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Introduction

This book is written for all those who are interested in exploring whether and how Christian ethics might be able to make a significant contribution to health care ethics today in the public forum of a Western, pluralistic society.

A generation ago such exploration might have been considered largely unnecessary. Many of the pioneers of modern health care ethics were hospital chaplains, church leaders or academic theologians. In the 1960s the American theologian Paul Ramsey, and later William F. May, anticipated many of the issues that have now become commonplace in health care ethics. In Britain Bob Lambourne and his successors at Birmingham, followed by Gordon Dunstan at London, were instrumental in nurturing an interest in ethical and pastoral issues in medicine. In addition, a number of experienced hospital chaplains, such as Norman Autton at St George's Hospital, London, and church leaders, such as John Habgood and Ted Shotter, were also key pioneers.

Yet within a generation the discipline – variously termed health care ethics, medical ethics, biomedical ethics, bioethics, or ethics in medicine[1] – has become largely secularised. An important factor here is that secular philosophers and academic lawyers – such as Ian Kennedy in London, John Harris in Manchester, Sheila McLean in Glasgow and Peter Singer, first in Australia and now in the United States – are now leading voices in health care ethics. They offer distinctive legal and philosophical skills that bring new clarity to the developing discipline. In addition, it is often maintained that they

[1] I prefer the term health care ethics here because it includes ethics involved in both healing and health care provision (in medical, as well as genetic, science).

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bring a more 'neutral' basis to health care ethics within a society increasingly perceived to be pluralistic and multi-cultural. Pluralism, multi-culturalism and what is often termed 'globalisation',[2] have particularly impacted upon health care in the Western world. It is just about plausible to argue that some sections of the population even in the West effectively live in enclaves and are little affected by globalisation. Yet in health care there are factors that make this less likely: overseas doctors and nurses are now extensively recruited from both northern and southern hemispheres; there is considerable travel to international medical conferences; and there are frequent reports in the international media and internet on novel health care issues. Within this specific context, it has become less acceptable to identify Britain, let alone the whole of the West, as 'Christian', so, it is often argued, health care ethics needs to be moulded in an explicitly secular direction. However well intentioned the work of the pioneer ethicists from the churches, the discipline clearly ought to be relevant to doctors, nurses and patients whatever their country of origin, religion, culture or ideological commitments. More than that, in areas of sharp controversy involving medical practice (despite frequent protestations from English Law Lords that they are not experts in medical ethics) the judicial system has increasingly become the final arbiter. In a pluralistic society judges rather than bishops – and lawyers rather than theologians – may now be considered to be the most appropriate arbiters.

This pattern of secularisation can be viewed in quite different ways within Christian ethics. On one understanding of secularisation[3] it is yet another example of the marginalisation of religion in modern society. It is part of a larger process involving the gradual erosion of religious beliefs, practices and institutions in the Western

[2] For a recent summary of the connection between pluralism and globalisation in the context of Christian ethics, see William Schweiker, *Theological Ethics and Global Dynamics: In the Time of Many Worlds* (New York and London: Blackwell, 2004).

[3] See the following collections for a variety of understandings of secularisation and modernity: Philip E. Hammond (ed.), *The Sacred in a Secular Age* (Berkeley: University of California Press, 1984); James A. Beckford and Thomas Luckmann (eds.), *The Changing Face of Religion* (London: Sage, 1989); Steve Bruce (ed.), *Religion and Modernization* (Oxford: Oxford University Press, 1992); and Alasdair Crocket and Richard O'Leary (eds.), *Patterns and Processes of Religious Change in Modern Industrial Societies – Europe and the United States* (Lampeter: Mellen, 2004).

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world. Temporarily theologians and church leaders in the 1960s thought that they had discovered an area – namely health care ethics – in which they could uniquely contribute even within a largely secular society. Yet secular ethicists have now appropriated even this area for themselves. Moreover, this secular appropriation has taken place both in Britain/Europe and in the United States. There is no so-called European exceptionalism apparent here. Secular philosophy and academic law, and not theology, now dominate public health care ethics throughout the Western world, even in the United States (despite continuing high levels of private religious commitment there).

A quite different understanding of secularisation argues that it is the social function of churches to mould society at large in a more Christian direction. Once a particular change has been reliably initiated, churches can then return to their central function of worship and prayer. Just as there were a number of Christians who were instrumental in establishing the welfare state and the national health service in Britain in the 1940s, so there were also Christians who pioneered health care ethics in the 1960s. But, once their work was achieved, it was crucial that people of other forms of religious and secular faith also became 'owners'. It was no longer necessary – or perhaps even desirable – to claim that the welfare state, the national health service or health care ethics were dependent upon Christian precepts. Instead, they are all projects that owed much to the intervention of Christians in the first place, but which now are *sui generis*.

A good illustration of these alternative understandings of secularisation is the different ways that Christian ethicists have reacted to Tom Beauchamp and James Childress' influential *Principles of Biomedical Ethics*.[4] Many Christian ethicists today are critical of the approach championed by Beauchamp and Childress – arguing that it marginalises Christian belief, privileges secular moral reasoning, and offers four arbitrary 'principles' for health care ethics (autonomy, justice, non-maleficence and beneficence) with inadequate meta-ethical justification. For them this is a clear example of secularisation in the first sense. Despite the fact that Childress still sees himself as a

[4] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (Oxford and New York: Oxford University Press, 4th edn, 1994; it is this edition that will be used here).

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Christian ethicist, they argue that he makes little attempt in his joint textbook with the secular philosopher Beauchamp to articulate (let alone defend) a distinctively Christian perspective. Instead he has in effect capitulated to the secularist.

In contrast, other Christian ethicists argue that this misunderstands the Beauchamp and Childress approach and unnecessarily polarises secular and religious ethicists concerned with issues in health care. Adopting the second understanding of secularisation, they applaud this attempt to find a basis for health care ethics that secular and religious people alike can use within a pluralistic society. They believe that it would be counterproductive to argue for an explicitly Christian version of health care ethics within such a society. Instead, a combination of Childress' implicit Christian perspective and Beauchamp's principled utilitarianism allows health care ethics to be genuinely inclusive and to mould the moral perceptions of health care workers and patients regardless of creed.

This brief account of health care ethics misses an obvious piece of evidence, namely that, despite the apparent triumph of secular philosophers and academic lawyers, theologians are still regularly included in the membership of national ethics committees concerned with science and medicine both in Britain and in the United States. Sometimes they are given the broader title of 'religious ethicist' but at other times the term 'theologian' is still used and (in Britain at least) it is in some instances a bishop who is included on such committees. At present, at least, there even seems to be some pressure on national ethics committees to be inclusive in this way.

Again, those holding these variant understandings of secularisation are likely to interpret this evidence quite differently. Holders of the first approach may well see this as an attempt by secular bodies to appear to be inclusive but without their making any serious concessions to the religiously committed. As long as it is just one religious ethicist who is included on a particular committee (as is usually the case), then there is little prospect that she/he will much affect the predominant secular discourse. More than that, there may be an implicit bargain that the religious ethicist adopts the secular discourse herself, or, if she does not, that she uses religious language simply to identify the idiosyncratic beliefs of variant religious minorities – in effect a sociological rather than theological use of distinctively

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religious language. Ironically, it may be sensitivity as much towards the beliefs of Jehovah's Witnesses as towards those of mainstream practising Jews, Christians or Muslims that such a religious ethicist is expected to represent as a member of such a committee.

Holders of the second approach to secularisation may well view this evidence differently. For them it perhaps represents a significant retreat from an ideologically secular understanding of health care ethics. Two rather different interpretations of 'secular' are present here. On one, health care ethics needs to be secular in order to be inclusive within a pluralist society, but, on the other, health care ethics becomes secular in order to eliminate specifically religious interpretations. The former includes both religion and non-religion, whereas the latter excludes religion. It is, of course, the former that is likely to appeal to followers of the second approach to secularisation. So, for them, the presence of a religious ethicist on a national ethics committee can be welcomed as a genuine attempt to be inclusive. This is not simply a sop to religious minorities but a recognition that a pluralistic society includes both those who are religious and those who are not.

Chapter 1 will argue that critical insights from Alasdair MacIntyre, Charles Taylor and John Hare can take this second approach considerably further. All three of these moral philosophers might argue that a pluralistic society should recognise that, not only do religious minorities need to be respected if such a society is to be genuinely inclusive, but that a number of crucial, but supposedly secular, moral notions in health care ethics have religious roots and may even make full sense only when these roots are explicitly acknowledged. Chapter 1 will explore this possibility under the broad heading of 'Moral gaps in secular health care ethics', first by examining some of the philosophical weaknesses of secular health care ethics and then by identifying some of the moral gaps that theologians might be encouraged to address.

MacIntyre, in particular, argues forcefully that there is an evident gap between his philosophical claims about virtue within communities and his sociological scepticism about actual communities within the modern world. He maintains that, if modernity is premised upon individual rationality, it founders upon incommensurable moral conflicts (the very conflicts that moral philosophy was

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supposed to resolve). A more post-modern vision is premised instead upon local communities shaping virtuous people, but it founders upon the seeming impossibility of achieving general assent today for returning to pre-modern communities. Moral fragmentation seems – so it appears in MacIntyre – to be inevitable.

The Beauchamp and Childress approach to health care ethics attempts to stave off this fragmentation by offering principles that can be justified by people holding quite different meta-ethical positions. In later editions of *Principles of Biomedical Ethics* the authors have also attempted to show that their approach is compatible with the increasingly influential virtue ethics approach to health care ethics. At best this seems to be a truce. As long as these principles can be upheld by different groups in medicine, albeit for very different reasons and, in addition, buffered by lawmakers, then they can be used to foster ethical discussion. Yet they remain vulnerable. And Taylor, despite being more committed to personal autonomy in ethics than MacIntyre, nevertheless believes that we are now in an age in which publicly accessible 'cosmic order of meanings' is an impossibility. All that we can rely upon today is 'personal resonance' – and that of course will vary from person to person.

John Hare identifies a third moral gap in secular ethics. Using Kantian arguments, he maintains that there is a gap between moral demands and a human propensity to selfishness. He argues that Kant himself was aware of this gap. The latter's categorical imperative made high moral demands. Yet his implicit Lutheranism also made him aware of humanity's tendency towards selfishness . . . a selfishness that militated against the (unaided) human capacity to meet the demands of the categorical imperative.

Chapter 2 will explore how theologians have sought to make a distinctive contribution to health care ethics in the public forum, before addressing these three moral gaps: the gap between theoretical and actual moral communities; the gap between personal resonance and a shared understanding of cosmic order, and the gap between moral demands and human propensity to selfishness. Chapter 2 will identify a tension in public theology today between theological purists and theological realists and will then illustrate this tension within a specific area in health care ethics related to genetic science. A number of scientists would maintain emphatically that theology

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has nothing whatsoever to contribute in such an area. Even some religious scientists may be sceptical about any public role for theology on genetic issues. They may also be dismayed by what they regard as naïve theological utterances on specific scientific issues, especially on issues such as the genetic modification of food. In contrast, there is a growing theological literature which claims that a godless society is moving ever in a more destructive and irreligious direction, relegating (genetic) powers to itself that properly belong only to God.

It will be argued that there seems to be an increasing tension between those theologians who make sharply particularist claims (theological purists) and those who see only relative differences between Christian and secular thought (theological realists). The tension was apparent in the earliest phase of health care ethics – especially between pioneers such as Joseph Fletcher and Paul Ramsey in the United States[5] – but has become more pronounced today. Christian ethicists such as James Childress and Alastair Campbell contrast sharply with others such as Stanley Hauerwas and Gilbert Meilaender. Tristram Englehardt's, sometimes iconoclastic, work has been particularly important in exposing the issues involved in the tension. This chapter will take two books published in 1999 to illustrate it further, Michael Banner's *Christian Ethics and Contemporary Moral Problems* and Audrey R. Chapman's *Unprecedented Choices: Religious Ethics at the Frontiers of Genetic Science*. Since both Banner and Chapman are themselves involved as theologians on public bodies concerned with genetics and health care ethics, their work is directly relevant to this question about public theology. In theory, at least, they represent opposite positions on public theology, with Banner an enthusiastic Barthian, particularist and theological purist, and Chapman as more consensual, sympathetic to process theology and a theological realist. In practice, it will be seen that their differences are not so clear-cut. Both Chapman and Banner hold that Christian ethics has a distinctive critical function addressing moral gaps within the public forum. Whether this takes the form of questioning the sufficiency of autonomy as a moral principle or of pointing towards justice and concern

[5] See G. R. Dunstan's review of *On Moral Medicine* in *Journal of Medical Ethics*, 26:2 (2000), p. 77.

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for the vulnerable (Chapman), or whether it entails reminding a pluralist society of the theological roots of many assumed values (Banner), there does seem to be a critical public role for the theologian.

This chapter will finally argue that public theology in health care ethics has a threefold critical role – criticising, deepening and widening the ethical debate in society at large. The deepening and widening aspects depend upon theistic and Christological assumptions, offering a vision for those who will hear of how things could be if all shared these assumptions and were committed to a Christian *eschaton*. Where this position differs from both Chapman and Banner is in expecting that the second and third functions can play a role in the direct work of public bodies concerned with ethics. It will be argued that the latter should remain sensitive to the beliefs of those who are religious within society at large, but that it is inappropriate in a pluralist context for them to adopt explicit theological beliefs themselves. Indeed, public bodies are likely to regard such explicit adoption not just as inappropriate but, given their fear of religious wars (strongly reinforced by September 11), as dangerously partisan. In addition, it is when public theologians imagine that, by virtue of being theologians, they have some special capacity for moral discernment on complex issues in bioscience that they can be most misleading. On this understanding, theologians do still need their secular colleagues: conversely, these colleagues may sometimes underestimate the motivation, commitment and depth which religious belonging and beliefs (or the heritage deriving from them) can still give people when making difficult ethical choices.

This dual perspective suggests that a cautious approach should be taken before claiming that theologians alone can close the three moral gaps identified in chapter 1. Continuing the discussion started in *Churchgoing and Christian Ethics*, religious communities do provide evidence of relative distinctiveness in the values/virtues held and practised by their participants. They supply at least partial evidence for the sort of virtuous communities envisaged by MacIntyre, but there is still a gap between their heritage and its actual implementation. Again, there is some evidence that even secular health care ethics contains implicit virtues derived from Judaeo-Christian communities (and also present within Islam) which may serve to narrow

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the gap between personal resonance and a shared understanding of cosmic order. Finally, there may be implicit residues of grace and faith within secular health care ethics that can narrow the gap between moral demands and a human propensity to selfishness. The suggestion made at this point is that virtues deriving from the specifically Judaeo-Christian heritage of the West (and resonating, at times, with virtues from Eastern religious heritages)[6] may yet implicitly inform secular health care ethics.

Chapter 3 will examine these implicit virtues, looking in detail at the healing stories in the Synoptic Gospels. It will be argued that, in the context of modern health care ethics, the 'miraculous' features of these stories (discussed in detail by Hugh Melinsky, from a tradition of theological realism, and by Colin Brown, from a more purist theological perspective) are less relevant than the virtues that shape them. It will also be argued that it would be anachronistic to jump from practices in these stories to modern medical practice. Following John Howard Kee and Gerd Theissen, this chapter will argue that the Synoptic healing stories should be understood in a first-century context before they are applied carefully to the twenty-first century. And, following John Pilch's biblical research using insights from medical anthropology, it will be argued that these stories have more to do with 'healing' than with 'cure' in the modern sense. A method will then be devised, derived from qualitative research in the social sciences, for identifying the most common virtues shaping the Synoptic healing stories.

Four virtues will be seen to be most distinctive. Compassion is the first of these, not because it is more frequent than the others but because it often comes at the beginning of a story. Occasionally the healing stories directly recount that Jesus was moved by compassion before healing someone. More often it is those to be healed or their friends/relatives who ask Jesus to show mercy or compassion. Sometimes the latter beg Jesus to respond. Compassion is also an important element within parables such as the merciful servant, the

[6] Although this book is a study in Christian ethics, I am certainly sympathetic to this wider religious resonance and will attempt to identify it *en passant*. But I must confess that I am a complete amateur in this area.

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good Samaritan and the prodigal son, and is given by Mark as the initiating point for the feeding of both the four and the five thousand.

Care is a second distinctive virtue. This takes several forms. The most common of these forms is personal touching. An important part of many healing stories is Jesus touching the one to be healed, including touching those already identified in the story as 'unclean'. Many commentators identify this as ritual, even magical, action. However, from a perspective of healing, it may be viewed in more personal terms as the healer reaching out to care for the one who is to be healed but who has already been rejected by others as unclean. Another common form that care takes in the healing stories is anger. Sometimes Jesus appears to be angry at the illness or disability itself, sometimes Jesus 'sternly' warns those who have been healed not to tell others, but more often Jesus' anger is directed at religious authorities who place their principles (especially about keeping the Sabbath) before helping the one who could be healed. Care in this double sense – Jesus caring through personal contact with the vulnerable and unclean and Jesus passionately caring that they should be healed – is a strong feature of these stories.

Faith is a third distinctive virtue. Jesus often notes the faith of those to be healed or of their friends/relatives, and, conversely, can do little to help when there is an absence of faith. A recurrent conclusion he draws is that 'your faith has made you well'. On two occasions – the centurion's servant and Canaanite woman – he particularly commends the faith of those who are not Jewish.

Reticence is a fourth virtue shaping the healing stories. A frequent end to healing stories in Mark, but also in places in Matthew (see especially Matt. 8 and 9) and Luke, is a command (in one place 'repeatedly') to the person healed to tell no one. Not surprisingly this feature has puzzled many biblical commentators. Even though Wrede's notion of the so-called messianic secret is now largely discounted, its shadow still remains in many commentaries. Viewed from a perspective of healing it may appear rather differently. There are frequent mentions in the Synoptic stories of the amazement of the crowds at the healings and alongside some of these are other indications that Jesus was anxious to withdraw from the crowds. Viewed as miraculous 'signs' – an occasional observation in the Synoptic Gospels but far more explicit in the Fourth Gospel – Jesus' healings

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