relationships, and health workers are responsible for people when they are often at their most vulnerable. But that responsibility goes far beyond the mere responsibility to provide the best level of care and treatment available according to the best of our abilities. It also includes the responsibility to give an account of

what we are doing and why we are doing it. In America, the threat of litigation casts a constant shadow over relationships and honesty between doctors and patients. The high cost of negligence awards and the ever-increasing costs of medical insurance mean that we have to look carefully at some means of no-fault liability that is clearly separable from professional negligence proceedings. Doctors must be answerable not only to their own colleagues but also to society and to their patients. This does not imply that we must create a legal system that destroys such responsibility. Rather it is an opportunity to create a system where we allow confidence on both sides. The patient needs confidence that the doctor will do his or her best, and that if something goes wrong, this will be taken care of in an appropriate way. The doctor needs the confidence that this patient is seeking to do what is required to get well, has been honest and open about the situation and does not pose an unknown threat either in terms of disease or as suer and litigant.

What this naturally comes to is a proper covenantal relationship between doctor or nurse and patient. We must resist any slide towards the contractual model of medicine where the doctor and patient merely contract with each other to fulfil legally agreed and qualified responsibilities. The move to law only happens when relationships break down. That is why we have laws in the first place. But a covenant relationship implies mutual responsibility and mutual trust. It is based on faith and confidence, not fear, on both sides. It is genuinely mutual and reciprocal where both parties have a crucial part to play. God's pattern for relationships in our fallen world is that of *covenant*. Medicine and nursing historically rests on that cov-

enant model. We must preserve this covenant model against all factors that might change or destroy it.

### ***Justice, Mercy, and Love***

We turn now to the application of the themes of *justice, mercy and love*. If we look at medical codes of practice and can get past the fact that two thirds of each code historically was given to doctor to doctor relationships (like not stealing each other's patients, not being nasty about another doctor to patients and always paying your medical colleagues on time), we can see four major principles at the heart of medical ethics. These are *non nocere* (do no harm), *the principle of beneficence* (act kindly towards others), *the principle of respect of persons* (expressed in the principle of autonomy), and *the principle of justice* (fairness in respect of treating equal cases equally and unequal cases unequally).<sup>3</sup> I would suggest that these four principles are in fact the principles of justice and mercy.

It seems to me that the idea of not harming someone is the first step in a merciful relationship. This then leads to the second step, which is to act with kindness and seek to benefit and do good to and for one another. Interestingly, Jesus turned the negative form of the golden rule ("do not do to someone what you would not wish them to do to you") into the positive form that was at the heart of his moral teaching ("do to others what you would wish them to do to you"). Thus, both the not harming and the doing of good lead naturally to the third step, which is to treat others with respect. This respect involves treating them as equals and giving them their proper and appropriate dignity and worth. Thus the principles of justice and mercy—God's required standards—are

embodied in the codes of medical ethics and the requirements for the practice of medical care. But these are minimal standards and the love command as set forth in the Old Testament means an end to begging the question in our own favor and selfish interests. Moreover, the demands of the Old Testament law are not as high as the demand Jesus placed upon his followers in giving his love commandment—the new command to love as he loved.

It is proper then for a society to expect justice and mercy if that society is to grow and flourish. Indeed it is vital if that society is to survive at all. It is not reasonable for the Christian to expect or demand more without the power and inspiration of the Spirit of Jesus himself.

### **Vocation and Service**

Part of the problem is a growing awareness in Britain and in the USA that our pattern of recruitment and selection and the processes of medical and nursing training used in the last few years may have been fundamentally flawed. This soul-searching extends not only over whether to include medical ethics in the curriculum, but also over the kinds of doctors and nurses that have already been produced. There is a widespread fear that we have concentrated too much on technical skills and an academic approach, so that those in training are not being trained to serve. We have created splendid scientists whose abilities are beyond question. We have been less successful in creating a generation of doctors and nurses who relate well to patients and who gain and hold the confidence of those they treat and care for.

On both sides of the Atlantic, we are already seeing a shift in selection and

recruitment from the purely scientific skills to the more personal and relational capacities. Thus successful interviews and greater awareness of the kind of persons who are offering themselves for training and more concentration on their ability to relate well and function well as human beings is increasingly the order of the day. I think that we need to go back a stage further and resurrect a notion that is sadly out of fashion. It is that of vocation. Once medicine was as much a vocation as ministry in the Church. Both were seen as callings of God that were crucial means of serving our brothers and sisters and God himself. That notion of vocation is disappearing even in ministerial selection, let alone in medicine and nursing. This is a sad loss. The idea that God has a purpose and a job for each one of us should encourage us to reflect very carefully and seriously on what God might call us to do. The kind of service given by doctors and nurses is one of the highest callings and one of the most worthwhile. Financial greed and selfish desires for fulfilment need to be dismissed as the dead ends they are. But the recovery of a sense of vocation will not in and of itself be enough. With it we must ask some penetrating questions about the kind of training our health care professionals receive.

What I have in mind here is to explore the notion of the medical and nursing character. What virtues or characteristics ought we to expect and to nurture in and among those who are called to serve humanity as doctors and nurses?

The traditional account of the cardinal virtues was that they were justice, prudence, temperance and fortitude. To these were added the so-called Christian virtues of faith, hope and charity. If we were to start afresh and to ask patients what vir-

tues they might expect and hope for in their medical and nursing practitioners, then I think the list would be something like the following. A good doctor or nurse is one who has or makes the time for his or her patients. He or she has a genuine interest in the people he or she deals with. There is a real capacity for and desire to communicate, recognizing that communication is a two way process. He listens carefully to what he is told and that makes a difference to what happens. He has a high level of practical skill and scientific knowledge, but that is tempered by a genuine humanity and evidence of what we call the common touch. He remembers that he is human too and is not afraid to confess his weakness and ignorance when it is appropriate. He practices medicine as an art and not just a skill. He is responsible, encouraging and, in short, a fine human being. At a more formal level we might express the virtues by avoiding the vices of paternalism, reductionism, pragmatism and self-interest. In a sense what we have been describing is the role we traditionally expect from public servants. Perhaps this recognition brings us back to the realization that good doctors and nurses are servants. Servants are responsible for particular duties and do them for the sake and benefit of those they seek to serve.

### What Is Health?

David Atkinson offers an interesting definition of health. He declares his dependence on Moltmann by offering for consideration the working definition of health as "the strength to be human."<sup>4</sup> On that account sickness is the impairment of that strength that thus cripples and weakens a person. Moltmann claims that if we understand health as the strength to

be human, then we make being human more important than the state of being healthy.

While I can understand the apparent enthusiasm that greeted this deceptively simple definition, it does seem to be just that—deceptively simple. It seems that it either proves too much or too little. It proves too much for it makes being human the equivalent of being healthy. Yet there is a serious risk of misunderstanding here. Human beings experience all kinds of states and conditions. They flourish, are fit and well, and feel off color, sick, and diseased as well. Health is a description of one state of human being. But it is not the equivalent of being human. Sick human beings are still human. When I do not have the strength to be human or the will to struggle to be human or the desire to be the human being I was created to be, that condition does not remove my humanity from me. It seems that to equate humanity and the strength to be human (health) is really a circular definition. Circularity is not a weakness unless it is a vicious circularity. The problem here is that we do not add to our understanding of health or humanity simply by defining the one in terms of the other. This is also why the definition seems to prove too little, for it begs all the questions about what exactly constitutes being human and what exactly is meant by strength in the phrase "the strength to be human."

To be fair, Moltmann does state that being able to stand up to both conditions of health and sickness are important. This is surely correct. For too long we have been mesmerized by some absolute definition of health that was parasitic on the World Health Organization's definition of complete well being. We need to move away from a limited understanding of

health in terms of disease limitation and control, and regain a positive idea of health in terms of shalom. My fear is that our model will remain like that of the marvelous setting of Lake Woebegon, where all the women are strong, all the men are good looking, and all the children are above average.

One way forward in our understanding of health is to look at what is appropriate and fitting for human beings at different stages of life and in different contexts. F. H. Bradley wrote an excellent essay called "My Station and its Duties."<sup>5</sup> It would serve as a useful guide for those who wished to explore the stress on responsibility rather than rights. But at its heart lies an emphasis on what is fitting. I believe that one concept we need to recover in society is a greater sense of what is fitting and appropriate. This is both a useful moral and social tool, but it is also a way of helping us see clearly that the health expectations of a twenty year old must be very different from those of a ninety year old. We should not expect a child in the womb to have the same kind of life as fully-grown young adults. We should not be surprised that we will be dependent on others when we are children or elderly, or when we are handicapped or disabled in some vital way. As the world of the media seems to offer a stereotype of what is normal, we need rather to stress an understanding of what is appropriate. This is not an excuse for settling for what we have, but rather a corrective to the wrong kind of expectations and complaints when our health is not the same as that of the stereotypes.

In a sense, I have been unfair to Moltmann. In driving us back to the question of what is human being, he does help us see that we must express not just what it

means to be human but also what may properly be expected as appropriate for and from human beings in relationship with each other and in themselves.

But I want to see how we should respond to issues in our society when we as Christians are confronted with moral challenges in the medical area. What does it mean for us as Christians to be critical participants in the issues of our society?

### **A Strategy for Justice: A Model Applied**

John Rawls has written what is properly regarded as one of the finest discussions of justice.<sup>6</sup> We have already referred to the nature and distribution of justice in terms of health care in a general way, but it is worth pondering what such justice might mean in greater detail.

Rawls first expressed his ideas of justice in an article "Justice as Fairness."<sup>7</sup> Rawls describes two different stages in the process of creating justice. The first stage is when we actually create law where no law exists. Rawls is particularly concerned with the kinds and levels of argument that are presented and appropriate in this stage of the proceedings. Then there arises a second and different level of justice. It is the setting where and when we appeal to the laws in existence as the standards by which to judge the justice or otherwise of particular actions and classes of behavior. Rawls argues that the kinds of arguments that are appropriate to justify practices in light of existing laws are different from the kinds of arguments we may properly use in the creation of such laws.

In other words, there is a crucial distinction between setting standards and justifying existing law in light of those standards. It seems so obvious that it is hardly worth stating, yet it is important

to realize the difference and its significance. For all too often arguments miss each other and the point, because, in fact, they are moving backwards and forwards between these two levels without recognizing that this is the case.

Nowhere is this more evident than in the debates over abortion. The critique of the abortion laws often fails to make an impact because it is really focusing at the level of whether or not there should be any laws about abortion at all, or to be more precise, whether or not there should be any abortions at all. If your view is that there should be no abortion under any circumstances, then you are really engaged in presenting a case that there should be no such law and the arguments presented are those appropriate to the framing of standards and the setting up of laws.

If, however, you accept that there are such laws and that in a pluralistic society there will be those who wish to have and to permit abortions and look to enshrine that permission in law, then you will present arguments that seek to amend the laws in existence and to examine the various practices and justifications for abortion in light of the standards in existence. Here the focus is not so much whether or not there will be or whether we ought to have such laws, but what changes in these laws ought to be brought about.

Obviously, the two levels do come together when we make changes in the laws. But that must not cause us to confuse the arguments that are appropriate to the creation of laws, from those that are properly presented to justify actions in light of those existing laws and standards.

The anti-abortion cause is not always helped by refusing to recognize that there are abortion laws in existence and that these laws are here to stay in the foreseeable

future. Hence, many who are genuinely opposed to abortion adopt a different strategy, which we may call the death of a thousand qualifications. Their aim in abortion law reform is to kill the practice and law about abortion by the death of a thousand qualifications. By a steady process that adds more and more qualifications to the abortion law, there is a move, albeit slow and imperceptible, towards the abolition of such laws. Thus, if the present law permits abortion up to twenty eight weeks, then one might qualify that time scale down to twenty four weeks, and then down again to nineteen weeks, then sixteen and so on until the death of a thousand qualifications has taken place.

Besides abortion, we also face questions relating to fertility and infertility. There were overwhelming reasons to introduce legislation in this sensitive area. We know that one in seven couples who wish to have children are unable to do so. They suffer from problems of infertility. In our society, after asking where persons come from and what they do for a living, we tend to ask them about their families. If we are unable to have a family, then there is a perceived lack, genuine hurt and pain, and embarrassment and often feelings of disappointment and even inadequacy. We also know that one third of the problems are the result of female infertility, usually in relation to the fallopian tubes. One third are male related problems usually related to a low sperm count. One third are unknown.

Modern science and medical technology are able to help not only in terms of various hormonal treatments and surgical options, but also in terms of AID (artificial insemination by a donor) and AIH (artificial insemination by the husband), IVF (*in vitro* fertilization), donation and

surrogacy. However, it seems obvious that just because we have the capacity and can do something, does not imply that we ought to do it. The morality of the techniques is a separate issue from the technical possibility. It is interesting that the pressure for legislation in this area arose not from society's concern to control mad scientists and prevent them from creating monsters; it arose because scientists themselves realized that what they were doing and able to do raised fundamental moral and ethical questions, and they therefore asked government and society to help them draw lines. Thus Parliament decided and legislated what is and is not to be permitted in terms of embryo manipulation and research.

It is instructive to consider the legislation brought forward concerning the experimentation on human embryos in the UK. A new authority—The Human Fertilisation and Embryology Authority—was created to license and control centers for infertility treatment, to control AID, IVF and egg donation, to limit surrogacy, and to supervise the experimentation on human embryos up to 14 days development. At the same time, the new law changed the details of birth certification to remove any legal rights and responsibilities from egg and sperm donors.

We may comment on each of these steps in turn. It is important that there be such a statutory licensing authority. It is frightening to realize that in the past there was more formal control over experimentation on animals in UK than there was on experimentation on human embryos. Artificial Insemination and IVF using the egg and sperm of the husband and wife raise a few moral or theological questions. Some are uneasy about artificiality, perceiving an unnatural element in which

procreation is moved from the bedroom to the laboratory. Others are concerned about the use of masturbation to collect sperm and seem to misunderstand the sin of Onan in this connection (Gen 38:8ff). But when it comes to the already widely practiced Artificial Insemination by donor and egg donation leading to IVF involving someone apart from the husband and wife, there are proper moral questions to be asked about the rights and responsibilities of donors.

There have been various attempts to limit the financial gain from such a donation and to make the case that the motive for such donation is one of compassion and concern for those who are childless. But loving motives are not enough to establish the morality of an action. There can be no doubt that while there is not an act of adultery in any sexual sense, there is a clear intrusion into the marriage bond and a putting asunder of what is intended to be a unique and exclusive relationship. Many men in particular find the idea of another man's sperm being used to inseminate their wife abhorrent. It may seem easy to dismiss this as chauvinism, but it may also point to a sense of fundamental intrusion into the exclusive relationship of marriage. What is equally concerning is that the law about birth certification was changed to allow the social parent to be named as parent; this raises two issues. The first is truth telling. While I might be glad to be allowed to tell lies when I fill in a governmental form such as my Tax Return, a society needs to require and to expect truth from its citizens. Truth telling must be enshrined at the heart of our society and no amount of glossing will change the fact that it is the institutionalization of lies that is being practiced. This leads to the second issue.

We have struggled long and hard to allow adopted children the right to discover their natural parents. It now seems that in order to protect the donor's anonymity and limit his or her responsibility that children will be denied the right to discover their natural parents. There was a tragic case of a couple whose daughter died in the USA and who discovered that the hospital had made a mistake over two girls at birth and the wrong child had been given to the wrong parents. It was fascinating to see that no one suggested that the child be removed from the loving home setting where she had been brought up and cared for as the daughter of those parents. But it was established that the girl had the right to know who her true parents are and that those parents had the right to see and visit their natural daughter. We have tended to look at the case from the angle of the parents, but we need also to be aware of the child's perspective. It is almost always the case that a child goes through a stage of doubt about his or her origin and desperately tries to discover if their so-called parents are really their parents. The lengths to which adopted children are willing to go witnesses their desire and need to know their parentage. It seems unjust to deny that right to IVF / AID children.

But many have argued that such a right to know on the part of the child will inevitably lead to a lessening in numbers and enthusiasm for donation, as has happened in Sweden, where such a right has been established. This may be the case and it may point us to a greater awareness of the responsibility of donation. We are responsible for what we do and what we give and donate. It may seem that sperm and eggs have little significance for us as individuals, but they are the carriers of

human life. We do not need to raise hard cases (e.g., social parents both dying, a donor discovering that he or she is no longer able to have a child and a child who resulted from their donation being available for adoption) to realize that we do have responsibilities for our donations.

Therefore we must ask hard questions about why most of us agree that surrogacy ought to be prohibited and yet are fairly casual about the practice of AID. Is there really a difference in kind or is it simply a matter of degree of involvement? Will that distinction really hold up?

I recall a discussion with an Irish friend who admitted that he, like myself, had serious reservations about the wisdom of having children. He said that his main concern was what the world might do to his children in days to come. I had to confess that my concern was a little different. I was more bothered about what my children might do to the world.

This brings us to what for many must be the heart of the matter. What is a parent? It is one thing to have adoptive or foster parents for children who have been deprived of normal parental care. To create a situation where social parenting is the aim from the start is quite a different matter. While it may be hard to help people cope with infertility, we do need to beware of any idea that any of us have a right to have a child or that the medical profession has the responsibility to give us children. This is especially a cause for pause when we think who might claim that right and under what circumstances it might be claimed. The end of giving a childless couple a baby might not justify the use of any means to reach that end.

On the issue of research on human embryos in the UK, it is clear that the limit of fourteen days was chosen because this

is the putative point at which the primitive streak is held to begin to develop and accordingly the point from which pain might be felt. To be a little more precise, from this point the capacity to feel pain is there, for the structure to experience pain is in place.

Inevitably this drives us to ask when human life begins. Then we are treated to the whole gamut of responses ranging from the moment of fertilization to independent living as a child able to care for him or herself. I am unconvinced that any definition of what constitutes a person or even reaching agreement about when life begins will necessarily solve the problem of disagreement. The real issue seems rather to be what value inheres in or is attached to human life at its various stages of development. What this reduces to in the end is: under what conditions, if any, are we able to justify the taking of human life. Make no mistake about what is intended in terms of embryo research. The use of fertility drugs means that a woman can produce perhaps as many as twenty three eggs in a cycle. No more than three fertilized eggs will be implanted in the womb or in the fallopian tubes. The demand for more than sextuplets is not very high. This means that there will be spare embryos. It may also mean that some medical fertility experts will selectively reduce the three implanted eggs to one in order to enhance the possibility of a successful pregnancy. Selective reduction is the polite term for killing. In the same way the spare embryos might be used for research purposes and experimentation. For example, experimentation on such spare embryos may help us learn more about the problems of fertility, about the nature of human development, about genetic abnormality and enable more

effective genetic screening (which inevitably leads to more abortions), and learn the effects of experimental drugs on human tissue.

All of the above may seem like very worthy ends, but, even if we accept the worth of the ends, we still must ask whether or not the end justifies the means. Many will argue that these things will continue to happen anyway and that science must progress. But surely the point in discussing the kinds of laws and issues at stake is to set some limits to what we allow and what we forbid. At this point it is possible to draw stricter lines and then, if all is well, to ease these restrictions. If we open the flood gates, it is hard to see how we can then try to close them even in a minor way. The debate is not whether or not we should have restrictions and limits, but rather what limits are to be imposed and how these limits are to be enforced and inspected.

Scientists need to have limits and where a society is itself paying for that scientific research it is proper to draw those limits. This is not an imposition on unwilling researchers, but rather a proper response to their initial request for structure and for lines to be drawn.

This will still leave us with problems of infertility and experimentation. Helping infertile couples live with the limits of this fallen world will be part of drawing some lines in fertility work. We might consider following the model of some of the States in the USA where only one egg is fertilized at any one time so that the issue of spare embryos is avoided. We might recommend that we only permit experimentation on a human embryo for the benefit of that particular embryo. Normally we only allow experimental treatment where there is consent and where

there is some possibility of good or benefit for the one being treated. The area of consent is a minefield here, thus we are driven back to the likely benefit for the one being treated.

Whether the issue is abortion, euthanasia, AIDS, fertility treatment, or human embryo experimentation, we are all in the business of drawing lines and setting limits. These limits must be drawn as conservatively as possible. This is not only because some things are worth conserving, but because it is so hard to recover ground once lost. Taking a mile when we are given an inch is a well known human failing. Therefore, we must draw lines carefully and stick to them. But even that drawing of lines and sticking to them depends on fundamental assumptions about human nature. If we are serious about the fallenness of ourselves and of all humanity, then those lines need to be very carefully drawn indeed and that means conservatively and with genuine and serious sanctions.

In the debate over legislation regarding human embryonic research, we must speak up for what we believe, in as winsome a way as possible. That will mean appealing to the creation bases of human being and seeking to mount arguments that will be effective and successful on the grounds of our common relationships as human beings.

### The Pattern of the Church

There yet remain an ever increasing number of health issues to be faced. Questions about the nature of health care and the structure of health care delivery systems will be high on the agenda of all nations. Resource allocation issues in health care require wisdom and careful

thought. We must not throw away the benefits we have won through the valiant efforts of so many. Preventative concerns, health education, and increasing responsibility for our own health will be the mark of the next decades. There will be a continuing tension between selfishness and service and the caring professions are more than likely to be caught in the middle. As the population demography changes and the elderly predominate, as continuing polarization in society in terms of wealth and poverty remain, as technology produces more opportunities and hazards to be faced, as new diseases like AIDS appear and threaten, as our global village becomes even smaller, and our neighbors even nearer, as costs and prices continue to escalate, and as we discover more of the health dimensions of our close interrelationship with our environment and our natural world, health matters will continue to challenge us at the level of philosophy and of practice.

In all this Christians and the Church must continue to proclaim the ideal of God's shalom in every aspect of human being and in all our relationships. The Church must then continue to be critical of all efforts and plans that fall short of that ideal. The Church must be constructively critical and seek to build on the pattern of creation that God has given to us all. But the Church must also live like the city set on a hill whose light cannot be hidden. In that sense, it is indeed God's new and perfect society and should show by its life together and its witness that shalom is not just an ideal, but a living and growing reality.

There will be many for whom life is marked not by shalom or health but by sickness, pain, distress, and disease. To them the Church must minister the love

of God in real and practical ways. It is no use preaching transformation unless we enable people to be transformed. That transformation comes not simply through human effort. It comes ultimately from the grace and power of the God who calls us to follow him and to be his witnesses and transformers where we are, and reaching out from there to the uttermost parts of the earth. The God who calls us goes with us and he enables us to fulfill that call, for his strength is made perfect in our weakness. His gift of shalom can be our experience and the basis for that ideal of just health for all.

## ENDNOTES

<sup>1</sup>T. Inglis, "Health Care—Towards a Christian Prospectus" (unpublished paper).

<sup>2</sup> "Issues in World Health," *Population Reports*, Series L No 7 Sept 1988.

<sup>3</sup>See T. Beaucham and J. F. Childress, *Principles of Biomedical Ethics*, 4th ed. (Oxford: Oxford University Press, 1994).

<sup>4</sup>David Atkinson, "Toward a Theology of Health," in *Health: Strength to be Human*, ed. Andrew Ferguson (Leicester: Inter-Varsity Press, 1993) 34.

<sup>5</sup> F. H. Bradley, "My Station and its Duties," in *Ethical Studies*, ed. F. H. Bradley, 2nd ed. (Oxford: Oxford University Press, 1962) 160-213.

<sup>6</sup>John Rawls, *A Theory of Justice* (Cambridge: Harvard University Press, 1971).

<sup>7</sup> John Rawls, "Justice as Fairness," *The Philosophical Review* 67 (1958) 164-194.