Does the Healthcare Profession Require a Christian Ethic as its Foundational Basis?

Stephanie Redfern Jones
University of St Andrews

It is the view of Peter Singer, that the traditional ethic is no longer relevant as a working basis in the healthcare profession. However, this paper shall argue that the traditional ethic not only imperatively remains relevant, but also should be further built upon to incorporate true Christian values of self-sacrifice, vocation, presence and love.

Singer argues that the traditional ethical view that all life is of equal value, should be replaced with the recognition that the worth of human life varies.[1] It may be important to note here that Singer addresses healthcare from a non-religious perspective, whereas this paper attempts to reclaim the necessity of Christian virtues within the secular healthcare model. As such, in contradiction to Singer's view, the value of all life must inherently be seen as equal. Singer's view is not one with a secure foundation. It leads to the possibility of trivialising life, and killing those who we subjectively deem to be of little, or indeed, no value. This is not a premise on which an ethic should be based, for it leans too much in the way of demeaning life rather than affirming it. Likewise, Singer argues that if we were to take seriously the traditional ethic of valuing all human life equally, we would have to neglect "quality of life judgments." (191) His assumption here is too limited. Taking seriously the value of all human life as equal does not mean abandoning difficult issues in weighing up decisions of quality of life. It is pedantic for him to assume that affirming all human life means that we cannot consider one's quality of life. In the midst of difficult situations, in a Christian context, discussions should be weighted in such a way as to preserve and protect the life in question; and such a perspective requires both compassion and courage, and the affirmation of our empathy towards another human being. Singer's definition of quality of life is about future human functioning, whereas a Christian ethic would consider a proper definition of quality of life to be future human functioning, in conjunction with one's relationship with God.

Singer also claims that the old ethic falls apart when "life is of no benefit to the person living it." (191) He says that when a person is no longer sentient it is moral to assist in their dying because "in a public health-care system, we cannot ignore the limits set by the finite nature of our medical resources." (192) I acknowledge the finite nature of resources, but our duty to care supersedes economic concerns. Singer omits the issue of the limitations of our human freedom – we cannot place ourselves in the jurisdiction solely reserved for God, "Know that the Lord is God. It is he that made us, and we are his."[2] It is not proper that we should determine who lives and who dies based upon our perceptions of who is a person or not, for we are not our own creation. We belong intimately to God, and although we have free will, we have a duty to act responsibly.

[1] Peter Singer, *Rethinking Life and Death.* (Oxford: Oxford University Press, 1995), 190. Subsequent references to this text shall be included within parentheses as in-text citations.
[2] NRSV, Psalm 100:3.

Singer claims that the responsibilities due of us "demand too much in the way of self-sacrifice in order to provide assistance to strangers," (196) and this energy should be reserved for ourselves and for our friends. Singer's point here is deeply undermined when the 'strangers' of whom he speaks are viewed as brothers and sisters in the Christian community. Within the healthcare environment, where assistance to strangers is encountered and affirmed every day; Singer's new ethic is undermined because self-sacrifice becomes an important part of caring for someone. Self-sacrifice is a virtue often not immediately recognised in the healthcare profession but it is a virtue that is necessarily required from both patients and carers. Singer's model slips into irrelevance where the meaning of suffering is concerned – suffering is seen as something to be rid of because it poisons the patient and their relationships; which is true insofar as suffering is not something we would wish to be present in our lives, for it does not innately bring happiness. However, what Singer does not consider is that suffering possesses meaning in the context of the loving God who is present with us in our suffering, and that faith can have a strengthening purpose for patients. I understand that this may be a seemingly impossible claim, for example, in cases of loss of consciousness, such as people in a comatose state; but the necessity of faith in self-sacrifice is imperative in *all* cases, in order not to fall into the pit of trivialisation, as Singer does, and also to affirm the equality of all life. The merit of self-sacrifice shall be later discussed when I utilise the work of Pellegrino and Thomasma to argue that becoming a healthcare professional is a vocation.

Singer's model of ethics fails to incorporate the unconditional love of God. As humans we falter and our love often falls short of the standard it should – our shortcomings are, after all, a product of the Fall; but if our actions are motivated by self-sacrifical love, we will rarely go wrong. If the primary intention of healthcare professionals is to take the Golden Rule of the Gospel, 'Love thy neighbour,'[3] and to judge what is best for the person who requires care, rather than what is best for oneself, our ethic becomes an all-encompassing model of communal love. This shall be the final aspect of my essay in which I shall, using both the work of Hauerwas and Meilaender, argue that if we take seriously the duty of love and self-sacrifice which is so desperately required in the healthcare profession, we shall be fulfilling our duty in emulating the love of God.

Therefore, in critiquing Singer, the necessity of four Christian virtues have come to the fore: self-sacrifice, vocation, faithfulness and mutual cooperation, which all find their grounding in divine love. These are the four central aspects which I believe to be necessary to be put into practice in the healthcare profession and are central to a Christian ethic of medical practice. These themes shall now be discussed by four theologians.

[3] KJV, Matthew 22:39.

In questioning Singer's model which delegates the healthcare profession to an industry, Pellegrino and Thomasma claim that this type of thinking is "disassembling the Hippocratic-Christian tradition and substituting the ideals of the physician,"[4] and that being drawn to become a healthcare professional is "a commitment to medicine as a special calling dedicated to the interests of the sick," rather than simply a profession. (46) The self-sacrifice that Singer loathes in granting becomes paramount in caregiving in the Christian model. Pellegrino and Thomasma acknowledge the difficulty that Singer addresses, that we "shrink from the sacrifice – of our time, emotions, energies, and money – that the care of the sick so much requires," but their argument is that self-sacrifice is necessary in order to achieve empathy so that the "healer suffers something of the patient's suffering." (86) Logically therefore, self-sacrifice necessitates vulnerability - just as the sufferer is vulnerable, not only to illness, but to the social world and judgements around them; the healthcare professional must too be vulnerable, and share in this emotion as "an act of humility, not of hubris." (87)

The vocation of healthcare professionals is not simply "the minimalistic interpretation of avoiding harm." It involves sacrifice in order to "reconstruct the person" wholly. Here is the recognition that illness is not purely biological, but rather a "deconstruction of the self." (87) Though physicians have a duty to heal, they are not a substitute for the healing that God brings, but they can strive to emulate this divine healing. The importance here is the humility of the physician – it is understandable that they may perceive their position to be elevated because they are liberating people from illness; but as members of community and humanity, they share in equal status to the suffering patient. This relates to Pellegrino and Thomasma's point of seeing all as brothers and sisters in Christ, which requires "a level of dedication above the ordinary." (89) We should view patients as members of the community which is the Christian family because "in every suffering human we recognize Christ, who suffered for all of us." (96) Therefore, self-sacrifice is mutually required from both patient and physician, which enables patients to be involved as "full participants in their own healing." (89)

Pellegrino and Thomasma provide a four-fold model in which care is understood in the healthcare profession – firstly, compassion, in which we are moved to aid because we feel a commonality "because we share the same humanity." Secondly, assistance in living, in recognising that "caring is to do for another what he or she cannot do for himself or herself." Thirdly, assurance, which is the forum for healthcare professionals to put into practice the expertise of their vocation in clinical

[4] Edmund D. Pellegrino and David C. Thomasma, *The Christian Virtues in Medical Practice.* (Washington, D.C: Georgetown University Press, 1996), 51. Subsequent references to this text shall be included within parentheses as in-text citations.

terms, and finally; competence, which combines the aforementioned modes of care into a single model of healing. (94) Their argument is that these elements "are not really separable in the optimal clinical practice." One can understandably see how it may be difficult to juggle all four simultaneously, for we are not the omnipotent God we profess to believe in! However, we can strive to emulate God when we "enhance the healing relationship for each patient." (95) Pellegrino and Thomasma argue that following our aspirations of idealistic values in healthcare is accepting "the grace God gives us to behave compassionately toward all of our fellow persons in the human community." (96) Ultimately therefore, the healing process is about union – union of the self, union of the relationship between physician and patient, union between members of community and "the only thing that will heal completely, union with a caring God." (96)

Therefore, with the role of self-sacrifice and vocation in healthcare practice now outlined, it can be seen how relevant a Christian ethic is within the healthcare profession. I am in no way suggesting that everyone must necessarily be Christian in order to work within healthcare. What I am suggesting is that healthcare professionals should value the human individual as seriously as God does, and in doing so, this requires practical action in the world which emulates God, and such an attitude assimilates with the Christian way of thinking.

Hauerwas addresses the subjectivity of pain and suffering, "What is only a minor hurt for me may be a major trauma for someone else,"[5] and so he observes that "when we are in pain our alienation from one another only increases." It is my view that in the current healthcare systems, we further alienate ourselves, for our care is often limited physiologically, and we are not given adequate support psychologically and indeed very rarely is there any spiritual support from secular professionals. I would suggest within this reforming practical model that the role not be allocated only to religious specialists. This is not to say that hospital chaplains are not important – they are of course, and I am in no way undervaluing the the fine work they do; but it should also be the duty of the secular healthcare professionals – surgeons, doctors and nurses to contribute to the spiritual wellbeing of the patient through a wholesome holistic approach.

Hauerwas acknowledges that healthcare professionals "have been trained with skills that enable them to alleviate the pain of the ill." (78) However, he points out that this is limited because although it may objectively cure an illness, it does not cure the person – it does not provide wholesome treatment. Hauerwas therefore puts forward a communal model in which Christians must emulate "God's faithfulness," because Christians are a community "who have learned how to

[5] Stanley Hauerwas, *Suffering Presence.* (Notre Dame: University of Notre Dame, 1986), 76. Subsequent references to this text shall be included within parentheses as in-text citations.

be faithful to one another by our willingness to be present, with all our vulnerabilities, to one another." (80) This very central aspect of faith is also implicit within the healthcare profession, for the vulnerability of illness is what healthcare professionals are called to be attentive to, and to attend to; body, mind and soul in union. Hauerwas therefore does not call for Christian hospitals, or even a Christian ethos in medical practice, but he makes the correlation between the church "as a resource of the habits and practices necessary to sustain the care of those in pain," (81) which are two common and central values of both the Christian way of life and the medical vocation. It is a vocation to care for another, because "the physician is pledged to come to our aid again and again." This unconditional presence and service intimately mirrors the love God has for us. The duty of the physician is therefore to emulate the faithfulness that God shows humanity through the vocation of healing and caregiving.

Although suffering is intrinsically negative, it can be used to seek a positive purpose within our experience. As Gilbert Meilaender states, "At the heart of Christian belief lies a suffering, crucified God."[6] If there is any great meaning to be found in suffering, here is the ultimate example. Meilaender focuses on who should bear the burden of decision making in medical ethics. In our current modern society there is "an increasing emphasis upon patient self-determination," (79) yet he questions this because the patient should talk with the physician in order to discuss the best possible forms of treatment for the patient's benefit. Here therefore is the necessity of patient and physician cooperation. The physician's opinion is of equal measure because he is "involved as he commits himself to care for us." (80) There should be transparency and honesty between patient and physician and neither should feel compelled to submit to the other, but they should aim to work together in harmony in order to achieve a healing relationship. In this respect, the autonomy of one person does not override the other, "and all live by that shared love Christians have called charity." (87) There is a turn of phrase that we are all born alone, and we will all eventually die alone, but in the theological thinking of both Hauerwas and Meilaender; we are all born in relation, and we all die in relation within the context of the loving Christian community.

In respect of the virtue of Christian ethics previously discussed, I would like to point out three practical recommendations, which I believe would be highly beneficial in healthcare practice. The first practical recommendation is that of presence. Healthcare professionals, under a Christian virtue of self-sacrifice should feel compelled to get to know the patients they treat – to be in communion and solidarity with patients, motivated by empathy. Though time is understandably limited in a busy, stressful hospital setting, quotas and paperwork (though important in pertaining to information

[6] Gilbert Meilaender, *Bioethics: A Primer for Christians.* (Carlisle, Paternoster Press, 1996), 7. Subsequent references to this text shall be included within parentheses as in-text citations.

about a patient's medical history) are secondary to the person the healthcare professional has in front of them. What becomes lost in the anonymisation of healthcare procedure is the integrity of the patient's personhood. We must reclaim an ethic which involves the entirety of the patient's being, and not just their diagnosis. That is, an ethic which first and foremost sees the person, rather than the illness. It is not good enough for healthcare professionals to claim that they are stretched in the way of resources or time – every patient, with the right to claim unique personhood, deserves the time and presence that God allocates to them. Hauerwas claims it is the physician who has "the privilege and the burden to be with us when we are most vulnerable."[7] As such, they have the responsibility to enact God's presence in caring for the sick.

There is a certain disposition that comes with a vocation – one of gratitude, faithfulness and humility. Vocation necessitates striving in practical terms to illustrate the purpose of a calling. First and foremost, a calling to the medical profession does not mean ladder-climbing and 'coldness' – this is the psychological hardening, or self-defence mechanism which Hauerwas (perhaps ironically) refers to as 'professional distance'.[8] This prohibits true empathy between physician and patient, and prohibits a free-flowing of information. It is the presence of mutual vulnerability which should characterise the relationship between physician and patient to allow honest healing. There are times, of course, which call for a mature approach perhaps akin to professional distance; but this should not govern the caring relationship between the two. Central to the physician's disposition should be the virtue of humility. It is admirable and reassuring for a doctor to have confidence in his or her abilities, but it is another thing to be boastful. The presence of humility in one's actions assures us that we serve another, and not ourselves; and in serving another we are serving God, "'Just as you did it to one of the least of these my brothers, you did it to me.'"[9]

Finally, the third practical aspect of the model is the virtue of emulating divine love. Though perhaps obvious, it necessarily is the central (yet perhaps most underestimated) value in the healthcare profession. All too often we forget that the motivation of our good actions in caring for another person necessarily must be borne out of love, and it is this love that enables us to empathise, to understand and to cure. This intimacy allows us to truly relate to another individual and communicate in such a way that profoundly affects those whom we serve – beyond physical healing it creates a relationship of mutual trust and love, emulating the divine. The medical profession should not be about self-righteousness, professional distance or treating 'strangers' as Singer perceives it to be. It should be about intimately wanting to help another human being in their

[7] Stanley Hauerwas, *Suffering Presence.* (Notre Dame: University of Notre Dame, 1986), 79.
[8] Ibid.
[9] NRSV, *Matthew* 25:40.

suffering and that through the knowledge and faithfulness of one's vocation; one is able to heal and to care, motivated by true and altruistic love. This love requires self-sacrifice, patience and an openness to really listen to the people with whom we engage. As Eric Fromm perceptively observes, "To be concentrated means to live fully in the present, in the here and now, and not to think of the next thing to be done, while I am doing something right now."[10] The recreation of divine love in human vocation requires true presence in the healing relationship.

Therefore, it can be clearly seen that the traditional ethic that Singer criticises certainly does not need to be eliminated. It requires re-examination in the light of Christian values, in order to bring to the fore to true purpose of the physician. The healthcare profession should not be Christianised in a dogmatic or institutional sense, yet it does require a Christian basis insofar as the basic principles that underlie the foundation of care and healing align so closely with Christian virtues of love, self-sacrifice, presence and vocation and it is with humility that physicians can emulate the love and presence of God in their profession.

[10] Eric Fromm, *The Art of Loving.* (London: Unwin Books, 1962), 89-90.

Bibliography

The Holy Bible. New Revised Standard Version. Anglicized Edition. Oxford: Oxford University Press, 1995.

Fromm, Eric. *The Art of Loving.* London: Unwin Books, 1962.

Hauerwas, Stanley. *Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped, and the Church.* Notre Dame: University of Notre Dame, 1986.

Meilaender, Gilbert. *Bioethics: A Primer for Christians.* Carlisle, Paternoster Press, 1996.

Pellegrino, Edmund D. and Thomasma, David C., edited by David G. Miller. *The Christian Virtues in Medical Practice.* Washington, D.C: Georgetown University Press, 1996.

Singer, Peter. *Rethinking Life and Death.* Oxford: Oxford University Press, 1995.