ETHICS & MEDICINE

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Ethics and Medicine seeks to develop a Christian mind on the complex and fundamental challenges posed to society by the break-up of the Hippocratic consensus and technological advance in medical science.

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Henk Jochemsen

Guest Editorial: The Christian Heritage in Cure and Care

Editor's note: We are pleased to welcome Dr. Henk Jochemsen, director of the Prof. Dr. G. A. Lindeboom Institute, as editorialist for this issue. Dr. Jochemsen lives in Ede, Netherlands, holds the Lindeboom chair for medical ethics, and is active in addressing the issues at the intersection of ethics and medicine. The Lindeboom Institute is one of the kind sponsors of Ethics & Medicine.

When Jesus sent his apostles into the world to preach the gospel, he promised that among the signs that would follow them would be the healing of the sick (Mark 16:18). The apostles would not do so through medicine, but by the power of the Spirit. And especially during its first centuries, healing and caring for the sick has been a mark of Christianity. Whether this ministry of the church could also be fulfilled by the use of medicine has been a matter of debate. Some of the church fathers argued that the use of drugs was allowed for non-Christians but not to Christians. Christians, they said, should seek healing by prayer and exorcism. On the whole, however, the church gradually accepted important elements of the pre-scientific medicine of the Hippocratic and Galenic tradition. They rejected those forms of medicine that were related to idolatrous cults like those of Aesculapius and Apollos.

It appears that Christianity contributed little to 'scientific' medicine until well into the middle ages. Up to that point there was not much scientific advancement anyway. However, during the decline of antique culture, caused by the fall of Rome and the migration of the nations in the fifth century, significant elements of Hippocratic and Galenic medicine were preserved and used in the Benedictine monasteries. There medicine was integrated into a view of health and disease and a practice of care for the sick that was historically new and specifically Christian. By 325 AD the Nicene council obligated the bishops to establish *hospitia*. These were not so much hospitals in the modern sense as guest houses for all who needed shelter and, if need be, care. These *hospitia* developed into the later hospitals in which care and treatment were combined. By the end of the 19th century the modern clinic was established, primarily to give medical treatment to the sick and care for them at the same time. So, a reversal of focus took place, compared to the old *hospitia*.

I recall these rough historical notions to point out that in today's healthcare it is not so much 'cure' as 'care' that has specific Christian roots. This is not to deny that Christians have contributed significantly to medicine, nor that medicine can be seen as a way to fulfil the Christian duty to seek healing for the sick. But in its methods and models, modern medicine is not specifically Christian, whereas institutions for (long term) care have specifically Christian roots. What does this imply for the responsibility of Christians with respect to today's healthcare?

Our modern societies demonstrate a strong emphasis on health and on medicine to preserve or achieve it. Huge sums of money go into medicine and its development. And there is a lot in today's medicine for which to be grateful. But what about those who are beyond cure and above all need shelter and care—the seriously chronically ill, the psychogeriatric and psychiatric patients, terminal patients, and the homeless? Are we not spending *too* much on curative medicine at the expense of care? When Christians are true to their heritage they will resist the neglect of care on behalf of cure. These two often-intertwined elements of healthcare should be kept in balance.

This journal points out regularly that medical ethics demonstrates a shift from respect for life to emphasis on the quality of life. In my opinion this shift is related to the increasing emphasis on cure rather than on care. Respect for life certainly motivates us to seek cure for the sick to preserve their life. But it also motivates us to look after persons who cannot be cured and whose quality of life (in the medical sense) will deteriorate until they die. The principle of respect for life requires their lives to be respected as much as that of those who can be healed. When quality of life becomes the central value in medicine, it is believed that health and cure should be pursued at (almost) all cost. But when it becomes impossible to maintain or achieve a certain minimal quality of life, the experience of life as meaningful fades away, not only for the patient but also (and perhaps even more) for those around the patient. Clearly, this attitude not only leads to acceptance of physician assisted suicide and euthanasia but is also consistent with a strong emphasis on cure and a neglect of long term care for incurable and terminal patients.

To avoid misunderstanding I want to stress that for an individual doctor the emphasis on cure does not necessarily imply a neglect of care. The priority to cure in our society and healthcare may not even be an intentional choice. Instead, it may be an unintended manifestation of our society's values. It is a value system, however, that is inconsistent with a Christian view of life, health, and disease.

Nursing, with its historical emphasis on caring, is preserving better than medicine some of the typically Christian healthcare values. That is why I am very pleased that in this issue of *Ethics & Medicine* a number of articles deal with nursing care from a Christian perspective. I hope it will remind all of us who work in the health sector of the rich and valuable Christian heritage. We must not lose this heritage, but cherish and revitalize it for today's world.

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Arlene B. Miller, RN, MDiv

A Worldview for Nursing

Revolution in Nursing Theory

When nursing education moved into the academia via science departments, the need developed to establish a research based body of knowledge. Serious efforts in theory development began in the 1950s and proliferated in the 1960s and 1970s.

Those early nursing theories took on characteristics of naturalism and positivism. They were couched in cause-and-effect language, often with elaborate diagrams showing complex relationships between concepts. It was assumed that facts about the world could be observed directly and that such knowledge was objective and value free. Many theorists of this era were psychiatric nurses, so their theories focused on the nurse-patient relationship.[1] Even these were framed in naturalistic language of cause and effect, although in a more personal tone.

Then in 1962 Thomas Kuhn published *The Structure of Scientific Revolutions* in which he challenged the prevailing assumption that science was value free. At the same time he argued that while our perception and values shape our understanding of reality, eventually 'reality fights back', telling us that our theories are incorrect. When the facts no longer fit the theory new theories are adopted.[2]

Kuhn also argued that changing our theories does not come easily to us, neither as individuals nor as a community of thinkers and practitioners. He likens such changes to a conversion, something that one *experiences*. They are not brought about by logical argument. The old ways of interpreting our experience continue to guide us until we suddenly see the facts in a new way.

Nursing is currently undergoing such a conversion experience. For many years nurses have known intuitively that there was more about ourselves and our patients than could be explained within naturalistic scientific theories.[3] Our theories were impotent to help us deal with matters of life, suffering and death we faced in our work. They told us about physiology and pathology. The psychosocial nursing theories told us to listen, to feel with, to support and encourage our patients. But we found ourselves powerless in the end. Many of us turned to our faith to help us, and for most nurses that was Christian faith.

Then in 1970 Martha Rogers published her little text *An Introduction to the Theoretical Basis of Nursing*.[4] Because her work was so radically different many dismissed both the book and Rogers herself. Few understood what she was saying, and even fewer grasped the significance of her work.[5] Rogers opened possibilities for new ways of thinking about nursing. She continued using the impersonal language of physics—energy, field theory, simultaneity—to describe the intangible in nursing but she loaded these words with new meaning. Other nursing theorists followed suit, exploring new approaches to nursing theory and science such as phenomenology and existentialism. Some used the language of *spirit, consciousness*, and *goddess*.[6]

In her 1994 textbook on nursing theory, Barbara Stevens Barnum notes the polarity between the older and newer nursing theories. The older nursing process theories are associated with taxonomies and quantitative measures, whereas the new holistic theories use more qualitative measures and softer phenomena.[7] Nurses in both education and practice are feeling the impact of the shift from the old to the new approaches. This shift affects not merely our thinking about nursing, but also our nursing interventions and the way we make ethical decisions.

Barnum, like many other nurse thinkers, advocates a live-and-let-live approach between these two paradigms in nursing, arguing that both have something to contribute. If Kuhn is correct in his analysis, however, ongoing conversation between those using different paradigms is not possible. The struggle between them will continue until the new paradigm succeeds the old. While the naturalistic theories alone are much too narrow for nursing there are serious problems with many newer approaches. Christian nurses appreciate the new openness to spirituality but merely to add religion and spirituality as if they were the missing parts is to fail to grasp the depth of the issue. What is happening in nursing (and in our larger culture) is a major shift from one worldview to another. The new theories in nursing reflect this shift. It is at the worldview level that we must begin.

Beginning With Worldviews

Until recently the term worldview was part of the technical language of philosophers and anthropologists. Philosophers refer to worldview when they mean the basic assumptions that underlie a system of thought. Anthropologists use the term worldview more broadly to identify not only the well-springs of our thinking but our way of life as well. 'It shapes and integrates our various fields of knowledge from theology, anthropology, and missions to physics and the culinary arts. Worldview governs everyday behavior.'[8] 'They are made up of the categories, values, and assumptions we use to examine our world'.[9] Worldviews provide the cultural lenses that shape how we see the world and they give meaning to life, both personally and for humanity as a whole. They are like maps that give direction for action. The richer sense of worldview used by the anthropologists is most helpful for nursing.

Scholars trace some themes of the modern western worldview back to the Indo-European culture of the third

millennium BC. Anthropologist Paul Heibert describes the dualism of this worldview.

> . . . all reality is divided into two camps and the line between them is sharp. We see this in our American tendency to categorize in opposites: good-bad, big-small, sweet-sour, success-failure, and truth-falsehood.[10]

Dualism in modern thinking was reinforced by the introduction of Greek thinking into western culture during the Renaissance. Medieval Christianity drew a sharp line between spirit and matter. Their focus was the supernatural realm of God, Satan, angels, demons, heaven, hell, sin, salvation, and miracles.

During the Renaissance thinkers turned to the natural world of humans, animals, plants and matter. They began to view the world as autonomous, operating according to natural laws. Their hope was that the newly developing science would enable them to understand and use these laws to solve practical human problems.[11] While early scientists saw the world as an orderly creation dependent on God for its existence, increasingly people thought of God as distant. Humans were responsible for solving their own problems. This view eventually led to modern secularism that effectively eliminates God from public life. Personal happiness, comfort, and property became the central goals of western culture and science was seen as the means to achieve them.[12]

However, when science was applied to human beings it reduced them, made them less than human.

> [People were] animals ruled by needs and irrational drives (Freudian psychology), as stimulus-response machines (behavioral psychology), or as robots programmed by their societies and cultures (sociology and anthropology). God was gone, but so was the human soul. There was no real meaning in human life.[13]

While the modern worldview retains these dualistic human-centred themes inherited from the ancient Indo-Europeans and the Greeks, it has also been influenced by Hebrew and Christian thinking. The Bible has given the western world its strong emphasis on the value of the individual person who is not to be lost within the group. The biblical teaching that life has its source in God and that humans are created with the capacity to relate to God in a personal way has undergirded our respect for each person. The Creation story undergirds our belief that creation is orderly and that the 'laws' of nature can be discerned by science. Westerners perceive history as a climax, rather than as endless natural cycles, because moving towards a climax in the biblical story God acts in history and will finally bring it to a conclusion. Biblical values of love and justice have shaped western ethics.

Many thinkers argue that the modern worldview is collapsing and that we now live in a post-modern world. Despite the powerful benefits of science there is increasing recognition that science cannot give meaning to life. Many, including health-care givers, are calling for a more holistic way of thinking.

Recent theorists of nursing reflect this rejection of the modern worldview: Patricia Benner, Joyce Fitzpatrick, Margaret Newman, Rosemarie Rizzo Parse, Martha E. Rogers, and Jean Watson. Each of these thinkers is quite different from the others in her approach, but each is calling for something beyond the mechanistic, natural science approach to nursing.

Many postmodern nursing theories are based on an assumption that the world is made up of an impersonal energy that can be manipulated and controlled.[14] These theories are drawn from various sources in Eastern philosophy, Theosophy and traditional religions, including shamanism, native American spirituality, and Wicca.[15] Although this energy is claimed to be impersonal and non-religious, in practice it frequently takes on personality so that healing modalities become a 'channeling' or manipulation of spirits.

Some nurses—theorists, educators, and practitioners—are affirming pagan and folk religions as a source of new creativity and power. In these religions, 'not only humans, but also animals, plants, and even rocks, sand, and water are thought to have personalities, wills, and life forces'.[16] What these advocates fail to understand is that in these religions people are at the mercy of capricious invisible ancestors, demons, witches, ghosts, heavenly bodies, local gods, and impersonal forces of good and evil.

We challenge the idea that theories based on pagan religions are the answer to the inadequacies of mechanical naturalistic theories. Returning to shamanism and spiritism to appease spirits, or seeking to dominate reality by magic through rituals and formulas, will lead to dehumanization, disillusionment, and spiritual oppression. Instead nursing will flourish only by returning to its Christian roots.

The Christian Roots of Nursing

The beginnings of organized nursing in Norway illustrate a common pattern for how nursing became established around the world. Ingeborg Gjersvik tells the story:

> Around 1850 Norway experienced a spiritual awakening which motivated an important social awakening. People began to see the need to care for the sick and the poor The very thought of women caring for sick people outside of their own families, and furthermore establish a training course to do so, was unheard of and unacceptable in Norwegian society at that time. However, many prayer groups were formed, asking for God's guidance in this matter.[17]

The answer to their prayers came through Cathinka Gulberg, a pastor's daughter who used to make home visits to the sick with her father. One night Cathinka discovered that a homeless woman, who had been going from door-to-door begging for shelter, was found frozen to death in the snow. Deeply moved, Cathinka prayed about how she could make a difference. Soon afterwards, she found a leaflet about the Kaiserswerth Deaconess community and considered it an answer to her prayers. She studied nursing in Kaiserswerth, then returned to begin a nurses' training programme for deaconesses. The school expanded to include lay nurses, additional nursing schools were established and nursing spread throughout Norway.

Nursing grew out of a Christian worldview, in response to Jesus' teaching and example of caring for the sick. What

was it about the Christian worldview that motivated the early church to reach out to the poor, the sick and the marginalized?

While other worldviews of the time were focused on gaining control of the physical elements and spiritual powers, the early Christians looked instead to God as one who deserved love and obedience, and inspired loving service to others. That tradition of caring for others in the form of nursing has continued throughout church history.

What we believe about God shapes our understanding of human persons and the environment in which we find ourselves. That, in turn, informs our concept of health and directs us to the means by which we nurture one another toward health and healing. Hence, as Christians, we begin with a *theology* of nursing, more than a philosophy or theory. If we truly believe what we say we believe about God, we cannot help but act in obedience to him, which means communicating the good news of salvation, health and healing through word and deed.

The Christian worldview is neither the mechanistic understanding of modernism, nor the impersonal energy of postmodern theories. Rather it is characterized by personal relationship with God and other people.

God in the Bible

A theology of nursing must be centered on Christian doctrine as contained in the Scriptures and affirmed by the historic Christian creeds. The historic creeds of the church, such as the Apostles', Nicene and Athanasian Creeds, provide a definitive summary of essential theological understandings. Theologian Timothy Lull explains:

> The three Creeds specify the precise Jesus story which is the authentic witness of the Bible. They speak with increasing precision and length about the God who loved the world and about his coming among us in Jesus Christ. They speak of one God who made the world, but did not stand afar off when human beings fell into sin. Rather, 'for us and for our salvation he came down from heaven and . . . was made man.'[18]

The Trinitarian nature of God—Father, Son and Holy Spirit—forms the basic structure for each of the historic creeds. God is described as Creator of the universe who established both time and eternity, Redeemer of the world who entered history in human form to suffer and die for our sins, and Sanctifier of his people who continues to dwell among and within us. We can know God personally, but we cannot become God or force him to do our bidding. Furthermore, we can know God only as he reveals himself to us. We cannot merely shape God into whatever we want him to be. The Bible calls that idolatry.[19]

In Jesus we see God's presence with us in concrete terms. We know God is concerned about human illness and suffering because we read how Jesus healed the sick, cast out demons and even raised the dead. Furthermore, his whole earthly life was ordered around the ultimate purpose of going to the cross to suffer *for* us. 1 Peter 2:24 tells us, 'He himself bore our sins in his body on the cross, so that, free from sins, we might live for righteousness; by his wounds you have been healed.'

It is through Jesus that we receive the motivation and power to care for others. He is the clear demonstration of God's love for us,[20] and it is because he first loved us that we can love others.[21] Furthermore, he has blessed and commissioned us to go out in his name, continuing his works of caring, healing and exorcism.[22] Jesus said, '. . . the one who believes in me will also do the works that I do and, in fact, will do greater works than these.'[23]

We experience God's ongoing intimate involvement in our lives through the work of the Holy Spirit. Soon before his death, Jesus said that he would send the Holy Spirit as Counsellor (Advocate) to be with us forever.[24] This Spirit teaches us all things and guides us into truth. He guides us in our praying when we do not know how to pray.[25]

The Holy Spirit bestows gifts upon us and produces godly fruit in our lives. The *gifts* are those things which empower us to serve others in Christ's name.[26] Through these gifts we are able to participate in the work of God's kingdom. We are not left on our own to try to conjure up the power and ability to face the weight of suffering and death in nursing, the Holy Spirit gives us all that we need. We do all good things, including nursing, in partnership with God as we allow him to work through us.

The *fruit* of the Spirit is the character of God demonstrated in our lives—love, joy, peace, patience, kindness, generosity, faithfulness, gentleness, and self-control.[27] Jesus said, 'I am the vine, you are the branches. Those who abide in me and I in them bear much fruit, because apart from me you can do nothing.'[28]

At the same time we will become intensely aware of our own inadequacy and sinfulness. Recognizing our own sinfulness, and experiencing God's forgiveness, frees us to delight in the joy of his salvation. This relationship of grace overflows into praise to God and a life of service to humanity. Nursing, as a public ministry of the church developed out of this understanding of sin and redemption.

Implications for Nursing

How does this biblical understanding of God inform the way Christian nurses view the four basic concepts of the nursing metaparadigm: *person, environment, health,* and *nursing*? In the remainder of this article we will briefly consider each of these.

Person: According to the biblical worldview all people are created by God in his image[29] to live in loving relationship with God, self and others,[30] and to be responsible stewards of the environment.[31] Every person is separated from God by sin, but that relationship is restored by grace through faith in Jesus Christ in whom we are redeemed and sanctified by the Holy Spirit.[32] The person is a physically, psychosocially and spiritually integrated being with intrinsic value and significance.[33] Each person has a responsibility to adopt a healthy lifestyle[34] and to promote health,[35] but also to find meaning in inevitable suffering and death.[36]

Environment: According to the Bible the world was created by God, who declared it *good*.[37] The environment has been polluted by sin and awaits redemption by God.[38] The environment includes both physical and spiritual realities,[39] and encompasses the human community[40] and

culture. The creation is separate from God.[41] It is not God and cannot become God.[42] Each person has a responsibility to care for the environment as a steward of God's gifts.[43] The environment can bring both healing and illness. The effects of pollution and stress can contribute to disease. A clean, supportive environment can bring refreshment and healing. Thus nursing has a responsibility for the immediate environment of patients and and also the larger natural environment.

Health: Health is the goal of nursing, and the way we define it will have major ramifications in the way we practise nursing. It will shape our assessments and interventions, as well as the way we determine success.

In the biblical worldview, well-being/health is being able to live as God created us to be—as an integrated whole, living in loving relationship with God, self and others.[44] Health is central to the Old Testament concept of *shalom*[45] and the New Testament understanding of *salvation*.[46] The presence of sin in the world, and the predilection of each person to sin, impinge on health spiritually, physically and psychosocially.[47] Physical or psychosocial dysfunction can also cause spiritual distress.[48] While God's ultimate plan for us is complete health, a person can be spiritually healthy when physically or psychosocially limited.[49] Health is the goal of nursing and a sign of the kingdom of God.[50]

Nursing: Within the biblical worldview nursing is a ministry of compassionate care for the whole person, in response to God's grace. It aims to foster optimum health *(shalom)*, and bring comfort in suffering and death. Nursing includes the comprehensive physical, psychosocial and spiritual care of individuals in the context of families and communities. Because the healing work of Christ is a sign of the kingdom and a response to God's mercy,[51] nurses follow Christ's command to 'Go and do likewise'.[52] Nurses compassionately care for anyone in need, regardless of ethnic identity, race, gender, age, status, diagnosis or ability to pay.[53]

The actual tasks of nursing may vary as needs, contexts and resources change, but Christian nursing is always a faithful response to God's gift of salvation. We love others because God first loved us. That love is lived out in compassionate action toward our neighbours. This is both the understanding and motivation of nursing that a biblical worldview creates and sustains. Nursing developed from the Christian worldview. Only within this worldview can it flourish.

This paper was presented at 'The Christian Stake in Nursing' conference, sponsored by the Lindeboom Instituut, Christian Nursing College Ede and Reformed Nursing College Zwolle, May 29, 1998, Ede, Netherlands. It anticipates Shelly and Miller's forthcoming book, *Called to Care. Toward a Theology of Nursing* (Downers Grove: InterVarsity Press).

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2. T.S. Kuhn. *The Structure of Scientific Revolutions. 2nd ed.* (Chicago: The University of Chicago Press, 1970).
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9. Ibid., 204.
10. Ibid., 204–205.
11. B.R. Reichenbach, V.E. Anderson, *On Behalf of God: A Christian Ethic for Biology* (Grand Rapids, MI: Eerdmans, 1995), 11.
12. Consider for example the constitution of the United States in which life, liberty, and the pursuit of happiness are said to be the purpose of human life. The founders of America were strongly influenced by Enlightenment thinking.
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19. See Isaiah 44 for a graphic description of how God views our idolatry.
20. Jn. 3:16; 1 Jn. 3:1
21. 1 Jn. 4:19
22. Mat. 28:19–20; Mk. 16:17; Lk. 10:9; Jn. 14:12
23. Jn. 14:12
24. Jn. 14:16
25. Rom. 8:26–27
26. Rom. 12:6–8; 1 Cor. 12:8–10
27. Gal. 5:22–23
28. Jn. 15:5
29. Gen. 1:26
30. Deut. 6:4–6; Mat. 22:37–39
31. Gen. 1:26
32. Rom. 3:22–28; 1 Cor. 6:11
33. Ps. 8:4–8; 1 Thes. 5:23; Heb. 2:11–17
34. 1 Cor. 3:16–17; Eph. 5:29
35. Ex. 15:26; 3 Jn. 2
36. Rom. 5:3–5; 1 Cor. 15:54; 1 Thes. 4:13–14
37. Gen. 1
38. Rom. 8:22
39. Col. 1:16
40. Ps. 24:1
41. Is. 55:8–9
42. Gen. 2:7; Ex. 20:23; Is. 44:6–20
43. Gen. 1:28; 1 Pet. 4:10
44. Ps. 16
45. Ps. 38:3; Jer. 33:6
46. Lk. 18:42
47. Ex. 20:5; Ps. 32:3–4; Lk. 5:17–25
48. Job 16:7–9; Ps. 13;22
49. 2 Cor. 11:7–9; 1 Cor. 1:27–29
50. Rev. 21:1–7
51. Lk. 10:1–9
52. Lk. 10:37
53. Mat. 25:35–36; Is. 61:1–3; Lk. 4:18–19; 16:19–25; Gal. 3:28.

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Working Toward Shalom: The Core of Nursing Practice

Susan stood on my doorstep, a glowing picture of health. Her eyes flashed with enthusiasm for life and a deep sense of joy radiated from her face, but the large mass on her neck betrayed another force at work in her body. Susan was on her way home from radiation therapy for a rapidly growing thyroid cancer, but she had never felt more alive.

She wanted to tell me how much her relationship with God and the friendships she had developed within the congregation meant to her, and how that gave her a different perspective on her illness. She knew she was dying, but she felt at peace. She was ready to meet God, and she knew that her husband Joe would not be left alone—people in the church would continue to care for him.

Susan's view of the church had not always been so positive. As a young woman, Susan and Joe were active church members in a neighbouring congregation. She raised her family in a Christian home, and taught Sunday school for several years. However, after her daughters were confirmed they gradually drifted away from the church. When her oldest daughter became engaged, she called the pastor asking him to officiate at her wedding. The pastor refused, stating that she was no longer an active member, so it was against his policy to perform the ceremony for her. The incident hurt Susan deeply. She grew angry and bitter toward God and the church. She and Joe withdrew from the congregation and did not participate in any church activities for about twenty years.

During those years away from the church, Joe passed our church every Sunday morning on his way to the golf course. Each time, he felt something drawing him into the building. Finally, he began attending worship, then joined a Sunday school class, where he once again began to grow in his faith and delighted in the fellowship with people in the church. For years the Sunday school class prayed with him that Susan would release her bitterness and return to church with him. She slipped in occasionally, but kept her distance. Then tragedies began to strike. First a son-in-law died in an automobile accident. Then Susan's brother died of a rapidly-growing thyroid cancer. Within months Susan faced the same diagnosis.

Throughout all the crises, the church ministered to Susan through notes, visits, flowers and prayers. Susan's resistance broke down. She came back into a vital faith and began to enjoy fellowship of the church community.

As Susan's illness progressed and she became homebound, I visited her as a volunteer Parish Nurse. We discussed the importance of taking her pain medication and why she didn't have to worry about becoming addicted. We developed a strategy to deal with the side-effects of her medication. Our primary focus, though, was on her relationships: with her husband, her family, the church community and to God. We prayed together, wept and hugged. Susan died just before Christmas. Her funeral was a celebration of life and faith—a testimony to the health God offers us in his shalom.

What is Health?

What is health? The popular media portray it as youthful appearance, hard muscles, sleek bodies, clear skin and cavity-free teeth. Nursing literature is increasingly moving to the other extreme. Health is 'expanding consciousness' according to nursing theorist Margaret Newman.[1] It is 'essentially synonymous with *becoming*, which is an open, rhythmically co-constituting process of the human-universe interrelationship' according to theorist Rosemarie Parse.[2] One nursing text summarizes the current definitions of health as:

- 'a dynamic process
- determined subjectively and objectively
- a goal
- being able to take care of yourself
- optimal functioning in body, mind, and spirit
- integrity of self
- a sense of wholeness
- coping adaptively
- a subjective experience
- growing and becoming
- a broad concept.'[3]

According to current nursing literature, health is indeed a broad concept; so broad, in fact, that it ceases to be an adequate goal for nursing. Margaret Newman even states that, 'Health encompasses conditions that heretofore were described as illness, or in medical terms, pathology.'[4] For the most part, contemporary nursing definitions of health focus primarily on a state of mind. Older definitions and conventional wisdom (as represented by television commercials) focus on the body. The World Health Organization (WHO) idealistically defined health in 1946 as, 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'. This is a definition which medical ethicist Daniel Callahan says set the stage for a conception of health that literally encompasses every element of human happiness.[5]

Now I have said that Susan radiated health, despite her tumour. She obviously did not meet the WHO standard of health. On what basis could I say that Susan was 'healthy'? What is the difference between that understanding of health and Margaret Newman's? Susan demonstrated health in her attitudes and relationships, but the tumour itself was not encompassed in her health—it remained a very serious pathology. However, if we view the person as an integrated whole, created to live in harmony with God, self, others and the environment,[6] then health means being able to function as God created us to be. It involves reconciliation with God and others, forgiving and accepting forgiveness, loving and being loved, finding meaning and purpose in life leading to a sense of joy and hope, as well as freedom from physical ailments.

Health is Culturally Defined

Health, to some extent, is culturally understood. Boyle and Andrews identify three major worldviews that influence the definition of health: magico-religious, scientific and holistic.[7] The *magico-religious* views the world as an arena dominated by supernatural forces. It incorporates everything from primitive animistic cultures to Christian Scientists.[8] The *scientific or biomedical* health paradigm views health as the absence of disease and the body as a 'human machine'. It is based on determinism, mechanism, reductionism, Cartesian dualism, and objective materialism, and it 'disavows the metaphysical'.[9] The *holistic* health paradigm is similar to the magico-religious in that the forces of nature must be kept in balance or harmony and the human being must live in harmony with the larger universe. In this category Boyle and Andrews put American Indian and Asian cultures, as well as a growing following in the United States.[10] In the holistic model, health becomes 'achieving the best possible adaptation to the environment by living according to society's rules and caring appropriately for one's body'.[11] Despite a claim to be accepting of all cultures, it is quite clear which worldview the authors advocate.

Nursing theorist Madeleine Leininger explains: 'Our rapidly growing multicultural world makes it imperative that nurses understand different cultures to work and function effectively with people having different values, beliefs, and ideas about nursing, health, caring, wellness, illness, death, and disabilities.'[12] She sees human caring as the heart of nursing and a universal phenomenon. '*Health* refers to a state of well-being that is culturally defined, valued, and practiced, and which reflects the ability of individuals (or groups) to perform their daily role activities in culturally expressed, beneficial, and patterned lifeways.'[13] Hence, nurses must draw their goals for nursing from the persons or groups in their care.

Biblical anthropologists Bruce Malina and Richard Rohrbaugh attempt to uncover the cultural understanding of health found in the time of Jesus.[14] They stress that in ancient Mediterranean culture, a person's state of being was more important than the ability to act or function.

> Illness is not so much a biomedical matter as it is a social one. It is attributed to social, not physical, causes. Because sin is a breach of interpersonal relationship, sin and sickness go together. Illness is not so much a medical matter as a matter of deviance from the cultural norms and values.[15]

Hence, they view Jesus' healings primarily as restoring the person to the worshipping community. Healing is directly related to the cultural belief system.

Missionary physician Tony Atkins describes the African view of health in a similar way, as a function of community. He explains: 'It is an indigenous concept that acceptance within, and harmony with, family and society are important elements in healing and preserving the health of people.'[16] He compares the African view with the biblical understanding of health and concludes: 'For the Jew, as for many people in tribal societies today, health was essentially a positive quality that derived from the fact that people existed in total harmony with the world and in harmony with God.'[17]

A Biblical Understanding of Health

The biblical understanding of health is closely related to the concept of *shalom*. Often translated as *peace*, shalom actually incorporates all the elements that go into making a God-centred community—peace, prosperity, rest, safety, security, justice, happiness, health, welfare, wholeness. Christian philosopher Nicholas Wolterstorff defines shalom as 'the human being dwelling at peace in all his or her relationships: with God, with self, with fellows, with nature'.[18] The new Jerusalem described in Revelation 21:2–4 illustrates the meaning of shalom:

> And I saw the holy city, the new Jerusalem, coming down out of heaven from God, prepared as a bride adorned for her husband. And I heard a loud voice from the throne saying, 'See, the home of God is among mortals. He will dwell with them as their God; they will be his peoples, and God himself will be with them; he will wipe every tear from their eyes. Death will be no more; mourning and crying and pain will be no more, for the first things have passed away.'

Like the WHO definition, the concept of shalom is too broad to be the goal of nursing, but it provides a perspective through which we can frame our understanding of health. Linked to the biblical understanding of the person, shalom points us to how the healthy person functions. It includes the physical, psychosocial and spiritual dimensions of the person.

Theologian Paul Tillich illuminates the idea of *dimensions* by saying that the person should not be considered 'as a composite of several levels, such as body, soul, spirit, but as a multidimensional unity'. The dimensions do not 'lie alongside, but within each other'.[19] He then describes six dimensions: mechanical, chemical, biological, psychological, spiritual and historical. He proposes that health cannot be defined apart from its opposite—disease—and disease affects all dimensions of the person. True healing takes place only when all six dimensions are healthy; however, in this life we must usually be content with limited healing. Ultimate healing comes through Jesus Christ, who is the

soter—a Greek term that means both *saviour* and *healer*.

The inter-relationship between health and salvation in the New Testament is striking. When a group of men brought their paralyzed friend to Jesus, he responded by saying to the sick man, 'Your sins are forgiven.'[20] He then went on to heal him physically. There seems to be a relationship between the man's need for forgiveness and his illness. When a woman with chronic vaginal bleeding touched the hem of Jesus' garment, he replied to her, 'Your faith has made you well.'[21] implying a relationship between faith and healing. The Greek word, *sozo*, used here and elsewhere for *healing*[22] is translated in other passages as *salvation*.[23] When Jesus cleansed the ten lepers,[24] only one returned to thank him. Jesus told that man, 'Your faith has made you well *(sozo)*.' All ten were cleansed of leprosy, but only the one who returned found complete healing—and it was intimately wrapped up in his ability to praise God. The whole point of Jesus' healing of people was to restore them to a fuller, richer relationship with God and the faith community. Theologian Jürgen Moltmann explains:

> Healing consists of the restoration of disrupted community, and the sharing and communication of life. Jesus heals the sick by restoring their fellowship with God.[25]

Such a definition goes far beyond the scope of nursing, but it also reveals something of our relationship to other members of the health care team, and to the Christian community. Because we are multi-dimensional beings in need of holistic healing, we are also a multi-dimensional healing community. Nursing encompasses only one dimension of health care. However, the role of the nurse does not necessarily 'lie alongside' medicine and pastoral care, but in many ways it is 'within' both. It involves recognition that both the nurse and the person receiving care are members of a community and dependent upon God. Healing requires us to function harmoniously within those communities and in partnership with God.

Implications for Nursing Practice

What, then, are the implications of this multi-dimensional understanding of health for nursing? Florence Nightingale understood nursing to be taking 'personal charge of the health of others'.[26] If we are to take charge of it, we must know what it is!

While it may be true that we can never fully grasp the concept of health (hence the wide range of definitions) most people instinctively know what it means to be healthy. Perhaps Tillich's insistence that health can be defined only in contrast to its opposite—disease—can help to direct our understanding. People all over the world, in every culture, seek health care when pain or disability prevent them from attending to the activities of daily living. What are they hoping to find? At first they are looking for relief from pain, ability to function, and restoration to their social environment. This level is primarily physical. Beyond that, people may seek to eliminate the underlying causes of the immediate problem. At this level the psychosocial and spiritual dimensions enter into the health care spectrum.

When our operational definition of health neglects the physical dimension, nurses can justify avoiding the hard—and often unpleasant—work of caring for the body. We also eliminate the primary motivation most people have for seeking health care. Pain, nausea, fever and conditions that limit our ability to work and play drive us to seek help.

God created us with bodies. The physical is real. It is not an illusion. Regardless of how strongly nursing theorists may argue that the biological functions are illusory and can be controlled by the mind, we are still subject to injury and illness. We have only to stub a toe to be convinced. While the mind certainly has a great deal to do with well-being and healing, disease is real. Bacteria and viruses can invade even the strongest immune system. Cancer and heart disease afflict the most ardent health enthusiast.

Our definition of health must also include the psychosocial and spiritual dimensions. It is here that New Paradigm thought has stepped into the gap left by our over-dependence upon the scientific 'medical model' of health care.[27] New Paradigm holistic health care strikes a chord in people who have been conditioned by our modernist culture to expect that every physical problem can be 'fixed'. They turn to alternative therapies when scientific medicine does not work completely, or results in unpleasant side-effects, or proves exorbitantly expensive. One of the primary drawing points of these alternative therapies is the emphasis they place on touch and spending prolonged time with clients, as well as their appeal to ancient spiritual wisdom. Psychologist Elisabeth Hillstrom provides some helpful insights into why these therapies appear to work.[28]

First, they may be conferring actual physical benefits in ways that are not yet apparent to scientific inquiry. Research has shown real physical benefits of some herbal remedies, acupuncture and acupressure. It has not been able to demonstrate *why* they work, but it does suggest that these therapies may cause the body to release endorphins. Some alternative therapies may also bring real physical improvements indirectly through reducing stress and giving hope, love and a sense of meaning and empowerment.

In many cases, people attribute healing to alternative therapies when it is actually due to the body's ability to heal itself. Hillstrom quotes doctors as saying that 80% of physical ailments they treat would resolve themselves without treatment. Some benefits from holistic treatments can be attributed to placebo effect. Placebo effect has an actual physiological basis. It causes the body to produce endorphins which reduce pain and worry, allowing the immune system to function more effectively. The beneficial effects of emotional support and the communication of caring and concern can also aid in healing.

If these were the only effects of alternative therapies, we could easily incorporate them into Christian nursing. However, there are problems involved. Some apparent healings are fraudulent, and trick people into thinking they are healed. This can have devastating effects when the 'healed' person stops taking essential medication, or discontinues life-sustaining traditional health care. Furthermore, many holistic alternative therapies turn to occult spiritual beings for their power. Earlier nursing literature tried to cover these pagan influences with scientific language, but more recent articles blatantly advocate Eastern/occult spiritualities.[29] Hillstrom warns that

participating in these activities may well be flirting with the demonic, and we must keep in mind that God has strictly forbidden interactions with the spirit realm.[30] A Christian view of health must also incorporate a realistic understanding of human suffering and mortality, and the hope of eternal life. There are other forces at work in the world that we cannot fully control—micro-organisms, genetics, environmental pollutants, violence, accidents and spiritual influences. We are not God. We will eventually get sick and die. To view health as shalom means to stand with those who are sick and dying, and to encompass them within the fellowship of the Christian community and the presence of God.

Putting Health in a Larger Context

The Christian, then, places health within a larger context. It can be a radiant health in the midst of terrible physical disability. Conversely, health can be absent in a person with a well-toned body. Health usually shows itself as 'a state of physical well-being',[31] but ultimately it is shalom, a God-centred wholeness which enables the person to live in harmony with self, God, others and the environment.

Medical ethicists Stephen Lammers and Allen Verhey assert that 'Definitions of health turn out to be important because in doing the defining, we must explore the relationship of health to other human goods; the relationship of health and responsibility, both of individuals and of the medical *[nursing]* profession; and the relationship of health and those conventional modes of treating and coping with illness.'[32] So, how does health shape our goals for nursing?

Let's go back to Susan, my radiantly healthy, dying friend. As a nurse I acknowledged the value of expert scientific medical care, and dealt with her physical condition. At the same time, as a parish nurse I represented the caring Christian community, and worked toward a different kind of health. Together we worked toward shalom.

Health is essentially living according to God's purposes, even in the face of suffering and death. It includes the physical dimension; therefore, we work toward maintaining optimal physical function and providing comfort measures. However, complete health also means living in harmonious relationship with God and our neighbours; therefore, nursing also includes assisting patients in establishing and maintaining a relationship with God through Jesus Christ, as well as facilitating healing relationships among people.

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22. See Mk. 5:23; 6:56; 10:52; Lk. 8:48–50; 17:19; 18:42; Acts 4:9; 14:9; Jas. 5:15.
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Professional Responsibility in Nursing Theory and Practice

Response to Arlene Miller and Judy Shelly

What is the responsibility of Christians in nursing? The answer is not self-evident. Christian nurses are members of two communities: that of their fellow Christians and that of their fellow nurses. Membership of each community involves distinct responsibilities. How, then, do their Christian responsibilities relate to their responsibilities as nurses? For instance, as a Christian one has a responsibility to care for one's neighbour, but a nurse can care only for one patient at the time and only for a limited time.

How the responsibility of Christian nurses is developed depends in large measure on the challenges one faces. Some challenges are more urgent in a certain situation than in others. The challenge of how to draw the borders between nursing and medicine may seem more pressing to Dutch nurses than to nurses in some other countries. Perhaps in other countries the main challenge is a scarcity of resources—of which Dutch nurses have plenty. Christian responsibilities in nursing vary with the challenges faced by nurses.

Major Challenges

What, then, are the main challenges faced by Christian nurses, today? I would name the three following ones:

- *Resentment toward the Christian tradition of care.* In the Netherlands, many health care institutions which formerly were Christian have merged with other, non-Christian institutions. As a result, the Christian character has been watered down and the personnel ask themselves why they had a Christian character in the first place. In nursing theory, too, we discern a departure from the traditional, Christian point of view. Since the Second World War many nursing theorists have sought academic respectability by engaging in research and theory. The influence of the natural and social sciences on their thinking has, however, coincided with the marginalization of the moral and religious tradition of nursing care. Compassion, dedication, the sense of having a call, all those things are considered private at best, and old-fashioned at worst. The liberal, anti-religious stance affects both the methodology and the mentality of nurses. It affects them in theory as well as in practice.[1]
- *Depersonalisation or dehumanisation of care.* Again and again, we see an increasing reliance on science, technology, economics, and health care law. Care is provided according to protocol, routine, remuneration, and contracts. But however sound care may be from the scientific, technological, economic, or legal viewpoint, there are many who feel that something is missing from this bureaucratic, managed care. What they miss may be a bit of humanity, a personal touch, or an eye for the individual.[2] The businesslike approach of care suggests that the provision of care is religiously neutral and that anyone who works according to theoretical, technological, economic, or legal principles can do the job.
- *The pluralist, multi-cultural society.* Today's society shows increasing cultural diversity. Compared with a generation ago, patients as well as nurses are confronted with many completely different religious beliefs, habits, and needs. This is reflected both in theory and practice. In addition to the anti-religious and the religiously neutral challenges, then, a multitude of alternative religions face the Christian nurse.

The major challenges just mentioned are intrinsically interwoven. For they are manifestations of an increasingly modernist and secularized society.[3] The modern mind holds that human behaviour should not be governed by the tradition of Christian belief, but by the faculty of reason, which is seen as independent of any tradition or belief. Yet, religious independence or neutrality requires an often resentful liberation from the regnant religion, that is, Christianity. Indeed, it entails its own specific worldview: man as an autonomous, rational being; the world as manipulable building material; and God's existence as hypothetical. Thus, both resentment and neutrality toward Christianity invite alternative non-Christian worldviews in its place. Christian nurses may face different challenges in different situations, yet underlying them all is the communal challenge of the post-Christian society.

Shelly's and Miller's Approach

Given different situations, it comes as no surprise that several answers have been given to the common challenge

of post-Christian society. The answers provided by Judy Shelly and Arlene Miller deserve special comment.

Shelly's answer hinges on the biblical concept of health as opposed to other concepts of health that have entered nursing.[4] Some of these concepts broaden or narrow the biblical *shalom* concept of health in a way that is alien to the Christian worldview. But her answer is also relevant to the challenge of the depersonalisation that is taking place in health care and, also, in regard to questions such as: What aspects of the patient-nurse relation are the most important? What is the ultimate purpose of her interventions? Still further, her answer is a response to the abandonment of the Christian tradition of care. For it clearly addresses issues that rose only as a consequence of that abandonment. If we raise questions regarding the value of life, one of them must be who is worth caring for if there is no God calling us to care?

Like Shelly, Miller addresses the plurality of rival religions and world-views in today's theory and practice of nursing.[5] The modern world-view—as distinct from the postmodern one—centres on human control of the world, seen primarily in materialistic terms. The main instruments are said to be rationality and theory. As a consequence, nursing comes to focus on scientifically based methodology, theoretically warranted nursing diagnoses and rationally justified intervention. But, as Miller explains, this may conflict with the Christian way of thinking. This happens, for example, when the human person is seen merely as a mechanism or a machine, and the world is viewed as a system of merely natural processes.

The postmodern worldview, too, may conflict with the Christian way of thinking. This view replaces the mechanistic, naturalistic nursing theories with the diversity of experiences, needs and wishes of patients, emphasizing the subjective aspects of illness and disease. According to this understanding, there is no objective reality, let alone morality. The mind is all-important. This clears the path for many alternative, non-Christian world-views.

Miller's work also clearly responds to the challenge of depersonalisation in health care. It discusses the question of what theory and rationality, on the one hand, and the patient's perspective and spirituality, on the other, have to do with nursing practice. Furthermore, Miller's contribution is relevant in view of the abandonment of the Christian tradition of care inasmuch as this tradition avoids both physicalist reductionism and subjectivism by its holistic approach to the physical and the mental, the objective and the subjective, the material and the spiritual. In conclusion, Miller and Shelly are of help regarding the challenges Christian nurses face today.

History and the Nature of Nursing Care

Shelly's and Miller's defence of a Christian perspective on nursing is reinforced by other accounts of Christian nursing, such as the one by Ann Bradshaw published in this journal in 1997.[6] Her article focused primarily on the challenge constituted by the abandonment of the Christian tradition of care. She argued that the character of nursing changes irrevocably, both in theory and practice, when it is no longer inspired by the gospel ethos. In support of this claim, she points out how vital the Christian understanding of neighbourly love was to the history of nursing. This is to put the selfless attitude of caring care for vulnerable fellow human beings back on the nursing agenda. Undoubtedly, the abandonment of the ethos of neighbourliness harbours the risk of an instrumentalist, depersonalising attitude toward patients.

The Lindeboom Institute, too, supports a Christian approach to nursing. This is seen in its concept of ethically responsible care. Good care is not determined by what the majority wants, or what is scientifically or technologically possible. Nor is it determined by what health economics or health care law allows. It is defined in terms of the ultimate purpose of good care. By contrast, cost containment, limiting professional autonomy, will, at some point, run counter to the purpose of care, when for instance the good of the patient is no longer promoted.[7] Alternatively, if we take the view that professional behaviour in nursing is religiously neutral, this ignores the normative principles from which nursing originated.[8]

In these issues, the challenge of depersonalisation is central. To determine to what extent depersonalisation may be ethically acceptable, the Lindeboom Institute unpacks what care is all about. Such an inquiry necessarily implies a certain world-view. Ultimately, we say, care means supporting a fellow human being in need by promoting his health. To help is the primary intention behind nursing interventions. This intrinsic purpose of nursing is traditionally derived from the intrinsic value of the patient, that is, of the human being. It means, broadly speaking, to work towards shalom.

It should be added that the value of health is seldom achieved by a single intervention. Normally it requires a complex set of interrelated interventions, which we may call a 'social practice'.[9] Professional nursing is an example.[10] Inherent in such a practice are not only values, but also ways of achieving these values, and norms specifying which ways ought to be pursued rather than others.

As a normative practice, nursing evolved from a religious outlook according to which individual life is intrisically valuable. Attitudes, knowledge and skills took form within a particular social framework, which became a profession. Its members assume the responsibility of upholding its values and norms. Thus, the cause of good care is promoted when the practitioner herself shares the values and norms central to nursing.[11] However, nursing care changes dramatically when nursing's Christian heritage is abandoned, and is replaced by an appeal to theoretical, or economic, or even overtly alternative religious principles.

Conclusion

Reflections on the history and the ethical nature of nursing reinforce Miller's and Shelly's contribution. The challenge of alternative and rival world-views is intimately related to the abandonment of the Christian tradition and the arrival and acceptance of alternative world-views. But these challenges raise the question of whether one can change the values and norms of nursing practice at will. Surely, the ultimate responsibility is to care for a patient, which rules

out certain alternative accounts of the virtues involved in nursing.

In the face of the modern, western culture the Christian nurse faces anti-religious, religiously neutral, or alternative religious concepts of nursing. It is a battle on several fronts, which requires a shared effort on the part of the members of the body of Christ.

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'Why me, God?' Understanding Suffering

Introduction

One of the greatest acts a person involved in health care can perform is bring relief from suffering. This occurs in many ways, but from a Christian perspective the greatest source of comfort comes directly from God himself. In addition, God uses those who have earlier experienced his comfort to help those currently suffering. As the apostle Paul summarised:

> Blessed be the God and Father of our Lord Jesus Christ, the Father of mercies and God of all comfort; who comforts us in all our affliction so that we may be able to comfort those who are in any affliction with the comfort with which we ourselves are comforted by God. (2 Cor. 1:3–4)[1]

When Jesus Christ first made his ministry public he announced that he had come to bring relief and comfort to the poor, the captives, the blind, and the downtrodden (Lk. 4:18). Yet what we find in our own experience, as do many others, is that the very existence of suffering casts doubt on the very existence of God. If he is there, some conclude, he cannot be the all-loving and all-powerful God portrayed in the Bible. The tragedy is that those times when we most need the comfort and reassurance of a loving God can be the very times we most doubt his existence and his care and concern for us.

Many of the current ethical dilemmas in medicine revolve around suffering. Those experiencing suffering, and watching others suffer, propose ways to deal with the pain. Abortion is viewed as a legitimate way to deal with the 'suffering' of an unwanted pregnancy, or of preventing the child from having a life filled with suffering. Assisted suicide and euthanasia are proposed as solutions for those suffering too much. New technology is often developed to help people avoid suffering. But does the relief found with Viagra, for example, warrant its expense, and the broader goals it requires of medicine? The lengths to which society goes to avoid suffering reflects an inability to deal with its very existence and to understand the redemptive role it can play in life.

For those in the midst of pain, illness, or grief, questions about suffering are more personal. People ask such question as: 'Why is such a good person in so much pain?' 'How could such a healthy woman be struck down so young?' 'Where is God in all of this?' 'Why me?' This article will provide an overview of the many reasons given from Christian perspectives for the existence of suffering. Intellectual answers, no matter how reasonable or logical, may not bring relief to some in the midst of the suffering. Comfort, emotional care, and being present with the person may bring more relief.

However, to find comfort in God and his love, it is important to have seriously struggled with this problem and its proposed solutions before our bodies and feelings are screaming at us in pain. We need to think this issue through, and decide to believe that the God of the Bible is loving and powerful, in spite of the existence of suffering. Then we will be better able to cling to him in the midst of our own suffering. It will then be easier to accept in faith the

comfort and endurance he promises. Having dealt with the issue ourselves, we will be better prepared to help others reason through this problem and find God's comfort in their time of need. Having seen God work in our own pain and suffering, we will be more able to bring his comfort to those who need it.

The relentless nature of suffering forces everyone to struggle with this issue and to seek to understand why people suffer. Many great minds over the centuries have grappled with this question and have come to a variety of conclusions. Before accepting any of these, they must be evaluated in light of some authority. For Christians, that authority is the Bible (2 Tim. 3:16–17). However, even this is not a simple task, and some of the struggles in this area have been exaggerated by faulty interpretations of passages in the Bible regarding the causes of suffering. The proposed interpretations must be carefully evaluated since people's pain can be worsened by false solutions to the problem of suffering (Clendenin, 1988, p. 322). When interpreting a passage, proper attention must be paid to the context of the passage, and to the overall teaching of the Bible. This paper will evaluate the different explanations for suffering, and their objections, and particularly how these proposals compare to biblical teaching.

Statement of the Problem

The problem of suffering is usually presented in two ways, with different responses required of each. First of all, there is the claim that the existence of suffering (as one aspect of evil) and the existence of God are contradictory, or logically incoherent. This philosophical and logical problem requires an answer of the same nature. The second issue is why, even if it is logically consistent, God would still allow suffering to exist? What possible reasons could God have for allowing suffering? After considering the logical problem, the bulk of this paper will deal with the latter.

According to most commentators (for example, Plantinga, 1967, p. 116), the five propositions essential to traditional theism are: (a) that God exists, (b) that God is omnipotent, (c) that God is omniscient, (d) that God is wholly good, and (e) that evil exists. No formal contradiction exists between these, so another proposition must be added which is either necessarily true, or an essential part of theism. This is usually done by spelling out the meaning of the terms good, evil, or omnipotent. J.L. Mackie provides one example of how this is done:

> These additional principles are that good is opposed to evil, in such a way that a good thing always eliminates evil as far as it can, and that there are no limits to what an omnipotent thing can do. From these it follows that a good omnipotent thing eliminates evil completely, and then the propositions that a good omnipotent thing exists, and that evil exists, are incompatible. (Mackie, 1955)

At the outset, Mackie's principles appear logical, especially when today good actions are often considered to be those which cause no suffering or pain to others, and bad ones those which do. But, a closer examination reveals that this is not always so. Sometimes the choice of an action which causes suffering is judged as good if there is some greater good which is then achieved. For example, a physician causing pain by giving an injection is viewed as doing good if the substance injected brings a greater amount of relief. Similarly, if the consequences of relieving suffering would be an even greater evil, the good thing would be a lack of action. For example, when children are learning to walk, parents stand back from them, even though this may bring about suffering when the child falls. The greater good is that the children learn to walk, in spite of the suffering involved. Thus it is not necessarily true that to relieve suffering is always the most loving action for a person to take.

An objector may reply that this analogy with human actions fails because of human limitations. An omnipotent God would be able to figure out a way to remove the suffering without having to remove these greater goods. These arguments view an omnipotent God as one who can do anything. But this is not how omnipotence has traditionally been defined by Christian theists. It has been taken to mean that God has the ability to do anything which is not self-contradictory (Lewis, 1940, p. 16). Thus omnipotence does not mean that God can do something like creating an uncreated person. In relation to suffering this means that it would be impossible for God to make a world with certain types of good without at the same time allowing for the possibility of some types of evil.

Harold Kushner has responded to this issue somewhat differently. He concluded that God cannot be omnipotent, but is limited by the laws of nature and human moral freedom (Kushner, 1981). While Kushner finds it more comforting to believe in a God who wants to relieve suffering, but can't, this view is not compatible with the biblical description of God. But for most people it is not enough just to show that logically an omnipotent, loving God could allow suffering to exist. The existence of suffering and evil is not merely a problem of logic, but is a problem in our daily experience.

> If truth is a legitimate philosophical interest, then pastors and philosophers, believers and sceptics, theists and atheists all share a common problem of evil—the need for insight into the mystery of human iniquity and tragedy. (Wetzel, 1989, p. 6)

To turn to an all-loving and omnipotent God, who also allows us to suffer, requires that we truly believe he has some very important reasons for allowing suffering to exist. There must be some greater good that would not be possible in this world if God were to eradicate all suffering. Christians have made a number of proposals concerning what this greater good might be.

Theodicy

A theodicy is a justification for the existence of suffering and evil. A number of theodicies have been developed by theists, the most popular of which will be examined here. Each theodicy does not necessarily seek to explain all suffering, or claim to be better than all the others, but seeks to explain certain instances of suffering. One simple answer to the problem of suffering does not exist. But, when taken in combination, these theodicies provide many reasons for

believing that an all-loving, all-powerful God does exist and that he wants to comfort people and care for them in the midst of their suffering. However, Christians need to evaluate each of these theodicies since they are not equally consistent with the Bible.

1. The Free Will Defence

The most common theodicy is that the world is a better place because it contains moral agents who are free to choose between good and evil, even though this requires the possibility of evil occurring. The alternative is a world with agents who are not free to choose, and would therefore be more like robots than humans. It is taken as generally accepted that a world with only robots would be less good than one with moral agents. We see this in the desire many people have to raise children instead of buying robots. Children are morally free agents, and thus we cannot guarantee their choices. The same action performed by a freely choosing child and by a robot are regarded very differently. The child's action could be seen as morally good while the robot was simply performing its programmed task. Morality is not an issue with a robot. Thus, in our own lives we regard the existence of morally free agents as better than the existence of only robots.

To have a world where moral agents love one another, there must be the freedom to choose whether or not to love. If God created agents who were not free, then they would love others because they had no choice in the matter. It could even be argued that without freedom there could be no love. The good that comes from people loving one another, and God, outweighs the evil that results from people choosing not to love one another.

One objection raised to this theodicy is that if God could create people who could choose either good or evil, why did he not create people who would always choose good? But, this situation implies one of two things. (1) God could have created people who were free to chose good or evil, and then ensure that they always choose good. In this situation, God would be responsible for all actions, and not people, and thus we would not have morally free people. (2) God could have created people who always choose to do good. But this contradicts the idea of freedom, which entails that when faced with a choice either the good or the evil can be chosen. People who always choose good are not free to make moral choices. Therefore, this objection actually creates a contradiction. As C. Stephen Evans states:

> If God creates beings who are truly free, then whether they do right is at least sometimes up to them and not to God. (Evans, 1982, p. 136)

A second objection is the claim that God could have created people who were better able to resist temptation. Thus, while having the freedom to choose good or evil, they would have a greater ability to resist evil. Jesus is usually given as an example of just such a person. Although he was tempted in every way, he did not sin (Hebrews 4:15), and Christians are challenged to be like him (Philippians 2:5). John Hick admits that there is no contradiction in God making people who always choose to do good 'so long as we think of God's purpose for man . . . exclusively in terms of man's performance in relation to his fellows' (Hick, 1966, p. 310). But God's purpose also includes people entering into personal relationships with him. For a relationship to exhibit the attributes of trust, love, faith, obedience, etc., it must 'arise in a free being as an uncompelled response to the personal qualities of others' (Hick, 1966, p. 309). For this reason, each person must be able to choose whether or not to be involved in a relationship with God. If it has been predetermined in any way that a person must have a relationship with God, that relationship would not be viewed as authentic.

A third objection raised against the free will defence is that while God is justified in allowing people to choose to do evil, he is not justified in allowing that evil to come to pass. Instead, God could arrange a coincidental miracle to counteract the intended evil. This view is espoused by Steven Boer and Robert McKim, but has been critiqued (Dilley, 1990). Dilley raises three main objections. (1) A world governed by these constraints would require such a large number of miracles to prevent evil that the natural laws that we now have would need to be drastically revised. The Natural Law Theodicy section later in this paper will show that this type of world would not allow meaningful choices. (2) If evil cannot result from our actions, then the result must be good, and this would divorce outcome from intentions. This would also make intending to do good meaningless. (3) If every intended evil led to a counteracting miracle, the existence of God would be as empirically well-proven as the existence of Europe. It would then be irrational not to believe in the existence of God. But, God chooses to remain somewhat hidden from humans so that they will respond to him in faith, trusting that he exists and is loving (Hebrews 11:6). Otherwise, belief and trust in him would be forced on people in order that they might avoid being seen as irrational.

A fourth objection to this theodicy is the assertion that humans are not morally free in the first place. This view, called determinism, claims there are earlier events and circumstances which combine to be the sufficient causes of every apparent choice. Support for this position is usually derived from the successes of modern science. Physics shows us that the universe runs according to natural laws, while biology and biochemistry show that the physical body does also. It is claimed that all human behaviour can be explained in terms of Freudian unconscious motivations, Skinner's behaviourism, and operand conditioning, or the impact of society. For those areas where free will still appears to exist, it is held to be just a matter of time before science will show how these areas also are completely determined by pre-existing causes.

But this position is not as firmly established as it may appear. Determinism can be taken as a presupposition, but the evidence for it is far from conclusive (Hasker, 1983, pp. 29–55). With the advent of quantum theory, and the randomness seen in subatomic particles, modern physics is becoming less committed to absolute determinism on the subatomic level. Chaos theory is revealing that determinism may not be as valid on the macroscopic level as once was thought. Human behavioural sciences have made many predictions based on determinism which have not been borne out in practice. But most seriously, there is a high cost to holding to determinism. If reality is completely

determined, the experience of free will and moral responsibility must be an illusion. It can even be argued that rational thinking would not be possible in a determined world as even our thoughts would be simply consequences of earlier events. Creativity would no longer be real. Complete determinism can be rejected based on a lack of evidence, and the fact that its implications lead to a discounting of much of what makes human experience unique.

The Bible claims that God places a high value on free will and the choices that humans make. God created humankind in his own image (Genesis 1:27). The precise meaning of this term has been much debated, but in its immediate context it results in humans having dominion over the earth. The Hebrew term translated by image refers to the statues which were left by a king in those regions which were under his authority as reminders of his sovereignty and character. Given this meaning, humans are to serve as the representatives of God, carrying out what God would want accomplished on earth, and also revealing the type of person who God is.

But almost immediately, people rejected doing what God wanted, and decided to do what they themselves wanted (Genesis 3:6). The Fall was the source of the first human suffering. But rather than destroying humanity, which would have brought into question just how free human choice was, God decided to continue to work through humans to further his ways. God chose Israel, freed them from slavery, and gave them a land, not because of anything they had done, but so that he could bless them, and thereby bless all the nations (Genesis 12:1–3). If Israel had responded in gratitude to God, and obeyed his Law, relief from suffering would have occurred, and the world would have been drawn back to God (Deuteronomy 4:6–8; 7:14–15).

But Israel generally chose not to bring peace and comfort to others, but became as selfish a nation as any other. However, God was preparing to send someone who would be able to fulfil his law (Isaiah 49:5–6), and who would bring true healing (Matthew 8:17). This was Jesus Christ, whose death on the cross paid the debt owed by every person for sin (Colossians 2:14), thus restoring people's relationships with God and allowing the Holy Spirit to dwell in each new believer.

Rather than doing nothing about suffering, throughout history God has been preparing the way for true comfort and healing to occur. Through the empowering of the Holy Spirit, each Christian can have a powerful impact on suffering in the world. This is what God wants, but he still allows each individual to decide whether or not to pursue him and bring comfort to others. Some may feel that he should have given up by now and taken over control again, but he claims he is being patient so that more can decide to have eternal comfort with him (2 Peter 3:9). By 'holy conduct and godliness' Christians can even hasten the arrival of the day in which God will restore justice and end all suffering (2 Peter 3:10–11). This is a powerful acknowledgement of the significant role God offers to every Christian. God offers help and guidance to anyone willing to bring comfort to others, but the responsibility lies with each person to choose to do so, or to choose to increase suffering in the world, either actively or passively, through neglect or apathy.

2. Punishment Theodicy

Given this link between people's choices and suffering, the punishment theodicy claims that suffering is sent by God to punish people for their sin. This can be viewed either as punishment for one's own sin, or for sin in general. The Bible does teach that all human suffering ultimately stems from sin since God allowed suffering to enter his creation because of the first sin (Genesis 3:16–19). But this only begs the question as to why God would choose that consequence as opposed to some other one not involving suffering.

However, the link between sin and suffering is often expressed in a more individualised way. Some claim that God inflicts suffering on a person as a punishment for a specific sin. This is the sense in which this theodicy will be discussed here. In the face of suffering, reactions of the type 'What have I done to deserve this?' or 'Why is God punishing me this way?' reveal this belief. This belief is also revealed when people expect suffering to diminish in their lives as they mature in Christ or simply become 'better' people.

This view is often claimed to be presented in the Bible. The Old Testament repeatedly states that God will reward those who obey his law, and punish those who do not (e.g. Deuteronomy 11:26–28). But many of these rewards and punishments were promised to the nation of Israel as part of the covenant which they willingly entered into during a period when God's kingdom was geophysical, in addition to being spiritual (Deuteronomy 5:27). These punishments were given for specific actions, often after many warnings, and did not have the random character of general suffering. They should not be taken as the normative way God deals with all people at all times.

The Bible does say there are blessings for those who obey God (Psalm 128). While miracles may still occur, the blessings which are promised are linked predominantly to spiritual health and growth (3 John 2). Yet the abundant life promised by Jesus will include overall good health (John 10:10). The quality of our lives as Christians should always be improving, but this does not guarantee immunity from sickness or suffering. What is promised is a better way to deal with those times (Philippians 4:10–13).

If the Bible did teach that suffering occurs in this life in proportion to the wickedness of people, one quick look at the world would reveal the fallacy of that argument. The wicked obviously do get away with many things while apparently good people have to suffer their whole lives. This corresponds exactly with the type of world described in the Bible. Ecclesiastes 3:16 notes that wickedness has replaced justice and righteousness. Psalm 73 makes the same observation, which briefly led the author to wonder if he was keeping his heart pure in vain. The apostle Paul, in his desire to follow God and do his will, lived a life filled with suffering to a degree which most do not have to endure (2 Corinthians 11:23–33). In fact, Christians are promised that their suffering will increase simply because they are Christians (Hebrews 12:5–11).

This theodicy can also be objected to if punishment without explanation is viewed as retribution, not true justice. If suffering comes as punishment for particular offences against God, we do not usually get an explanation for it. Much of the anguish in holding to this theodicy comes from

trying to figure out what we did to merit this particular pain or suffering. Instead of randomly inflicting punishments on us, a just, loving God would explain why each punishment is being inflicted so that we can amend our ways.

Another objection is that if suffering is punishment for sin, how have children born with congenital diseases sinned? The only obvious answers were raised by Jesus' disciples when they asked him this same question (John 9:2). (1) The person sinned in the womb. This is discounted by Jesus, and the doctrine of the age of consent (Isaiah 7:16). (2) The person sinned in some earlier life, as various reincarnation doctrines hold. This doctrine is opposed to biblical teaching (Hebrews 9:27). (3) Children suffer for the sins of their parents. Some passages (e.g. Exodus 20:5; Numbers 14:18; Psalm 79:8) refer to the iniquity of parents being passed on to their descendants, which is viewed by some as support for this teaching (Reichenbach, 1982, p. 92). Reichenbach mentions that other passages teach that parents' punishment will not be passed on to their children (Deuteronomy 24:16; Ezekiel 18:20), but discounts them as being fewer in number. However, the Hebrew[2] and Greek[3] words most commonly translated by 'iniquity' do not represent the judicial punishment for sin, but the painful consequences of sin (Martin, 1969, pp. 34–5). These are manifested in the guilt which a person feels, destruction of community, and separation from God (Isaiah 59:2). Jesus' reply to his disciples in John 9:3 makes it clear that all suffering is not a form of punishment, and offers an explanation which will be considered shortly.

Two other passages in the Bible make it very clear that suffering is not usually sent as punishment from God. In the Book of Job, Eliphaz tried to convince Job (Job 4:7–8; 15:24–25) that his misfortunes were the result of his sin and that if he repented all would be well. But Job denied that this was the case, and was later vindicated by God (Job 42:7). In Luke 13:1–5 Jesus denied that the Galileans killed by Pilate and those killed by the falling tower of Siloam had died because they were worse sinners than those who had survived.

All the suffering in this world cannot be explained as punishment for sin. However, God has at times punished people for their sin by inflicting suffering. He did it at the Tower of Babel, Sodom and Gomorrah, the Flood, and a number of times to the Jewish people. When disease or suffering are sent by God as punishments, they are usually specifically warned of ahead of time. Many wonder how God could have done such deeds to so many people, but he looks at things differently. The Bible teaches that we all deserve death because we have all sinned (Romans 6:23). Instead of asking why God can be so cruel as to kill some people, we should be asking why God can be so merciful as to withhold the death penalty from many of us for so long.

Sickness may still sometimes be connected to some sin, which in that case should be confessed (James 5:13–16). Suffering may come as the natural consequence of sin, such as when sexual immorality leads to disease or emotional pain. But sickness is often completely unconnected to illness (John 9:1–3). Many godly people mentioned in the New Testament became ill without any suggestion that it was due to sin (Acts 9:36–37; 2 Corinthians 12:7–10; Philippians 2:25–30; 1 Timothy 5:23).

When we suffer from pain and illness, we need, in general, to look elsewhere than to God for its cause. He may choose to allow it to continue for reasons that are explored below. This was the essence of Jesus' response to the questions in Luke 13. He told his audience that there was no particular reason why those people died. However, those listening to him should examine themselves and note that they deserved the same fate. In light of that, they should turn to him and ask for his mercy and forgiveness. God's normative way of dealing with people is not to punish them with suffering every time they sin. We are told that God will punish individuals for their sin, but often not until the Day of Judgement. Those who appear to be getting away with evil will be punished at that time (1 Thessalonians 1:6–10). This truth allows us to bear with the apparently unjust distribution of suffering in the world.

3. Repentance Theodicy

This theodicy introduces the first of a number of possible beneficial effects of suffering. God designed people to be in intimate relationship with him and empowered by him for everything. But this has not been people's natural tendency since the Fall. We now want to be in control of our own lives and destinies, and are thus blind to our true needs (Jeremiah 17:5–8; Revelation 3:17–19). God wants to woo us back into his care (Jeremiah 31:20; Matthew 23:37). But often it takes suffering and need to get us to the point where we will turn to God. C.S. Lewis put it this way:

> God whispers to us in our pleasures, speaks in our conscience, but shouts in our pains: it is His megaphone to rouse a deaf world. (Lewis, 1940, p. 81)

This appears to be part of Jesus' response to his disciples in John 9:3 concerning why the man was born blind. He says that 'it was in order that the works of God might be made manifest in him'. In John 10:38 Jesus claims that the purpose of these works is that people might come to know the Father.

In the story of Cain and Abel, God allowed the righteous person to suffer an untimely death, while the evil person lived on (Genesis 4:1–15). God went to great lengths to rescue Cain because he was in danger of eternal death, while Abel's acceptance with God was secure (Stump, 1985). God's numerous interactions with Cain revealed that he was committed to helping Cain get right with him, something God wants for all humans (2 Peter 3:9). God even allowed his own Son to suffer terribly and die on the cross so that the greater good of many people coming to know him personally became possible (John 3:16–17).

Pain and suffering can be used to show us that our lives are not as they should be. They can awaken us from our pursuit of material things and worldly happiness. They show us that we are not really in control of our lives, no matter how much we think we are. They can cause us to turn to God in repentance. We may grant him the control of our lives we should have given him in the first place. This pattern is often heard in the testimonies of Christians. Many people have accepted Christ only after going through some type of bad experience: death of a friend or family member, illness, divorce, career failure, or a

life-long dream being put completely out of reach. It is also revealed in one of the common jibes thrown out against Christianity: that it is a crutch for people who can't make it themselves. In many ways this is actually true; Christians have come to see that we cannot make it in this world without God.

4. *Character Building Theodicy*

The positive effects of pain and suffering do not stop with the initiation of a relationship with God. God can use times of pain in our lives to mature us and deepen our relationship with him. For Christians, this also includes God's discipline. Just like a parent God sometimes allows his children to suffer, or even does things which feel painful to his children. Always, this is done for the good of the one disciplined:

> All discipline for the moment seems not to be joyful, but sorrowful; yet to those who have been trained by it, afterwards it yields the peaceful fruit of righteousness. (Heb. 12:11)

C.S. Lewis explains in great detail how God's love for people is the type which is committed to making them into the best people that they can be. This involves pointing out our faults, and empowering us to change. This is, by definition, going to be painful. But because of the good that comes from it, God is justified in allowing this type of suffering.

> You asked for a loving God: you have one . . . not a senile benevolence that drowsily wishes you to be happy in your own way, not the cold philanthropy of a conscious magistrate, nor the care of a host who feels responsible for the comfort of his guests, but the consuming fire Himself, the Love that made the worlds, persistent as the artist's love for his work and despotic as a man's love for a dog, provident and venerable as a father's love for a child, jealous, inexorable, exacting as love between the sexes. (Lewis, 1940, p. 35)

This explanation is also given in more philosophical terms when it is claimed that many positive human attributes develop only in the face of pain and suffering.

> Courage develops amid danger, perseverance in difficulty, honesty defying temptation, charity confronted with privation and need, self-sacrifice in the context of struggle, self-esteem in the face of challenge, confidence against uncertainty, love where obstacles abound. (Reichenbach, 1982, p. 97)

An objection raised against this theodicy is that while the suffering may sometimes lead to good character development, it often doesn't. For example, poverty may lead to charity, but it may also lead to indifference and even exploitation of the poor. In this area alone, who is to say whether the existence of poverty in the world leads to more evil or more good? Illness may bring some people closer to God, but others have rejected God because of sickness and disease.

While the points raised by this objection are valid, they do not invalidate this theodicy. It is the necessity of suffering for character development that is proposed, not the necessity that good must result. The outcome is ultimately determined by people's choices, which leads back to the free will theodicy. Much suffering exists because of the way people treat one another. God offers a way to bring good from this by changing people's characters, which will lead to less suffering. In this way, God can cause all things to work for good, for those who love him (Romans 8:28).

Another objection to this theodicy is that the characteristics said to be formed as a result of exposure to suffering could be developed in other ways. For example, courage and fortitude could be developed in light of a difficult or demanding task like space exploration, as opposed to being developed while in search for a cure for AIDS; help and co-operation could be developed in training for an Olympic team event, as opposed to carrying out complicated surgeries (Kane, 1975).

In response, Christianity claims that the problem with humans is not the characteristics they portray, but their will (Stump, 1985). As a result of the Fall, humans no longer have the capacity to will what they ought to will (Romans 7:14–21). This makes union with God impossible, and what is needed is the repair of our wills. God has left open the possibility that we can desire him to repair our wills, which an omnipotent God can do. Our experience of suffering is often what it takes to get us to the point of desiring this.

> Things that contribute to a person's humbling, to his awareness of his own evil, and to his unhappiness with his present state contribute to his willing God's help. (Stump, 1985, p. 409)

This is not a complete, instantaneous repair. As we experience God's healing in one area of our lives we are inclined to ask him to do more. The goal, then, is greater conformity to the divine will which allows greater union with God and leads to character traits more in accordance with those of Jesus (Galatians 5:16).

The character building theodicy has also been criticized for not explaining how evils like the suffering of a child can contribute to the child's salvation or character (Fales, 1989). This issue will be addressed later under Gratuitous Evil.

5. *Demon Theodicy*

The theodicies discussed so far deal with suffering which comes as a result of human choices, i.e. moral evil. But there is also much suffering which cannot be directly connected with the actions of humans, such as earthquakes, volcanic eruptions, and many diseases. These are collectively known as natural evils, and different explanations are often proposed for these.

Some evils which are often classified as natural evils may actually be moral evils. For example, famine may be regarded as due to a lack of action on the part of those who have abundant resources. One of the oldest theodicies treats all natural evil as moral evil by claiming that these are caused by Satan or his demons. Since the devil is the one in control of this world (1 John 5:19), he is able to use it to inflict suffering on people to push them away from God. For example, Jesus states that an illness he had just cured in a woman was inflicted on her by Satan (Luke 13:16). Conversion of natural evil into moral evil makes it susceptible to the theodicies covered earlier.

The main limitation with this argument is that there is very little evidence to support, or negate, it. Unlike Jesus, we humans cannot confidently declare that Satan caused an instance of suffering. While we must affirm Satan's continued involvement in causing suffering, the Bible gives few guidelines to allow discernment of this in actual situations. Anthony Flew claims that this is 'just another desperate ad hoc expedient of apologetic', to which Alvin Plantinga replies that 'to rebut the charge of contradiction the theist need not hold that the hypothesis in question is probable or even true. He need hold only that it is not inconsistent with the proposition that God exists' (Plantinga, 1967, p.151).

As such, this claim passes the test of logic. But for many people it does not provide a satisfactory explanation since it removes the discussion to a realm where we have little information, and in this sense makes theism a less realistic view. Therefore, other explanations for natural evil have been proposed.

6. Knowledge and Experience Theodicy

One of these theodicies is that God is justified in allowing natural evil because it is one of humanity's principal sources of moral knowledge (Swinburne, 1987). Through observing predictable events in nature people learn what actions cause or prevent pain, and thus what are morally bad or good actions. For example, from seeing the results of a fire started by a bolt of lightning we can deduce that it would be a bad thing for a person to start a similar fire. In addition, through experiencing the pain of natural evil, we can learn to sympathize with others experiencing similar pain, and also view inflicting that type of pain on others as wrong.

> If man is to have a free and responsible choice of destiny, he needs to have a range of actions open to him, whose consequences, good and evil, he understands, and he can only have that understanding in a world which already has built into it many natural processes productive of both good and evil. (Swinburne, 1987 p. 165)

An objection to this theodicy is that God could have given this knowledge in some other way which did not involve suffering. God did this in the past when he used prophets (Jeremiah 42:1–16), visions (Daniel 8–10), animals (Numbers 22:21–35), and inanimate objects (1 Samuel 23:9–11) to warn people of the consequences of their actions. But, even when it was widely acknowledged that these people brought knowledge directly from God they were rarely heeded.

Personal experience appears to be a better teacher than another's advice (Stump, 1983). It is important that people come to some understanding of right and wrong on their own so that they develop responsibility for their own decisions (Moser, 1984). If God had delineated right and wrong for every circumstance people 'would be so suffocated by God that they had little real choice of destiny' (Swinburne, 1987, p. 157). God's existence would become so obvious that it would be irrational not to believe in him. The problem with this situation has already been addressed.

This theodicy may give some helpful insight into the meaning of the tree of knowledge of good and evil (Genesis 2:17). Humans were tempted to become able to understand good and evil, and thus disobeyed God. The consequences were that humans were banished from the Garden of Eden and began to suffer pain. The knowledge of good and evil would then come through the pain which people would suffer. This would come from natural evil, but also moral evil, which would proliferate as a result of people's inherent sinful nature.

God accommodated the human desire to know good and evil apart from him. But this could be done only at the price of suffering. In his grace and mercy, God still instructs us about good and evil through the Bible and the Holy Spirit (John 16:8–11; 2 Timothy 3:16–17). But even this requires that we have some moral concepts with which to see the goodness of God's ways. Suffering teaches us enough about good and evil to enable us to judge that God is good, and that what the Bible teaches is good.

7. Natural Law Theodicy

Another explanation given for natural evil is that it is a necessary product of an orderly universe governed by natural law. In a world where choices are to be judged as good or bad, there must be a significant amount of predictability. Based on how things normally occur, a person can know with a good degree of confidence what the outcome will be. Therefore, they can be held accountable for the moral nature of their decisions. This can occur only in a universe bound by certain laws of nature which are independent of the desires of the involved parties.

So, when a boulder moves on a mountain-side we know that it will roll downhill. When it hits a larger boulder, it will probably be broken into smaller pieces. But when it rolls on to a road and hits a passing car, the car will probably be smashed and the passengers hurt or killed, causing grief to their relatives and friends and fear in other motorists. If the boulder was to stop rolling simply because its path could result in suffering, or if it was to cause no damage upon hitting a smaller, weaker car, we would lose much of our predictive powers. This would eliminate accountability and true moral choice, thus making natural evil amenable to the arguments of the free will defence. Therefore, God is justified in creating a world of this type and placing humans in it. However, when personal beings are introduced into a world based on natural law, natural evil and its accompanying suffering are inevitable by-products.

Some have argued that God could have made a world with different natural laws which would not have led to natural evils. However, natural laws are not abstract mathematical equations, but descriptions of how natural objects act and react under certain conditions (Peterson, 1982, pp. 111–7). To change these laws would require changing the very nature of objects. For example, water would have to become something in which people could not drown. That would involve changing all its related properties which make it the compound we are familiar with and which make it so essential for life. To change the natural laws would require changing almost all objects to such an extent that they would not be recognizable to us. Thus, we have no way of predicting what such a world would be like, and certainly no way of being assured that it would be a world

with less natural evil. In this case, the burden of proof is on the objector to provide a model of a universe with alternative natural laws. It remains reasonable to believe that God was justified in choosing the natural laws we have.

Another objection raised against this theodicy is that a loving God would protect his creatures from the negative effects of these natural laws by suspending them whenever evil was about to occur. So, for example, as the boulder continued on to the road it could become elastic and bounce over an oncoming car. But these types of 'miracles' would have to happen so often that people 'could not entertain rational expectations, make predictions, estimate probabilities, or calculate prudence' (Reichenbach, 1982, p. 103). The result would be a world 'in which wrong actions were impossible, and in which, therefore, freedom of the will would be void; . . . evil thoughts would be impossible, for the cerebral matter which we use in thinking would refuse its task when we attempted to frame them' (Lewis, 1940, p. 21). Therefore, moral choices would not be possible, which would not be desirable for the reasons given under the Free Will Defence.

8. Evidential Form of the Problem

This form of the problem admits that it is possible for God and evil to co-exist. This is treated as a hypothesis which is tested, based on the evidence available to support and refute it. Many people experience God as a loving God. They have read in the Bible that he is so, and believe he has acted in loving ways at many points in history. This counts as strong evidence for the theist (Evans, 1982, pp. 137–40). So, even though we may not be able to reconcile all the suffering we see, it must be remembered that our finite minds will not be able to comprehend everything. We must examine all the evidence, and though we may see the existence of evil as a difficulty; we can take it on faith that God is loving and has his reasons for allowing suffering.

This argument has the advantage of making use of all aspects of religious experience. It accepts the incompleteness of each theodicy. But taken together, they constitute a strong argument. It shows that there is an element of faith in people's willingness, or otherwise, to accept a resolution to this problem. On the other hand, it legitimizes the atheist's attempt to accumulate evidence and testimony contrary to the existence of a loving God, and boils the solution down to a choice between two arguments.

9. Gratuitous Evil

A problem with any theodicy attempting to explain every form of suffering is that some suffering seems to be beyond explanation. Foremost among these gratuitous evils is the extreme suffering which some children go through from birth. This, of all suffering, seems to have no redeeming value. This allegedly weakens the case for theism in that new explanations are seen as *ad hoc*. As we have seen, some theists claim that the apparent gratuity of some suffering is caused by the limitations of human reason, while others claim that these types of sufferings are punishments for sins committed. Others claim that it will all work out in the long run in heaven, so meanwhile we should just have faith.

However, some commentators have noted that these interpretations are not necessitated by beliefs about the character of God. Rather, they are based on the assumption that a loving God could not allow gratuitous evil to exist. This involves denying the experience and feelings of gratuitous evil and means that 'theodicy never relevantly addresses the very phenomenon it purports to explicate' (Wetzel, 1989, p. 11).

This assumption has been critiqued in detail (for example, Peterson 1982). This is not just a philosophical point of discussion, but has broader implications:

> A theistic case against gratuitous evil casts grave doubt on the reliability of human experience and on the moral and rational categories which condition it, and thus runs the risk of being self-defeating. (Peterson, 1982, p. 92).

Peterson assumes that if God gives people free will with the goal of accomplishing the maximum good, it must also be possible they can accomplish the maximum evil, which, by definition, would be gratuitous evil. Since the world needs to operate according to natural laws which do not seem easily changeable, the gratuitous nature of some natural evils is a consequence of the natural order, and not of a specific reason for that evil. Peterson claims that gratuitous evil is an essential part of God's hiddenness, which agreeing with Hick's thesis, is needed for humans to freely choose whether to believe in God or not. He claims that gratuitous evil is evidence *for* theism, revealing a God who places a high premium on creativity and moral effort and who wants to transform humans into his likeness. It reveals a God who wants to give the most to his creatures. But in order that this gift can be freely accepted, the environment must be a perilous one.

Theodicy does not explain each particular instance of suffering, but tries to explain the kind of world we have, which allows even the most gratuitous suffering to occur. This view leads to a change in the role of the theodicist (Schuurman, 1990). Instead of seeking an explanation for each case of suffering, the theodicist shows how suffering in general can be redemptive. This, in itself, can bring significant hope in the midst of pain. It gives someone reasons to cling faithfully to God while weathering the storm. This remains an important way to relieve suffering and spread the grace of God in the world.

Conclusion

Suffering exists, and causes problems for humans in their approach to God. We cannot be confident that we know why God allows each particular episode of suffering. Job never found out why he was suffering (Job 42:1–6). The relentless search for an explanation for each particular instance of suffering can even be a cause for further suffering. False explanations can cause even more pain, for example by inflicting false guilt, offering false hope, or denying the reality or extent of the pain. God does not promise to explain the cause of our suffering, but he does promise to be with us and help us get through the pain.

Not knowing why we are suffering is very different from claiming that suffering is inconsistent with God's existence. It has proved to be very difficult to demonstrate that

God could not allow evil to exist, even gratuitous evil. Instead, some very plausible arguments have been offered to explain why suffering in general does exist, and why God must allow it to exist.

In focusing on the intellectual side of this problem, it is important not to neglect or deny the emotional side of suffering. The Psalms reveal that God is very concerned about people's emotions and their healthy expression. Christianity goes much further than offering rational arguments for the co-existence of suffering and God. Through reflection on these arguments, a person's faith in God and trust in him in the midst of suffering will be strengthened. Having come to a personal conviction on this issue he or she will be less likely to waver at the precise moment when it is most important to cling to God. Our intellect can bring emotional comfort in the midst of suffering.

Through the example of Jesus' suffering we know that we have a God who can empathize with us in every way (Hebrews 2:9, 18). We have a God who wants to comfort us in our sufferings (2 Corinthians 1:3–11). This is accomplished directly by God and the Holy Spirit, but also through other Christians. The existence of suffering should motivate Christians to bring healing and comfort to those who are in pain (Philippians 2:1–8). The Christian also has a great source of hope in the knowledge that this suffering will come to an end, and will lead to a time of true peace and happiness (Romans 8:19–23).

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Notes

[1] Scripture references from the New American Standard Bible (La Habra, Calif.: Lockman Foundation, 1973).

[2] The most common Hebrew word translated as iniquity is *awon* (Harris, Vol. 2 1980:650–2). The other Hebrew word translated as iniquity is *awen* (Harris, Vol. 1 1980:23–4).

[3] The most common Greek word translated as iniquity is *adikia* (Brown, Vol. 3 1967:573–6).

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'Double Effect' and Palliative Care: A Legal and Ethical Outline

'Double Effect' in Medical and Nursing Ethics

Certain acts, such as torturing children, are always and everywhere wrong. Despite the popularity amongst some people, (not least certain prominent writers on medical ethics) of the notion that the end justifies the means, that nothing is wrong in itself and that the rightness or wrongness of an act turns solely on its consequences (a viewpoint often called 'consequentialism' or 'utilitarianism'), there is a widespread consensus that all human beings have fundamental human rights and that these rights ought always and everywhere to be respected. It is, for example, widely accepted that people have an inalienable 'right to life' and that it is wrong intentionally to kill an innocent person, even if killing that person would produce good consequences for other people.

Intention plays a crucial role in determining whether an action is right or wrong. 'Intention' means purpose, and should be distinguished from foresight. One may foresee something, even as certain, without intending it. For example, you may foresee as certain the discomfort associated with undergoing dental treatment, but you hardly intend it. Conversely, you may intend something without necessarily foreseeing it. You may, for example, buy a lottery ticket intending to win the National Lottery, but without foreseeing that you will.

Intention is important in medical and nursing ethics because it can not only determine whether an act is right or wrong, but it can define the very nature of the act itself. Take the example of two dentists, Filler and Driller. One day, both of them give their patients fillings. Both of them carry out exactly the same actions. Both of them know that those actions will cause some unavoidable discomfort to their patients. But imagine that, while Filler merely *foresees* that his patients will suffer pain, Driller *intends* them to suffer pain. We would surely say that, because of his bad intention, Driller's conduct, unlike Filler's, is morally blameworthy, and that while we might describe Filler's conduct as 'good dentistry', we might describe Driller's conduct as 'cruelty'. Driller's intention to cause pain determines the very nature of his conduct.

The importance of intention goes even further. For it not only tells us about the nature of the act: it also tells us about *the kind of person* who is doing the act. In a vital sense, we *are* what we *do*. As the ancient adage has it, an act forms a habit, a habit forms a character, and a character forms a density. If we are for others, we tend to form a charitable character. If we simply care for ourselves, we tend to form a selfish character.

So, morality is not just about consequences. Filler and Driller produced exactly the same consequences. But their different intentions meant that they were doing different things, one good, the other bad.

It is not, therefore, always bad to produce bad consequences. To know when it is morally permissible to produce bad consequences, we have to turn to the principle of 'double effect'. The principle explains when it is morally permissible to perform an act which has a good consequence, even though it may also produce a bad consequence.

You will find a clear discussion of this principle in Dr F.J. Fitzpatrick's *Ethics in Nursing Practice* (The Linacre Centre, London: 1988). Dr Fitzpatrick points out that the principle allows the performance of an act which has good and bad consequences only if the following 4 conditions are satisfied:

1. that the act itself is morally good, or at least morally neutral (that is, it is not an intrinsically bad act in itself).
2. the actor's intention is good (that is, he or she in no way intends the bad effect).
3. the good effect does not follow on from the bad effect (that is, the bad effect is not a means to the good effect).
4. that there is sufficiently serious reason for allowing the bad effect to occur (that is, the good effect which is intended is sufficiently valuable to justify tolerating the bad effect, and there is no other way of producing the good effect.)

It is this principle, long established in traditional Western ethics, which helps to explain why Filler acted ethically and Driller did not. This principle also distinguishes good palliative care, intentionally killing the pain, from 'euthanasia', intentionally killing the patient. It permits the intentional administration of palliative drugs to a dying patient to relive pain and distress, even if they will, as a foreseen but unintended side-effect, shorten life. Such conduct clearly satisfies the 4 conditions. First, the conduct (administering palliative drugs) is not bad in itself. Secondly, the doctor's intention (to relieve pain and not to shorten life) is good in itself and the bad effect is unintended. Thirdly, the

good effect (the alleviation of pain) is not produced by the bad effect (the shortening of life). Fourthly, there is a grave reason (the pain of someone who is already close to death) to allow the bad effect (the slight shortening of life).

The same analysis could be applied to justify the withholding or withdrawal of life-prolonging treatment which a dying patient would find too burdensome.

The principle has been criticised by advocates of euthanasia, who, as part of their argument that present medical practice and law are 'hypocritical' in allowing death to be foreseen but not intended, claim that there is no moral difference between foreseeing and intending death. Their arguments were, however, rightly and roundly rebuffed by the House of Lords Select Committee on Medical Ethics, which reported in 1994. The Committee concluded:

> Some witnesses suggested that the double effect of some therapeutic drugs when given in large doses was being used as a cloak for what in effect amounted to widespread euthanasia, and suggested that this implied medical hypocrisy. We reject that charge while acknowledging that the doctor's intention, and evaluation of the pain and distress suffered by the patient, are of crucial significance in judging the double effect. If this intention is the relief of severe pain or distress, and treatment given is appropriate to that end, then the possible double effect should be no obstacle to such treatment being given.

Dismissing the objection that intention is not readily ascertainable, the Committee observed: 'juries are asked every day to assess intention in all sorts of cases, and could do so in respect of double effect if in a particular instance there was any reason to suspect that the doctor's primary intention was to kill the patient rather than to relieve pain and suffering'.[1]

Finally, while intentionally killing the innocent is always wrong, it should not be thought that *un*intentional killing is not always wrong. For it is also unethical *negligently* to kill. And there may well be far more negligent killing in British hospitals than intentional killing.

'Double Effect' in Criminal Law

Just as the principle of 'double effect' is well-established in medical and nursing ethics, so too it is clearly established in English criminal law. In criminal law the word 'intention' bears its ordinary, everyday meaning of 'purpose'. The law, like traditional medical ethics, distinguishes clearly between intention on the one hand, and foresight on the other. For example, the offence of murder involves causing death with intent to kill or cause serious harm. Foresight of death or serious harm is insufficient. And while foresight can be evidence of intention, it is never the same as intention. For example, the fact that a brain surgeon who performed delicate neurosurgery on a patient, which proved fatal, foresaw that the patient might die as a result does not prove that the surgeon intended the patient to die.

That the criminal law incorporates the ethical principle of 'double effect' is illustrated by the trail of Dr Nigel Cox. Dr Cox, a hospital consultant, was tried for the attempted murder of an elderly patient who was dying in pain. The prosecution alleged that the doctor, who had administered potassium chloride to the patient, had done so with intent to kill her. The trial judge directed the jury:

> It was plainly Dr Cox's duty to do all that was medically possible to alleviate her pain and suffering even if the course adopted carried with it an obvious risk that as a side-effect—note my emphasis, and I will repeat—even if the course adopted carried with it an obvious risk that as a side-effect of that treatment, her heath would be rendered likely or even certain.

He added:

> There can be no doubt that the use of drugs to reduce pain and suffering will often be fully justified notwithstanding that it will, in fact, hasten the moment of death, but please understand this, ladies and gentlemen, what can never be lawful is the use of drugs with the primary purpose of hastening the moment of death.[2]

Dr Cox was convicted. By contract, doctors who follow the principle of 'double effect' have nothing to fear from the law of murder.

Conclusion

The principle of 'double effect' is well established in traditional medical ethics and in English criminal law. It informs and guides good palliative care and distinguishes it from 'euthanasia'—intentional killing of patients. The principle remains an essential aspect of sensible medical ethics, good palliative practice, and sound criminal law.[3]

Notes

1. *Report of the House of Lords Select Committee on Medical Ethics* (HL Paper 21–I of [1993–4] para 243.)
2. Kennedy and Grubb, *Medical Law: Text With Materials* (Butterworths, 2nd ed., 1994) p. 1309.
3. As further reading, see: Luke Gormally, *Euthanasia, Clinical Practice and the Law* (The Linacre Centre, 1994); John Keown (ed.) Euthanasia Examined (Cambridge University Press, 1995); John Keown, 'Restoring Moral and Intellectual Shape to the Law after *Bland*' (1997) 113, *Law Quarterly Review*, pp. 481–503.

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Book Reviews

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Remaking Eden: Cloning and Beyond in a Brave New World
Lee M. Silver
Weidenfeldt & Nicolson, London
ISBN 0 297 841351 317 pp., hardback, £20.00

As the title *Remaking Eden* suggests, this popular science volume by Lee M. Silver, of Princeton University, is about playing God. The subtitle, *Cloning and Beyond in a Brave New World*, further suggests that, like Aldous Huxley's book, Silver's book sets out to be prophetic. Time will tell whether or not it is.

Certainly, it clearly and succinctly explains to the layman the latest technologies in medically assisted reproduction.

In so doing, it proposes a number of different reproductive scenarios. Some of these may be described as science fiction, but they are not necessarily clairvoyant insights into the future.

They are all couched in terms reflecting a bias in favour of genetic determinism. This is a kind of reductionism that does not convince everyone. While single genes may determine or at least predispose us to a number of physical illnesses, the case for arguing that all or most of our intellectual and emotional make-up is thus programmed is much weaker. Insofar as mental characteristics are genetically regulated, these characteristics may prove to be linked to a combination of genes and mostly reflect needs or cravings and more specific potentialities and inabilities such as a gift for languages or dyslexia. Not only nature but also nurture plays a role in forming human character and, especially, in developing both physical and mental skills and artistic and moral awareness and sensitivity, all of which will be reflected in different ways in particular actions depending on the circumstances.

Silver's book opens with a vision of a future world, in which there are two types of human, the GenRich and the Naturals. The GenRich carry synthetic genes, enhancing different socially desirable physical or mental qualities. The Naturals are, like us, products of the mating of unadulterated paternal sperm and maternal egg.

Of course, there are no synthetic human genes available for this scenario to be realised today. But within the next few years the human genetic code will have been cracked. When this has been done, it might be possible to start experimenting with synthetic genes. But whether these experiments will initiate the development of a super-race is a moot point.

Speculating about the origins of life, Silver proposes an evolutionary theory, leaving it open whether life was initiated by a Creator or by chance. But optimistically he claims that this is a question for science and that one day it will have the answer. However, as theologian I take a different view and would argue that God does not let himself be known by science, though he may reveal himself in nature as well as in the Holy Scriptures.

The chapters dealing with embryological development propose a Lockean understanding of personhood in the vein of Peter Singer. Personhood or 'live humanhood' is described in terms of actual consciousness and self-consciousness. And so Silver argues that the human infant, fetus and embryo have little right to the protection afforded the adult human, since they lack those intellectual traits that characterise the normal healthy adult of our species.

Silver's accounts of various reproductive technologies such as *in vitro* fertilisation (IVF) with or without donated egg or sperm, of surrogacy and embryo storage are pedagogical and easy to read. So too is his explanation of the cloning technique and its applications both for reproductive purposes and for other purposes such as the generation of tissue identical to a person with a view to transplantation, the recipient being the very same person. But as a scientist he has little time for the moral aspects of the techniques.

This does not mean that his account is morally neutral. Discussing the kind of motives people might have for producing children by cloning is, he advocates the right to produce children by cloning in order to use them instrumentally as organ donors for sick siblings—though he does not suggest that the clones might be used purely as spare parts and killed. Moreover, in his view, there is nothing wrong in producing children as replacement copies of dead siblings. Nor, to his mind, is there anything wrong with the idea of a single woman gestating and giving birth to a clone, an identical copy of herself. In short, he would happily cater to the selfish individualist who takes an instrumental view of children.

Are negative reactions to his suggestions merely expressions of the yuk factor? Or, are they underpinned by more serious reasons, relating to our understanding of human dignity, human relationships and the needs of children? I think the latter. On the Judeo-Christian understanding, according to which all human beings are equal in dignity, because we are all created in the image of God, for one person to use another as a mere means represents a failure to respect the equal human dignity of that other person. And the concept of human solidarity, fostering respect for others, is not the prerogative of the people of the Book, but exists in other cultures too.

As an author of science Silver writes well but his is not a morally uplifting book.

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Bringing the Hospital Home: Ethical and Social Implications of High-Tech Home Care
John D. Arras, Editor
Baltimore and London: Johns Hopkins University Press, 1995
ISBN 0-8018-4990-X, 259 pp., $40.00

In the fast-growing and often volatile area of the health care industry, home health care has literally exploded, becoming 'the fastest-growing sector of the entire health care economy' (p. xiv). Such growth is partly due to the 'graying of society'—there are more people alive today who are susceptible to the chronic diseases that home care can often address. It is also partly the result of cost-cutting measures which benefit both the health care institution and the consumer. In many cases it is simply cheaper to treat the patient at home (p. xiv). Lastly, we as a society have come to realise that there is something therapeutic about dealing with disease at home, instead of in the sterile, often cold environment of the hospital. Patients often do better if they can heal at home.

But, in all this rush to move the patient home, there has been a dearth of ethical analyses that address the unique issues that accompany home care. Certainly bringing the hospital home calls for a new definition, not only perhaps of 'hospital,' but also of 'home'. Home is a place usually associated with the smell of baking cookies, not urine disposal; the sight of order and beauty, not bed pans and soiled sheets. Thus, home health care will definitely impact how we think about the family environment. Spouses and adult children may now experience firsthand what a nurse experiences —Arras' book is thus a timely addition to bioethical literature.

The text is careful in its reasoning and appropriately nuanced throughout. For example, Arras notes that there is not simply one level of home health care but many: it is really only at the most advanced level of home health care that ethical issues become so pressing (p. 1). For example, who can argue with technology such as patient sensors that warn when patients wander beyond certain boundaries? The cost and intrusion on patient autonomy is low, and such innovations can often be a substitute for the costly practice of having to hire an on-site worker.

But, as Arras notes, at the most sophisticated level, home health care can impose significant burdens upon caregivers (p. 6). Such unpaid caregiving means that not only will laypersons be responsible for machines often costing many thousands of dollars, but they must readjust their schedules to make time for operation and maintenance of the machine. Such impacts often serve not only to raise the stress levels of caregivers, but to impact their health significantly. Simply put, it is hard on one's health

to see one's home turned into an advanced geriatric ward.

Clearly, the benefits of a home-like environment have been noted by many segments of the health care industry for a long time. The hospice movement deliberately patterns itself after the soothing and informal ambience of home. But, as William Ruddick notes, in 'Transforming Homes and Hospitals', some patients actually *prefer* the formal environment of the hospital —especially when it comes to dying (p. 175). They are uncomfortable in 'imposing' their dying upon their family environment. In addition, the informality of home can lead to problems by well-meaning but uninformed and untrained family members and volunteers. There is more potential for abuse in such a setting.

Arras's text is well-organised, with contributors writing on the effects of home health care on families, as well as the more usual philosophical and ethical elements of the issue. It thus does a good job of balancing the theoretical and the practical, making it a necessary read for those contemplating 'bringing the hospital home'. As the baby boomers age, and they increasingly face the dilemma of how to care for themselves and their elderly parents, they will have to face (and deal with) precisely those issues raised in this book. Additionally, it would be a nice text in a bioethics 'issues' course—and it is also a good read. Who said scholarship had to be either impractical or dull?

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Alternative Medicine and Ethics
James M. Humber and Robert F. Almeder, Editors
Totowa, NJ: Humana Press, 1998
ISBN 0-89603-440-2, 220 pp., hardback $44.50

The Alternative Medicine Handbook
Barrie R. Cassileth
New York, NY: W.W. Norton, 1998
ISBN 0-393-04566-8, 340 pp., hardback $25.00

Alternative medicine continues to grow in popularity, especially in the US (Eisenberg et al. *Journal of the American Medical Association* 280 [1998]: 1569–75). However, this trend has, as yet, received little serious ethical reflection, and even less theological analysis. Hence, it was with great anticipation that I received Humber and Almeder's *Alternative Medicine and Ethics*. The cover of this 1998 addition to Humana's Biomedical Ethics Reviews stated the contributors were 'leading bioethicists and philosophers'. The issues addressed were certainly important, but were predominantly legal concerns, reflecting the legal background of most contributors. Ethics was rarely the focus of the contributions.

The first article provided an excellent overview of popular alternative therapies with little or no scientific evidence supporting their efficacy. Its author, Stephen Barrett, MD, is a long-time critic of alternative medicine through his involvement in the US with the National Council Against Health Fraud (recently renamed the National Council for Reliable Health Information). However, little discussion of ethics was included, apart from his assumption that only scientifically validated therapies should be promoted.

The second article, by Vimal Patel, PhD, helps explain the current interest in alternative medicine, and the forces behind it. However, his ethical positions reflect many of those implicit among promoters of alternative medicine, but are neither elucidated nor defended. For example, he claims that people should have complete freedom of access to all forms of healthcare. His only defence is to quote from Benjamin Rush, physician to US President George Washington. Patel does not mention that Washington died at age 57 while being treated for a cold and tonsillitis. Medicine of the time, unshackled from evidence, led to Washington being bled, purged, and blistered until he died (Arthur K. Shapiro and Elaine Shapiro, *The Powerful Placebo* [Baltimore and London: John Hopkins University Press, 1997], p. 29).

While making important points about problems within conventional medicine and benefits within alternative medicine, Patel was carried away by his enthusiasm for everything alternative. For example, he claimed that until a few years ago any medical institution would have been considered 'weird' for giving any importance to physician-patient relationships and communication. While improvements are certainly needed here, medical ethics has raised many of these same concerns for decades.

The next three articles provide helpful surveys of US laws related to alternative medicine, which at times touch on ethical issues. Grace Powers Monaco, JD, and Gilbert Smith, JD, reviewed the legal responsibility of insurance payors to act as gatekeepers. Insurance companies have needed to ensure covered therapies are scientifically validated to demonstrate wise stewardship of premiums. This has also protected insurance companies when sued for non-provision of therapies provided they could show there was little evidence supporting the therapy's effectiveness. If non-validated alternative therapies are now covered, this protection will disappear.

S. Mitchell Weitzman, JD, described the US insurance plans covering alternative medicine and surveyed the regulatory status of US alternative therapists. This was followed by G. Steven Neely, JD, explaining the law allowing Christian Scientists to refuse reasonable medical treatment for their children. This issue will become more prevalent as more people resort to spiritual healing instead of conventional medicine.

The final article, by John K. Crellin, MD, PhD, was by far the best, although also the shortest. Alternative medicine raises ethical challenges for pharmacy, and Crellin placed this within the context of pharmacy's debate over its primary identity. Herbal, dietary, and homeopathic preparations are commanding a growing presence within pharmacies. Whether this is appropriate depends on whether pharmacy views its scientific foundations or its commercial interests as primary. Many of these issues must also be debated by other health professionals. While this chapter raised the issues, little in the way of resolution was offered.

Another problem with this book was its frequent typographical errors, especially discouraging given its price. But the larger issue remains its failure to address ethical issues. For example, both Barrett and Patel conclude with glossaries including many of the same alternative therapies. However, after reading Barrett's description, one would wonder why anyone uses the therapy; after reading Patel, one would wonder why anyone opposes it. Issues of evidence are at the centre of many controversies in alternative medicine. What evidence should be demanded for the success of therapies before they are promoted to 'consumers'? How should this evidence be presented to patients? Should health care practitioners promote or critique therapies? How should health care practitioners present therapies for which little or no evidence of benefit exists?

These questions, and others, need attention so that alternative medicine, in whatever way it is provided, adheres to the highest ethical standards. While these discussions occur, accurate information about alternative therapies is needed. Among the myriad of handbooks on alternative medicine, Barrie R. Cassileth's stands alone. Other handbooks generally only explain the background of the therapies and repeat the positive claims made for them. Cassileth has been actively involved in researching alternative medicine since the late 1970s, but does not promote any particular therapy. She was a founding member of the Advisory Council to the NIH Office of Alternative Medicine, and holds faculty positions at three US medical schools. While critiquing alternative medicine's excesses, she has maintained open communication with its promoters.

Cassileth's handbook succinctly summarises fifty four common alternative therapies. Each is discussed under five headings: what it is; what practitioners say it does; beliefs on which it is based; research evidence to date; what it can do for you; where to get it. Since books have been written about each therapy, Cassileth does a remarkable job summarising them. The information is accurate and current, and Cassileth does not hesitate to point out when the claims made for a therapy are not supported by research. Her 'what it can do for you' sections give reasonable suggestions why a therapy may 'work' even if not physiologically active.

Cassileth's handbook provides an excellent general understanding of the therapies included. If patients are interested in trying a therapy, its summary, if here, would be very helpful. Unfortunately, to give enough detail, the number of therapies discussed is somewhat limited. A more significant limitation, though, is the absence of references or a bibliography. Those interested in evaluating a therapy more thoroughly would be greatly helped by a few references to other resources. Instead, Cassileth includes contacts for organisations providing the therapies, which may not be the most objective sources of information.

Readers of this journal should also be concerned about the spiritual implications of many alternative therapies. Cassileth describes these just as she does other therapies, raising no particular concerns about their spiritual dimensions. Before giving advice on these, such as with shamanism, Christians will need to read further and have spiritual discernment. In spite of these limitations, Cassileth's book is one of the best secular resources available.

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Genetic Ethics: Do the Ends Justify the Genes?
John F. Kilner, Rebecca D. Pentz, and Frank E. Young, Editors
Grand Rapids, MI & Cambridge, UK: Eerdmans and Paternoster, 1997
ISBN 0-85364-814-x, xi + 291 pp., paperback $22.00

Genetic Ethics: Do the Ends Justify the Genes? is an excellent and very readable overview of many of the aspects involved in the field of genetic ethics. After introducing the challenges and dilemmas facing the field of genetic ethics, the book is divided into three parts. In Part I, entitled Genetic Perspectives, the main issues addressed are those of History, God's Sovereignty, and Humanity. The historical perspective on the eugenics movement given by Arthur J. Dyck, PhD provides a framework for understanding how the science of genetics itself has promoted the philosophy of eugenics. It is very important that as Christians we understand and combat the humanistic world view behind the science of eugenics, a view that has its roots in social Darwinism, and that has been played out in the 'racial hygiene' efforts of Nazi Germany (p. 26).

This chapter also explores the underlying 'religion' of scientific materialism as described by E. O. Wilson (p. 36), which essentially has stripped away beliefs both in human equality, and in the human tendency toward sin in our fallen state. By doing this, Wilson has attacked the 'pillars of democracy without replacing them', and, 'He takes science . . . to be the one source of truth' (p. 36). As Dyck puts it, 'we would do well to remember that the appeal to pure science helped silence opposition to the Nazi party and helped gain support for Nazi policies' (p. 36).

The second chapter, written by Nancy R. Pearcy, MA, also deals with history by examining the evolution of 'world views' and their relation to the use of modern technology. In particular, the author discusses the influence of Christian thought in the advancement of scientific technology, as well as how Christian ideologies have been changed by liberalism which 'adopted Christian ideas and employed them out of context' (p. 45). The plea of this chapter is for Christians to understand the world views upon which beliefs are based, and to 'stand firm on the biblical meaning of charity, buttressed by an awareness of historic Christian thought' in order to 'discern the difference between true scientific progress and well-meaning totalitarianism' (p. 47).

The remaining chapters in the first section of the book biblically apply God's sovereignty to the problem of genetic abnormality, explore the philosophical problems surrounding the use of the term 'playing God,' and deal with the issue of our humanity. Genetic reductionism is defined (p. 75), and ways to combat this ideology by restoring context based on the 'Genesis mandate' are presented (p. 90).

In the second section of this book, both the search for and application of genetic information are discussed. Francis Collins, MD, PhD explains both the benefits and risks of the Human Genome Project in chapter 7, and challenges the church to become informed. Chapter thirteen of Part II, written by Martha Newsome, DDS, presents ways in which Christians can become better educated in the field of genetics, as well as how we can effectively present the Christian perspective on the 'new genetics' to believers and unbelievers alike. By acting in an educated manner, Christians can have greater influence on those to whom we seek to be salt and light. The other chapters in Part II inform the reader of basic genetic issues, including behavioural genetics and germ-line genetic intervention, the role of patents in the progression of genetic research, issues associated with genetic testing, and the role of genetic counselling.

In Part III of this book, the issue of Genetic Intervention is explored in the context of both assessment and engagement. Genetic Therapy is defined, and the theological and ethical standards for genetic intervention are explored. The implications of genetic intervention are examined through the case of Human Growth Hormone.

The second half of Part III deals with our responsibility as Christians. I believe this is the most important aspect for us to consider as we uphold the Christian ethical perspective in our post-modern culture. A belief in philosophical relativism by definition excludes a belief in any type of ethical values. As Charles Colson put it: 'Having erased any understanding of truth and objective moral order, the post modern mind is not interested in debate' (p. 221). Colson goes on to discuss the collapse of both conscience and the restraint of the rule of law in our country. Colson's chapter explains well the basis of the ethical problems in our society, and calls the church to defend the absolute truth in which we believe. In chapter 19, Ben Mitchell describes clearly and biblically how the church is to respond to the ideas of gnosticism, reductionism, the new eugenics, and gene-based discrimination.

Finally, Marsha Fowler explains the ministry of shalom as a ministry 'grounded in the gospel of Christ. It is the spiritual nurture of the children of God encompassing the fullness of the human condition as material and spiritual beings' (p. 254). Shalom 'seeks totality or completeness' (p. 254). 'It is nothing less than our best service for the glory of God, for our own joy, and for our neighbor's good' (p. 254). If we keep this standard of Christian responsibility in mind, it will help us as we seek to respond in a godly manner to the genetic ethics issues that face us, both now and in the future.

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Piety and Humanity: Essays on Religion and Early Modern Political Philosophy
Douglas Kries, Editor
Lanham, MD & Oxford, UK: Rowman & Littlefield Publishers, 1997
ISBN 0-8476-8619-1, xiii + 293 pp., paperback $24.95

Piety and Humanity examines the seminal works of several early modern political philosophisers in order to introduce a historical perspective on the continuing debate over the relationship between revealed religion (Christianity) and modern political philosophy. The essays seek to explain why the ontological uniqueness of Christianity proved problematic to the shapers of the liberal political project of modernity and how they attempted to reinterpret the message of Christianity, making it suitable for their political ideal. As editor Douglas Kries points out, 'the highly refined theological doctrines' (p. 5) competed with political thought as the universality of the Christian message 'tended to erode the citizen's attachment to a particular regime' (p. 6), both of which were viewed as subverting the modern political goals. He goes on to point out, however, that whereas modern political philosophy emphasised 'freedom' (earlier political thought had emphasised 'virtue'), religion was still deemed necessary for its moral influence on man so that he might be fit to rule himself.

According to Kries, this defines the essence of the theologico-political (Spinoza's term) tension, namely, 'how to take political authority away from religion and preserve religion's effects (at least the salutary ones) on the individual human soul' (p. 8). Kries aptly concludes (and the essays confirm) that '[S]uch a trick was clearly impossible without a radical transformation of the nature of revealed religion itself' (p. 8). The conclusion of the contributors is that the 'radical transformation' did remove Christianity as a competing political threat, but in doing so, rendered it powerless to exert the much needed moral influence on the individual soul.

The authors of the essays expose the thinking of the early moderns that defined the transformation of Christianity and thus shaped the current debate. Andrea Citiotta-Rubery challenges the clever language of Machiavelli, showing that his political theory was not only anti-cleric, it was anti-Christian (anti-pietistic). She points out that his recasting of Christ's two great commandments resulted in diminishing 'their moral intention' and should be viewed as 'a direct spiritual alteration of a revealed teaching and not just a slight reinterpretation of a vague command or practice' (p. 39).

David Innes's convincing interpretation of Bacon's *New Atlantis* reveals Bacon's contribution (intentionally or innocently) to the retooling of Christianity by his unabashed confidence in the progress of science as the answer to man's happiness. Paul Cook's review of Hobbes' *Leviathan* concludes that Hobbes redefined the religious terms of sin and redemption as political concepts, arguing for a politically 'serviceable religion' (p. 104). Cook concludes that 'human freedom and autonomy, and not human responsibility to God, rules in the teaching of Leviathan' (p. 104).

Martin D. Yaffe looks at Spinoza's *Theologico-Political Treatise*, showing that Spinoza wanted religion out of public life so that 'sectarian differences will not intrude on people's private freedom to buy and sell with one another and, in that way, to profit in common' (p. 111). Yaffe points out that this was an attempt to replace religion with economics as the social bond. Three authors, Peter Meyers, David Foster and Dale Kuehne, argue that John Locke's contribution lies in his promotion of human freedom and rationality which argued that the term Christianity embraced many professions of faith. According to Meyers, Locke's reasoning

led to the notion that 'the rational pursuit of happiness is identical with morality' (p. 155). Dale Kuehne concludes that although Locke held that 'human nature is untouched by the fall . . .' (p. 228) (thus placing him outside the Calvinist tradition), Locke nonetheless saw the 'Christian faith as essential to ultimate human flourishing . . .' (p. 128). Since Locke had a definite influence on America's political development, these essays should encourage any serious student of this subject to do further reading in Locke.

In his essay on Rousseau, Douglas Kries explains that Rousseau's view of religious toleration did not mean allowing people to believe whichever religion they wanted, but rather, 'accepting the idea that one may be saved by practicing any religion' (p. 273). In trying to remove the socially divisive potentiality of Christianity by changing its nature, Rousseau and others necessarily disarmed Christianity of its moral power over the individual. Domesticating Christianity in order to serve the powers of political reason and the goal of social harmony necessarily altered both its role and status in culture. Christianity in its revelational form could not be both the servant of politics and the moral authority for politics. A choice had to be made. According to the contributors to *Piety and Humanity*, we must not think we have done both. A choice has been made and we must not lie to ourselves regarding 'the sacrifices that were necessary to make the modern political project succeed' (p. 9).

Although *Piety and Humanity* may not tell the whole story of modernity's approach to the theologico-political tension, it does serve as a provocative introduction for a clearer understanding of what was involved in making Christianity politically friendly. The contributors have unearthed important philosophical and political assumptions of nascent modernity that help explain what was lost and what was gained in the radical transformation of Christianity. This is an important contribution to understanding the present day culture wars.

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Long-Term Care Decisions: Ethical and Conceptual Dimensions
Laurence B. McCullough and
Nancy L. Wilson, Editors
Baltimore and London: Johns Hopkins University Press, 1995
ISBN 0-8018-4993-4, 246 pp., $40.00

Perhaps it is an exaggeration to say that, 'If you've read one bioethics book, you've read them all', but such a remark carries more than a grain of truth. Most texts start with a good dose of metaethics, then move on to cover the usual issues-euthanasia, allocation of resources, patient autonomy, etc. McCullough and Wilson have tried a refreshingly new approach. Focusing on all the issues that surround the long-term treatment of the elderly, they have gathered an assemblage of essays that 'wrap around' the topic, addressing the sociological, practical, medical, ethical, and familial aspects that confront millions of families each day. Two articles in particular deserve mention.

Nancy Jecker's piece on how old age and/or disease can affect marriage is essential for all of us who think marriage is a worthwhile institution. She focuses on the responsibilities incumbent on spouses to care for their ailing partners, asking (and answering) the tough question: 'Are there limits to such care?'

In 'What do Husbands and Wives Owe Each Other in Old Age?' Jecker sees society viewing marriage in two very different ways. Although, in both visions of marriage, partners may have a quite reasonable expectation that the other person will 'be there' in the twilight of life, there is a considerable difference in how these marital models are played out in real life (p. 158). The first model focuses on the *telos* of relationship—it is inseparably linked to the idea that marriage is for the purpose of two people nurturing a vital personal relationship. Jecker points out that, although this view certainly wants more from marriage than mere romantic love, its reliance on relationship raises profound and often troubling issues when chronic disease strikes either partner. What happens if one partner is physiologically incapable of relating? As the ability to relate goes, so goes the marriage. As Jecker points out, this sort of marriage 'cannot support a duty to care for disabled spouses under all circumstances' (p. 162).

Jecker's second category has *commitment* not *relationship* as its goal. With obvious affinities to the Christian idea of marriage (as Jecker calls it, a 'holy union'), one would think that such sacred commitment would insure a high level of caregiving by the healthy spouse. But surprisingly, in an otherwise well-written essay, Jecker equates the Christian idea of marriage with the notion that sexual fidelity to one's partner is morally licit only while love lasts (p. 163). This bizarre reading of Christian marriage comes out of nowhere, but does not fatally wound her analysis of the limits of care. One can maintain a high view of marriage while acknowledging that there are limits to caregiving—even for the most devoted marriage partner. As Jecker says, 'marital responsibility ends where responsibilities have become impossible to meet or where competing obligations or virtues take precedence' (p. 167). Such an analysis may provide welcome relief to those who envision a loved one working herself into an early grave by caring for her husband.

Sarah Vaughan Brakman also addresses another timely topic: what responsibilities do children have when contemplating personally caring for parents. In 'Filial Responsibility and Long-Term Care Decision Making,' Brakman locates two possible sources for filial caregiving for an elderly parent. One, reciprocity, depends on the notion of justice, that is, paying someone what is owed them. In my judgement, Brakman is correct in seeing the key weakness of basing filial care on reciprocity alone: once the child's 'debt' of care has been paid—that is, once an equal amount of care has been given for that received—then the relationship based on reciprocity ends (p. 186). Such an account is too sterile, too calculating to capture the true source for filial responsibility.

Brakman sees *gratitude* instead as the proper locus for filial responsibility. Here, motive and feelings of love and goodwill are important components; here, as the adult child cares for the elder, the relationship is 'furthered and enhanced' rather than severed as the duties of care are met (p. 187). Such stilted words, but they stand for broken relationships healed, hearts once broken, now mended.

These essays are typical in their practicality. With the 'greying of America' quickly becoming apparent, the need for a work of this sort grows daily. The editors are to be congratulated—not only for having the foresight to think this project through, but the organisational skills to pull it off.

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Alzheimer's: Answers to Hard Questions For Families
James Lindemann Nelson and
Hilde Lindemann Nelson
New York: Doubleday, 1996
ISBN 0-385-48533-6, 224 pp., hardback $21.95

The Moral Challenge of Alzheimer Disease
Stephen G. Post
Baltimore and London: Johns Hopkins University Press, 1995
ISBN 0-8018-5174-2, viii + 143 pp., hardback $29.95

Forgetting Whose We Are: Alzheimer's Disease and the Love of God
David Keck
Nashville: Abingdon Press, 1996
ISBN 0-687-02088-3, 255 pp., paper $19.95

Alzheimer's stands in a class alone. Its slow, shattering effect upon the well-being of those who contract the disease, as well as their primary caregivers, distinguishes it first of all as a thief, rather than a killer, but a thief who steals that which is most basic to a person—his identity. A mean and especially spiteful thief, Alzheimer's may leave no sign of its forced entry, leaving whole the bodies of its victims while plundering their minds and, all too frequently, the spirits of the families of its victims. It strikes randomly, mysteriously, lingering often only as a shadow in the recesses of a person. But it is a shadow caught in glimpses through the corner of one's eye, often leaving the victim long aware of the presence of the intruder. As a result, the inner turmoil of those who are its victims may be unknown for a long period of time.

Because of the character of the disease, many of the problems associated with Alzheimer's are theological or philosophical or practical, rather than moral. Indeed, David Keck terms Alzheimer's the 'theological disease' precisely because it attacks the selfhood of persons and we normally think of God relating to us as selves or persons. What is the imago Dei in Alzheimer's patients? What are we to make of talk of a 'personal relationship with God' when the body remains, but personhood seems to have fled? How can one with Alzheimer's die well, in the

comfort of God? How are we to explain this evil?

As important as the theological questions created by Alzheimer's are, however, the most immediate issues are practical and moral. What is a family to do with one they suspect to have Alzheimer's? What support would a good husband, wife, or child provide for one stricken by the disease? What does it mean to be truthful and faithful to Alzheimer's patients? James Lindemann Nelson and Hilde Lindemann Nelson provide a gem of a book in dealing with these and other practical issues. The introduction of the book addresses moral issues of Alzheimer's, but the concern is not with a developed moral theory but with moral practice, with helping individuals and families feel and act well in confronting Alzheimer's. If an angle on the moral issues is noticeable, it is that Alzheimer's tests the character of the caregivers and, thus, developing and sustaining certain virtues of care should be central to the concerns of Alzheimer's families.

Their discussion continues, moving through considerations of early stage Alzheimer's, helping patients and their families make plans for their future care and caregiving, to middle stage care, nursing home care, and the final stages. The book concludes with two very helpful appendices, one identifying organisations to help those caring for Alzheimer's patients, the other a list of recommended readings. The Nelsons provide an important service here. Their book is a model of user-friendliness, employing stories as a means of entry into the issues that concern them. This is an ideal book to put in the hands of those with elderly or at-risk spouses or parents, those who early on ought to think through the impact of having an Alzheimer's victim in their family.

Stephen Post and David Keck, by contrast, write for scholarly audiences; Post for ethicists and healthcare professionals, Keck for the Christian theological community. Post's book raises the moral question well—how do we ensure 'a future in which those who are so forgetful will be treated with dignity'? He is realistic enough to recognise the possibility that we will abandon the demented, but optimistic that through a communal discourse we can identify and establish principles of protection for those with dementia. Although the rationalistic and capitalistic character of our culture disposes us to find personhood only where we observe rational and productive ability, and, thus, to abandon care for Alzheimer's patients, Post insists upon the 'essential unity of human beings and on an assertion of equality despite an unlikeness of kind'. Thus, Post intends to develop 'dementia ethics'. Dementia ethics recognises the 'noncognitive well-being' of Alzheimer's patients and advocates a care responding to whatever capacities and memory are present in the patient, fundamental respect owed to all humans because they are human. Dementia ethics result from practice and dialogue and are practical rather than 'deductive, abstract, and gamelike'.

One wants very much to like this book. In my judgement, Post's conclusions are humane and respectful of human dignity. Post has listened carefully to the voices of Alzheimer's patients and offers important observations about how much more can be done with and for Alzheimer's patients than is ordinarily assumed. Although he seldom slips into theological talk, his perspective is compatible with, if not informed by, a Christian valuation of persons and personhood. (His appeal to Karl Barth on the sanctity of life suggests that a robust theological ethic of persons lurks in the background.) His suggestion that the legalisation of suicide and voluntary euthanasia would probably prove incompatible with obligatory care for the demented and the dying is insightful. However, Post's journey to these conclusions is most unsatisfying. Exactly how and why he thinks a 'discourse ethic' leads to these conclusions is a mystery to me. Indeed, Post's discourse ethic strikes me as a rather clumsy and unpersuasive attempt at doing medical ethics without moral theory. If that is his aim, then he owes the reader an account of why moral theory fails. Whether it is the challenge of addressing medicine's moral issues in non-theological language (or merely the desire to inject novelty into the discourse of medical ethics) upon which he founders, I am not sure, although founder he does. At any rate, the book bears reading, for Post has listened attentively to those whose memories have failed and his book expresses well the care he advocates.

David Keck is a historian and a Christian who writes a narrative theology of sorts based upon his experience with his mother, an Alzheimer's patient. Keck struggles for a way to talk meaningfully about Alzheimer's, struggles to help the church speak meaningfully. His suggestion is that 'death and the loss of control belong at the heart of our theological reflection' and that theologies of 'self-fulfilment' fail precisely at this point, as a theological analysis of Alzheimer's reveals. Keck's book is a work of retrieval, of mining the liturgy, Scripture, and doctrine of traditional, orthodox, Christianity for the resources to enable us to address Alzheimer's well. He discovers resources aplenty.

In his second chapter he traces the importance of memory in the Christian tradition, memory even of that which is not good, and argues that for Christians the act of memory takes priority over the act of imagination. To be faithful is to remember who the church confesses, the God who is faithful to us, and what that God has done for us in Christ Jesus' dying upon the cross. Indeed, as Keck puts it, 'Orthodoxy is a deep longing to align one's own life and memories with the life and memories of the church.' What becomes important, then, is not that each individual Christian remembers; were this so, Alzheimer's victims would be separated irretrievably from God. Rather, the church, the community of the faithful, must remember what God has done for themselves and for all in their community. As parents and grandparents remember for those new-borns who do not yet know God's mercy, so parents and children must remember for those who no longer know.

In his fourth chapter, 'The Soul and Its Grammar,' Keck appropriately takes aim at reductionist materialism and its influence upon theology. He further explores human identity in his discussion of death and resurrection and the importance of the church preaching and singing the good news of resurrection of the selves who have been momentarily lost to Alzheimer's. Keck continues his study with chapters on forgiveness and apocalyptic, beauty and Christology, and caregiving.

There is great wisdom in Keck's *Forgetting Whose We Are*. Most readers will find difficulty with Keck's frequent references to his journey with his mother's illness. Most theologians will think that Keck often tries too hard to discover theological implications relevant to Alzheimer's where there are none. Despite this, all who read on will find a book that is theologically rich, a book that calls the church to greater fidelity in vicariously living and dying for those who can neither live well or die well. For many years to come, those who want to think theologically about Alzheimer's will need to begin with Keck. Indeed, those who want just to think theologically will find here a better starting point than most.

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Genetics: Issues of Social Justice
Ted Peters, Editor
Cleveland, OH: Pilgrim Press, 1998
ISBN 0-8298-1251-2, 262 pp., paperback $18.95

The race to complete the Human Genome Project has intensified this year, but most people are not prepared to deal with the effects its completion will bring. When a person's entire genetic composition may be known from a mere hair sample, how will the results be used? It is important to predict and examine the effects of this knowledge. This book thoroughly explores the social, ethical, and legal implications of genetics research through a theological framework. It serves readers by informing them of pertinent issues that will allow them to make informed judgements, preserve justice, and prevent the social errors of the past.

Researchers and guest scholars at the Graduate Theological Union in Berkeley, CA wrote the book as a project through the Center for Theology and the Natural Sciences. It is composed of eleven chapters divided into three parts. Part One, 'Genes and Justice,' provides the reader with a basic understanding of genetics, and reviews the goals and development of the Human Genome Project. Part two, 'Ethical Reactions,' explores aspects of morality, human life, and theological views of the project, with specific emphasis on the Roman Catholic view. Part three, 'Social Challenges,' explores issues surrounding genetic testing, insurability, and privacy. Each chapter presents the issues in a thought-provoking manner and prompts the reader to reflect on their implications.

Ted Peters's chapter, 'Genes, Theology, and Social Ethics,' provides an overview of how theological insights may guide ethical deliberation. The possible problems genetic research may cause need to be investigated before they materialise. The results of the Human Genome Project will put a new twist on issues such as abortion, determinism and free will, homosexuality, and original sin, while presenting new issues such as the patenting of genes, cloning, and germ-line intervention. Further, these issues will repeatedly prompt the reader to question, as Peters does: Are we playing God? Peters claims that reflecting on the issues through a focus on theological commitments to human dignity will aid people in their deliberation.

Henry T. Greely's chapter examines the proposed Human Genome Diversity Project and the ethical, legal, and social issues it presents. The project's focus is to study genetic variation throughout the world, but the ways in which it seeks to do this are questionable. How will samples be collected, whose property will they be, and who will reap the benefits of the research? If the information gleaned is not managed properly, the research could be used to provide biological support for racism.

In another interesting chapter, entitled 'Fair Shares,' Karen Lebacqz questions what view of justice will adequately inform the approach of the Human Genome Project. She examines the international scope of the project and how the information will be shared. The cost of the project and the work involved is not equally divided among all nations, nor can it be. Given this, she examines if and how the profits and information may be divided.

In the section examining ethical reactions, Philip Hefner posits that knowledge of one's genome may affect how people view themselves, original sin, and moral fallibility. Further, it questions whether people will see themselves as determined beings. Research has already attempted to attribute criminal violence to genes; what could be next and how will we hold people accountable for their actions when their defence could lie in a DNA test?

Roger L. Shin's chapter provides the reader with an understanding of the ecumenical discussion of genetics research and the technology that could develop from it, such as genetic therapy and genetic enhancement. Further, he explores whether the two may be clearly distinguished. This chapter is complemented by Thomas A. Shannon's chapter presenting a Roman Catholic Discussion of the issues.

The largest social challenges presented by genetics research are privacy and insurability. David A. Peters provides the reader with insight into the conflict between libertarian and egalitarian values in health insurability. When a person's genetic make up will be easily determined, how will they acquire health insurance? People may be denied coverage for genetic reasons. Should the costs associated with genetic risks be shared by all people or only those who carry the risk? Does the insurance industry have a right to a person's genetic information? Karen Lebacqz elucidates the issue of privacy and explains the dangers, social constraints, and technical problems it presents.

The issues covered in this book serve to expand the readers' knowledge, compel them to critique how genetic research is conducted, and question the direction in which humanity may be proceeding. Theological insight into the issues presented provides the background knowledge the reader may use to frame the questions in a way that they may one day be answered. The text was thoroughly researched and presents an unbiased view of the issues. It is an essential read for ethicists, theologians, scientists, and students, as well as any reader with an interest in understanding humanity and its pursuit of knowledge.

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Medicine, Money & Morals: Physicians' Conflicts of Interest
Marc A. Rodwin
New York, NY: Oxford University Press, 1993
ISBN 0-19-509647-9, 411 pp., paperback $13.95

My most vibrant boyhood memories include my family doctor's home visits when I was sick. These memories are not only among the most lively, but in contrast with today's 'encounters', they have also become my most cherished. Medicine has dramatically changed from those nostalgic times of four decades ago. This development may have less to do with the conflicts between money and medicine—since this tension has been present since the early part of this century—and more to do with the increasing number of, and the complexity of, the financial conflicts of interest associated with the physician patient relationship. If so, Marc A. Rodwin's *Medicine, Money & Morals* will provide helpful insight into the contemporary ethical tension between the physician's single-minded devotion to his patients and his own economic interests.

According to Rodwin, conflicts of interest are influences that compromise, or have the potential to compromise, known obligations. They are not actions nor do they ensure disloyalty to fiduciary duties. They differ from conflicting interests. His book concentrates on seven of the more popular incentives that pose financial conflicts. These include financial income resulting from the following transactions (p. 56):

Kickbacks for referrals.
Physician self-referral to medical facilities in which they invest.
Income earned by doctors for dispensing drugs, selling medical products, and performing ancillary medical services.
Payments made by hospitals to doctors to purchase physicians' medical practices.
Payments made by hospitals to doctors to recruit and bond physicians.
Gifts given to doctors by medical suppliers.
Physician risk-sharing in managed care organisations and hospitals.

Some incentives conflict with the patient's best interest when they result in needless, perhaps even harmful, services. Rodwin finds the response—both public policy and private regulation—to controlling this kind of incentives inadequate. A reason for this is that incentives that result in unnecessary services (such as the first six above) are indistinguishable from fee-for-service practice. This popular approach to medical reimbursement encourages doctors to prescribe services that they themselves provides.

The emerging delivery system transforms the structure of incentives away from payment based on the amount of services to a system of payment based on delivering appropriate services. This new policy requires the removal of financial incentives that increase services, a policy that can easily be construed as mere cost containment. Rodwin discusses the type of incentives targeting physician behaviour in their practices, such as bonuses, withholds and other risk-sharing arrangements. Incentives by themselves, however, are ethically troubling if only, and only if, they adversely impact the quality of care provided to patients. On this question, Rodwin rightly notes the limited research available. Indeed, this economic research suggests that only strong inducements to reduce services place patient care at greater risk. Nevertheless, his view is that 'small incentives may outweigh their size, especially when applied to every clinical decision physicians make. Even small rewards can shift perceptions and attitudes. Payment also has symbolic value. It can bond physicians to payers, producing commitments disproportionate to the sums of money involved' (p. 148).

Financial incentives are inherently unethical, according to Rodwin. What solutions does he propose to a practice that is pervasive in all medical reimbursement systems? He argues against the conventional solutions. Disclosing conflicts of interest is ineffective. Although the aim of medical disclosure is to produce trust in the relationship, patient vulnerability and the absence of institutional mechanisms to support and enforce appropriate disclosure undercut the effectiveness of disclosure, especially if a co-ordinated policy setting high standards of ethical conduct is missing. Rodwin is also critical of government-salaried physicians. Whether the physician is employed by a public or private entity (for-profit or not-for-profit), he serves two masters: the employer and the patient. As a salaried employee, the physician has interest in his continued employment—at least indirectly. In the end, Rodwin dismisses market approaches to controlling abuse from physician incentives. He is equally sceptical of self-regulation. Government regulation is said to be too costly and ineffective. In the end, he proposes that public policy prohibit the seven broad categories of incentives. Exceptions that would create financial incentives to alter physician behaviour would be required to show that no harm would come to the patient.

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Who's Afraid of Human Cloning?
Gregory E. Pence
Lanham, MD and Oxford: Rowman and Littlefield Publishers, 1998
ISBN 0-8476-8782-1, xvi +181 pp., $10.95

The author's stated purpose in writing this book is to debunk the 'knee-jerk reactions' against human cloning, and state the case for the other side. Pence, who teaches at the University of Alabama, admits that this work is 'unabashedly philosophical and one-sided' (p. xii). I quite agree with the one-sidedness of the text, although I can't say much for the 'philosophy' that supposedly drives it: it is filled with overt biases against religion, polemics against those with whom the author disagrees (most of the bioethical community), contradictions and fallacies, and, perhaps most disturbingly, no real rootedness in any moral grounding. Beyond the shoddy quality of much of the moral arguments found in the text, I can discern no consistent moral vision or focus of the book, no underlying

moral premise that clearly states what the author is *for*. It comes across like a shifting, portable, gun platform, made entirely for the shooting down of opposing ideas—but ideas never shot down from a consistent or solid perspective.

Some of the most well-respected bioethicists and philosophers—Richard McCormick, Alan Verhey, James Childress, and George Annas to name just four—come under withering attack from Pence, because they had the temerity to speak out against human cloning. Pence is not timid in calling their thoughts 'knee-jerk condemnations stem[ming] from fear and ignorance' (p. 2). In fact, typical of Pence's pejorative labelling is his treatment of James Childress, a member of the National Bioethics Advisory Commission. Pence disparages Childress's qualifications, calling him a 'professor of psychology, nursing, and religious studies' (p. 35). James Childress is actually the chair of the well-respected University of Virginia's Department of Religion, which itself has one of the country's premier bioethics centres. He has authored countless books, articles, and essays on the subject of bioethics. He has earned the right to be taken seriously, not dismissed as unqualified.

The only discernible thread that holds Pence's arguments together is his bias against religion and its voices in the cloning issue. 'For reasons unknown, the Commission [the NBAC] invited many people from religion to testify . . . the whole emphasis on religious views was quite odd' (p. 35). Is Pence really saying he can't understand why Jews, Christians, Moslems, and religious people generally would have an interest (and something to say) on creating life? Such myopia is sad even in a layperson, incredible in a professor of philosophy. It seems obvious that any religion that so much as dabbles in the transcendental would have an interest in the origins of life; certainly, all of the major world religions possess truth claims about how humanity comes forth. Do not Judaism, Christianity, and Islam all revere the relational imagery of God knowing Jeremiah 'before he was formed' in the womb (Jeremiah 1:5)? And, since surveys tell us that some 96 percent of all people believe in some notion of God, is it really surprising that a political commission might want to hear from a religious perspective? Hardly.

Philosophically, the story is little better for Pence. At one point he laments that it's a 'shame' there are no artificial wombs, so more premature babies could be saved (p. 44). Indeed, one of the underlying currents of the book is that cloning could well be a technological boon that could save many lives. Later on, however, Pence has no qualms about lambasting those who claim personhood begins at conception, by saying that such idiocy 'commits each of us, on an overpopulated planet,' to birthing as many people as possible (p. 89). If the planet is so overpopulated, from where does Pence's concern for saving more people come?

Pence's disdain for religion, his dubious reasoning, and his lack of moral foundations show most clearly in his arguments on 'why the embryo is not a person'. He accepts as final Joseph Fletcher's 'cognitive criterion of personhood', the idea that, in order to be a human *person*, one must 'be able to think, to remember one's life, to be capable of cognition' (p. 88). Leaving out the fact that such reasoning excludes most *children* from personhood (some professors might claim many college students as well!), Pence goes on to extend this criterion to the end of life, claiming that 'both Karen Quinlan and Nancy Cruzan were long since dead as their cases dragged through the courts' (p. 88). Despite the fact that both women were awake and taking nourishment, Pence apparently advocated that we should have *buried* both women. That is what is done with the dead, is it not?

Such sloppy reasoning is sadly typical of this work. Pence is right that there needs to be a book which deals more dispassionately with human cloning, assessing arguments both pro and con. This work isn't it.

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Bioethics, A Primer for Christians
Gilbert Meilander
Carlisle: Paternoster Press, 1998
ISBN:0-85364-793-3, xii + 120pp., paperback, £5.99

A primer should begin where the reader stands, and this slim book of 120 pages fulfils that criterion extremely well. It is a primer for Christians who wish to be better informed about the many bio-ethical issues which bombard us from the media almost every day, and who wish to take a closer look at these issues in the context of their faith.

The author starts from the foundation of a Christian vision and world view. He deals, very succinctly, with issues of the individual in community: freedom and responsibility, person and body, suffering, disease and healing, in the first chapter, as a backdrop to the specific issues to be handled, and, in doing so gives a very useful summary of a Christian position which is easily lost in the heat of debate and the onslaught of emotional sound-bite misinformation and disinformation which so often characterises media handling of these issues.

The major questions of ethical relevance are then discussed sensitively, compassionately and often quite humorously, with a great deal of help for those who may be wrestling with the issues in their personal experience.

Beginning of life issues such as procreation, abortion, genetic advances, and pre-natal screening are simply and clearly faced, always pointing the reader back to a Christian position. End of life issues—suicide, euthanasia, treatment cessation and refusal, and the vexed question of 'Who decides?' are similarly considered, and it is very helpful to have the arguments about autonomy and responsibility so well laid out.

The last two definitive chapters on organ donation and human experimentation caused me to think much more specifically about these issues than I had done previously, and it is always the sign of good writing that the reader has to re-examine his/her own position after reading it.

The closing chapter on 'Sickness and Health', brings us back to the basic concepts of Christian faith, and I found it salutary to be reminded that 'We place our ultimate hope for health and wholeness in the God who, Himself, has been broken by death—and Who, nevertheless, lives.'

I warmly commenced this book to concerned Christians.

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The Right to Know and the Right Not to Know
Ed Ruth Chadwick, Mairi Levitt and Darren Shickle
Avebury, Aldershot, UK, 1997
101pp + x Hb

The 'rights' considered here relate to genetic status. Is there a right to know one's own genetic status or that of someone else? And is there a right not to have unwanted knowledge thrust on one?

The dilemma is well illustrated by an example quoted by Jørgen Husted, associate professor of philosophy, University of Aarhus. (Of the eight contributors to this book, four are based in the UK, the remainder in Germany, The Netherlands, Denmark and Finland.) 'A man diagnosed with a mild form of adrenoleukodystrophy (ALD), an X-linked condition that can be carried by healthy females, did not wish his diagnosis or the genetic implications to be discussed with his family. Seven years later, his niece gave birth to two successive boys who have a more severe form of ALD. The illness only came to light in them when the elder boy started to display symptoms. The mother's sister, the man's other niece, has also given birth to a son subsequently diagnosed with ALD. Both families are bitterly resentful that the medical services did not warn them of their genetic risk.'

Was the anger of the mothers against the medical services justified? Did they have a right to know? Or did the doctor act correctly, on the ground that he had an over-riding duty of confidentiality, and no authority to impart unsolicited information? How would the mothers have felt if they had been burdened by the information regarding the risk they ran and had then given birth to healthy children? After all, genetic status only indicates a degree of probability—not certainty—so far as clinical outcome is concerned. It is argued that although unsolicited disclosure violates autonomy in a formal sense it respects and enhances it in a substantial sense, because the result is an increase in autonomy, an opening of options.

Knowledge is a mixed blessing. Once a fact relating to our future health is known, life is never the same again. Information about one's genetic risks is liable to have an impact not only on the individual's feelings but on his or her life as a whole. It may lead to a decision not to marry and thus not to seek deep emotional involvement with members of the opposite sex. It may lead a couple to decide not to have children of their own and, perhaps, to terminate their one and only pregnancy. It may involve giving up a career one has built the major part of one's life around.

These are some of the issues considered. What should physicians do? How much should insurance companies be told? Where should the law come in? To be guided towards the answers

to these and many other questions, you must read the book.

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What You Need to Know about Cancer
Special Issue: Scientific American
W.H. Freeman and Company, New York,1997
ISBN 0-7167-3102-9, 173 pp., $16.95

The diagnosis of 'cancer' has a devastating impact on the patient and core family. Initially, emotional support is the major need, but when the process of decision-making starts, clear, concise, accurate and up-to-date information is essential. Giving understandable technical information is where Scientific American excels and they have done so in this book: *What You Need to Know about Cancer*. Factual material abounds and is easy to understand. But the emotional and support information is not neglected. There is crisp text and unexcelled illustrations and graphs. The format is intended to teach and answer questions, not overwhelm with complex and arcane theory. This is a practical guide through a bewildering and awesome disease. It fulfils its intended purpose admirably.

This is not the book about decisions to remove the breast in toto or do a lumpectomy followed by radiation. But it does discuss briefly that these are valid treatment plans. Likewise, while no major ethical issues are put into focus, the problem of pain, use of alternative therapies, and obstacles to ideal care are touched upon. The patient, a family member or anyone who wants a clear understanding of cancer from its causes to its psychosocial impact will find this book an excellent resource. Ethicists without oncology training could use this as a primer on the medical issues surrounding cancer.

The subject is clearly outlined by introductory chapters on 'How Cancer Arises and How it Spreads.' Causes and preventative tactics are then discussed. Along with this are topics on early detection techniques and improvements in conventional therapies. Nestled in these pages is an impressive Fact Sheet on 12 major cancers. The book ends with sections on future therapies and meeting the challenges of living with cancer. Major sources of referral are current as well as the bibliography if further information is sought.

The ideal book about cancer should answer the following questions: What is it? How does it behave? What are the risks? What can be done to prevent getting it? How is it detected? How is it treated, and What is life like with it? One must know that the diagnosis of cancer is obtained by tissue biopsy or cytological analysis. From that the cancer must be staged. This means that evaluation is made for the size of the primary tumour, whether or not it has spread to lymph nodes or via the blood to distant areas such as the liver, lungs or brain. Only after diagnosis and staging can a treatment plan be devised. The usual modalities of radiation or surgery are reserved for loco-regional disease. For wider spread or systemic disease, chemotherapy is used. All modalities can be mixed and matched to treat specific types of cancer. It is a multidisciplinary process. After treatment there is a lifetime of follow-up on a regular schedule because of the potential for disease to recur. All these aspects of cancer are discussed remarkably well. The information is current and if there is new information since the 1997 publication date of this book, there is reference to a number of areas where more details are available.

Knowledgeable, experienced people assembled this compendium of concise, cogent information in a readable and almost eerily fascinating fashion. It is not a manual for treatment planning. It gives the information necessary to understand what may be recommended. The decisions reached are between the physician and the patient alone. However, this book meets the needs of the general public on this topic and is recommended highly. The introductory quote says it all: 'A single cure is still elusive, but for people touched by this disease, modern understanding is paying off in better treatments, better prevention and brighter prospects.'

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Reflecting the Divine Image: Christian Ethics in Wesleyan Perspective
H. Ray Dunning
Downers Grove, IL: InterVarsity Press, 1998
ISBN 0-8308-1545-7, 156 pp., paper $14.99

'I came to understand more clearly than ever,' H. Ray Dunning writes, 'how important it is to anchor Christian ethics in theology' (p. 8). The world is full of competing ethical systems which have varying bases, assumptions, methods and conclusions. In such a sea of plurality it is not surprising that many people, even Christians, have little idea of where ethically they are coming from or going to. But the Christian faith is founded upon God and deals intimately with our relationship to him. Accordingly, any ethical system that fails to take into account both divine and human nature is bound to be flawed. It is this aspect of ethics—where humans, and particularly Christians, are called to exhibit the divine image—that Dunning addresses in *Reflecting the Divine Image*.

This short, readable book discusses Christian ethics as based on the *imago Dei* as understood from the teachings of John Wesley. Wesley was concerned to develop a theology that stressed both the importance of faith and the necessity of holy living—a characteristic that seems sadly lacking in much of contemporary Christianity and which is absent altogether in a culture suffering from 'moral schizophrenia' (p. 12).

The first chapters lay the groundwork, with discussions of the seriousness of morality; the need for a theological ethic; and concepts important for ethical reflection. 'Morals describes what we do (or avoid doing), whereas ethics refers to why we do (or do not do) certain things' (p. 28).

Part two discusses the image of God as the benchmark for the ethical behaviour of humans created in that image. This is in sharp contrast to much modern thinking of the New Age kind which blurs the distinction between humanity and God. Dunning writes, 'The primary relation constituting the imago Dei is humanity's relation to God, in the sense that a person's right relation to others and the earth is dependent on a right relation to God' (p. 45). Once this relation has been marred by sin, there is need for redemption, restoration, and reconciliation between humanity and God. Here, as always, God takes the initiative, with works of grace. Ethics then (closely involved with relations between people), is a response to grace. And, in Wesley's view, this becomes a positive ethics of love and hope, not a negative ethics of sterile legalism. The redemption of humanity is the joyous restoration of a severed relationship (illustrated in the Bible as the marriage of Christ and his church). Like Israel of old, Christians are called to be a holy people, living a lifestyle that demonstrates God's intention in redemption.

From this (in part three) follows an ethical righteousness based on love for God and love of neighbour. Love of God results in obedience to God's commands, which results in closer communion with God. The character of Christ is to be our guideline for ethical behaviour, particularly the peace of Christ which is to rule in our hearts (Col. 3:15). Any activity that compromises our relationship to God (our sovereign as well as our loving Father) is to be avoided. The result is (or should be) a lifestyle markedly at odds with contemporary mores.

The church, as a community of believers, is important for providing a context for Christian ethics. Our relationships to the earth and to possessions are affected. There is a radical redefining of 'self,' particularly as it relates to the modern fascination with self-esteem.

Part four discusses the roles of both the church and the individual in applying Christian ethics to society. Dunning concludes, 'Redemption ethics is not an arbitrary imposition of rules on servile followers of Christ, but guidelines for meaningful family life within the community of faith and the actualisation of the imago Dei, the essence of human nature. Creation ethics is the basis for understanding how human society will survive and achieve a measure of justice in God's world with the hope that it will lead to the ultimate goal for which the Creator designed his most exalted creatures' (p. 137).

There is no discussion of the application of these principles as such to the practice of medicine, but an appreciation for the imago Dei would surely bring a fresh perspective and needed light into the ethical controversies of today. Only Christianity out of the world's religions provides this insight.

Ray Dunning has provided a valuable service in writing *Reflecting the Divine Image* and it is to be hoped that these insights will be explored and expanded. If we, as Christians, abandon theology and fail to anchor ourselves onto biblical views of humanity and God, then we will be as adrift on the sea of relativism as the most confused pluralist. It is hard to argue against the idea that if Christians lived a more holy lifestyle, we would have a greater effect on the world than we currently do.

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Ethics in Higher Education: Case Studies for Regents
Alexander Holmes
Norman, OK and London: University of Oklahoma Press, 1996
ISBN 0-8061-2857-7, 112 pp., hardback, $21.95

This small volume fills a void in the literature concerning the ethics of leadership and governance. Board or committee decision-making must be done without conflicts of interest, and with a clear eye for what is right and wrong in the process and the action. While common sense and personal experiences are the common guidelines for behaviour, it is good to pause and evaluate whether or not there are some rules associated with service on a board. Alexander Holmes has attempted to do that by giving fictionalised case studies from the Board of Regents at the University of Oklahoma. There are six different scenarios. Each deals with a different issue and each issue has one or two variations on the main principle under consideration.

Power and influence are vested in board members. This can become the source of potential ethical conflicts. The essential question a trustee, regent, or member of a board must ask is: 'For whose benefit am I using my power or influence?' If the answer is other than the common good, then one must examine the action to see if potentially unethical problems may arise. The basic role of governance is to set policy and see that the administration or management properly executes it. All seems simple enough until an invisible line is crossed where a board member enters into day-to-day operations. At that point there is greater potential to breach 'some canon of ethical conduct.'

Ethical issues can be organised into those prohibited by given statutes such as abuse of power, conflict of interest, violation of free speech, and others. This volume looks at six areas: 1. Financial issues, 2. Academic issues, 3. Personnel issues, 4. Student Press, 5. Student athletics, 6. Campus organisations. The delight of this volume is the surprisingly innocuous situations and scenarios that at first glance seem to pose no problems. There is the Regent whose husband is a major contractor in the state and there is a building project up for approval by the governing board. A trustee asks the athletic department for a block of tickets for the football games. Then there is the faculty member who is opposed to animal research, states this publicly, gets fired, and appeals to a Regent in a late night phone call defending his right to free speech. These little vignettes serve to expose real ethical dilemmas. What do I do, how do I respond, and how do I keep it within ethical boundaries? What is my responsibility to the governing board as a whole, the institution I represent, and the public at large?

There are no simple rules in this regard, but six guiding principles are set forth:

Does this action, official or unofficial, help a family member, friend or myself?
Am I getting something that I would not have received if I were not in this position of power?
Does this action, official or unofficial, make it difficult for the public to know what is happening at this institution of higher learning?
Is this action, official or unofficial, an administrative issue rather than a policy issue?
Does this action, official or unofficial, help or hinder one particular person or firm rather than a class of people?
Will this action, official or unofficial, require an explanation in the press to remove any suggestion of ethical misconduct?

This volume serves as a resource for board members to think about their responsibilities and actions as having greater import than many may have first thought. It could be an initiator for discussion in a board retreat, or even in an orientation to new board members. The issues are neither exhaustive nor, perhaps, all germane to various non-profit boards, but the thread that binds it all together and makes it useful is Holmes's clarity and ability to delineate issues without dispensing dogmatic rules of engagement. The volunteer who desires to serve an institution or organisation effectively will find this book of great benefit. It is better to think of these issues in the abstract rather than learning lessons is the midst of a high profile, bitter dispute. I highly recommend this volume as a wise, proactive choice for all who have duties of governance.

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Balancing Act: The New Medical Ethics of Medicine's New Economics
E. Haavi Morreim
Washington, D.C.: Georgetown University Press, 1995
ISBN 0-87840-584-4, viii + 184 pp., paper $17.95

This provocative volume is part of the Georgetown series on clinical medical ethics and discusses the way in which the scarcity of medical resources is forcing a new assessment of the physician's ethical and legal obligations. Her argument is essentially that the traditional medical ethic of physician fidelity to one's patient without regard to other stakeholders is no longer possible and must be reformulated. She argues that these other stakeholders are not 'intruders' as many physicians consider but have a legitimate stake in the care of the patient and the appropriate use of health care resources. In other words, a new context for health care demands a new look at the physician's moral obligations. Her suggestions concerning how this should be reformulated will surely be controversial and I suspect that many physician readers will dismiss some of her suggestions as not feasible due to the demands on physicians and on the competitive nature of the marketplace.

Morreim provides a helpful survey of how health care came to be in its present situation, in which managed care dominates the landscape. She briefly traces the transition from fee-for-service medicine to the vast array of managed care arrangements, not only for patients with their health plans, but also for providers with their partners and those with whom they contract. She shows how most early efforts at cost containment failed because there was a separation between consumer and payer. She suggests that the problem at its core was that 'physicians spend other people's money and distribute other people's property to their patients' (p. 22). To retain control of medical decision making, physicians have now had to face resource allocation issues as their financial incentives force them to do so. Either that or they lose control of medical decision-making, enabling those without licenses to practice medicine. Morreim insightfully points out how these new financial arrangements have forced physicians into conflicts of interest they did not face prior to the advent of managed care medicine.

The heart of the book comes in chapters five and six, in which she spells out the changing medical ethic for physicians and other health care institutions. She argues against the old ideal of professional altruism in which 'the physician must place his patient's interests above all others, including those of business, government and society as a whole' (p. 45). Scarce resources, in her view, mean an end to this way of thinking about the patient-physician relationship. She suggests that physicians now owe patients only what they are able to give them. The reformulated, and more limited, view of physician fidelity includes balancing the patient's interests with the interests of a variety of stakeholders, including the other patients for whom the physician has financial responsibility (under capitation), payers, institutional providers and society as a whole. She rightly condemns gaming the system to skirt the new rules accompanying managed care. She makes a helpful distinction between the two primary services the physician can offer a patient—his medical expertise and his access to medical resources.

Morreim argues for two aspects to the standard of care for any given patient; the standard of medical expertise (SME) and the standard of resource use (SRU). She rightly points out that patients are owed the same SME, but holds to the controversial notion that the SRU for any given patient depends on the coverage possessed by that patient. Reflecting a clear view of health care as a commodity (at least beyond the minimum standard), she argues that the resources owed to any patient depend on the financial arrangement the patient has chosen for his/her health coverage. Thus a dual standard of care is not only permitted, but required, since in her view, physicians cannot offer to patients what they do not control.

This is a radical and very controversial idea, and it's not until later in the book that Morreim addresses in any depth how difficult it will be to shift physicians' thinking on this. The reason for this is that the law does not currently support physicians who wish to operate according to Morreim's new medical ethic. She argues for much greater patient responsibility for their health care choices, and allowing patients to live with the consequences of their coverage decisions. This will clearly be more difficult to live with in a clinical setting than in an academic discussion. Until the law changes, there is no chance that physicians will embrace such a notion, nor can they be expected to do so. Until that time, what Morreim calls 'economic advocacy' or fighting for the resources one's patient needs is the physician's obligation. But even that has limits too, since the time and energy needed to be such an advocate for the patient can take away from advocacy for other patients and from time seeing other patients. She here underestimates the time necessary for such tasks, particularly in a managed care setting in

which physicians see more patients than their schedule can reasonably accommodate. Given the pace of most physicians today, even communication with patients is compromised, not to mention the aggressive advocacy that Morreim suggests.

A second area of physician fidelity that is changing involves a new set of conflicts of interest. The new obligation of fidelity involves a high degree of disclosure to the patient to insure that he or she makes informed decisions about the purchase of their care, again reflecting a strong view of health care as a commodity. For example, the physician owes the patient economic disclosure, chief of which is disclosure of the costs of the proposed treatment prior to making a decision about accepting it. She argues that physicians and hospitals have no right to assume that the patient will be willing to assume the financial burden of a course of treatment, and thus must be informed about its cost prior to the commencement of the treatment. This sets up a scenario that most physicians and patients alike would find very uncomfortable and could undermine the trust that patients place in their physicians.

Other items for disclosure that Morreim suggests include physician incentives that are part of a managed care contract, ownership in ancillary facilities such as labs and imaging clinics, and possible treatments that a patient's health plan do not cover. All of these disclosures are very controversial and have been hotly debated. In some plans, though gag rules are illegal, there is great pressure on physicians not to disclose information about what a health plan does not cover. It is highly unlikely that physicians will disclose their economic incentives and Morreim seems to assume that such incentives routinely affect the course of care for patients. That assumption is highly questionable as it pertains to the routine care of the vast majority of patients and thus, the physician would have no obligation to disclose such information. It may also erode trust in the physician and may violate his privacy as well.

Morreim rightly points out that current malpractice law expects physicians to do the impossible, providing a single standard of care with widely divergent standards of coverage. She calls for the law to change, but puts greater emphasis on increased patient responsibility for weighing the economic and medical trade-offs that come with choices of coverages. In other words, she calls for patients to be more involved in balancing the benefits of care with the burdens of paying for them. She rightly balances the freedom aspect of autonomy, which has dominated the bioethics landscape for some time, with notions of patient responsibility. I have reservations that society will, or should, hold patients to their coverage decisions when life is at stake, but she is surely right to call for greater patient responsibility for rationing their care. This is the new medical ethic forced upon patients and physicians by scarce resources.

One area of potentially serious conflict for physicians which was only briefly mentioned in the book concerns the new conflicts between an individual patient's interest and the interests of the entire patient population the physician is serving. Under many managed care schemes, chiefly with capitation, physicians must balance the needs of a single patient with the needs of his or her patient population, since the resources are roughly fixed for the entire group. Bioethics is just beginning to offer some guidance to physicians on how to navigate this very difficult set of conflicts. I'm sure that Morreim has given this area a great deal of thought. I wish more of it had come out in the book.

Overall this is a fine work that is becoming standard reading for anyone interested in managed care, health care reform and issues of distributive justice in health care. Though some of the suggestions are controversial and unrealistic given the demands on physicians and the state of the law, dealing with scarcity is the theme for the future of health care. Morreim's book is well-thought out and provocative and well worth the read.

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