

The Quest  
for  
Health  
and  
Wholeness

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for Medical Missions Tübingen



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To Martin Scheel  
who made so much of it possible





## CONTENTS

Foreword .....	IX
Preface .....	XV
1. The Churches' Involvement in Health Care and its Problems .....	1
2. Tübingen I and its Satellite Consultations .....	9
3. Tübingen II .....	23
4. The Surveys of Church-Related Medical Programmes .....	32
5. The beginning of the Christian Medical Commission - its Emphasis on Community Health Care .....	42
6. The Discoveries - New Approaches to HealthCare .....	55
7. The World Health Organization and Primary Health Care .....	70
8. The Expanding View of Health .....	81
9. The Present Studies .....	91
10. The Way Ahead .....	102
Appendix I .....	111
Appendix II .....	116
Suggested Reading List .....	117



## FOREWORD

*on being concerned both about medicine and about something more.*

We human beings do not always fare well. We get sick, we do not thrive, we inflict great harm on one another and we are at the mercy of many accidents. Sooner or later we all die. One of the great human enterprises which has grown up to improve the human condition and mitigate human suffering has been that of Medicine. One of the great claimants to a revelation about the truth of the human condition and about a Power and a Love which redeems and fulfils human beings has been Christianity. Naturally, therefore, in those parts of the world where Christianity has, for a time, been accepted as the true religion and the true source of truly Good News for humanity, Christianity and the practice of Medicine have tended to become involved with one another.

So much is this the case that when medical science and resources developed greatly in the nineteenth century and when there was a great expansion of Christian missionary activity from Europe to Africa and Asia in the same century a very considerable component in that missionary activity was medical mission which set up hospitals and set out to bring medical care to populations living in primitive and disease-ridden conditions »in the name of Christ«.

In the somewhat sombre light of the second half of the twentieth century things are not so clear. Christianity can be seen as mixed up with Western Imperialism and Medicine can be seen as a set of expensive technologies run by professionals who may be pursuing their own interests quite as much as, if not more than, promoting the health of communities and individuals within society. In any case it becomes increasingly obvious that Christianity is one among several religions which survive somewhat ambiguously in a world which has many doubts about the validity of any religion whatever. It is also clear that medical services have developed into something which is becoming too expensive even for Western developed countries, let alone for the more poverty-stricken majority of the world.

Yet human un-ease and dis-ease continue and there are those of us who remain convinced both that the God of whom Christianity speaks is the truly existent God who offers men and women hope and fulfilment (however often Christians have failed, and do fail, to



point to him truly and effectively) and that medicine is, at heart, a valid tradition of science and service for the comfort of men and women (however much both the science and the service get again and again distorted into mistaken idolatries and selfish-seeking).

The book which follows is an account of how some people who are committed to Christianity and committed to the practice of medicine have tried to face up to contemporary realities which call both in question. The questions which are posed, the criticisms which have to be faced and the problems which have to be solved emerge as the account proceeds. All that needs to be pointed out in a foreword is that the search described began from, and continues to be sustained by, convictions about the truth pointed to by the Christian Gospel.

To some the sharp criticisms which emerge of medical practice, health care provisions and the practices and institutions of the Christian churches -may seem predominantly negative. But there is nothing ultimately negative in facing up to criticisms which are forced upon one by the pressures of events and the deepening of insights. At any rate within a Christian perspective to face up to justified criticism is to receive indications about the required direction of changes which can restore, renew and, indeed, increase the positive possibilities of the persons or institutions under criticism. Neither Christian medical mission nor secular provision of health care are doing particularly effective jobs at the present time, judged by their own presuppositions and by their respective practitioners own perceptions of need. Christians can hardly claim that their proclamation of the Gospel is as effective as they could wish. It can scarcely be claimed that health care services throughout the world are as effective as any humane person would desire in meeting the evident needs of the sick, the disabled and the seekers after health.

If, therefore, we have faith, hope and compassion we are launched on a quest. This is a quest for new ways of responding practically and hopefully to the continuing evidences and experiences of human sickness and disease. If one is a Christian or a sympathiser who is seeking for a fresh vision of what Christianity, at its heart, has pointed to or might point to, then the quest is at the same time a quest for a renewed and effective understanding of the presence of God and of what He offers through a re-shaped and re-energized fellowship or church. Thus it will be found that the

account which follows naturally contains a number of strands. There is a search for more effective ways of serving communities with health care. There is a search for effective contemporary ways of understanding and sharing the Christian gospel. There is a search for new forms of expressing and being the Church in local service and in worldwide witness.

Across the world there is now an immense investment of both resources and expectations in the medical provision of health, increasingly or wholly financed by the state. It seems that the nearest more and more people come to having expectations of anything like >salvation< or a freeing from their ills is vested in what they expect of doctors and medicine. If you feel an un-ease or suspect you have a disease, the great hope is to be able to consult a doctor. In Western society at any rate if you cannot cope or just want time off - see a doctor - for a sick note and for a legitimization of your opting out of >normal< life. And if your life-style leads you to a heart-attack because you rush about too much or take too little exercise, or gets you into an accident because you drive too recklessly or gives you blood pressure and complications because you get too fat or drink too much then rely on hospitals to rescue you and drugs to keep you going. In less affluent societies scarce money can easily be diverted into the more expensive forms of medicine to the detriment of simple measures to help the majority of people at the level at which they are obliged to exist.

All this investment in medicine and in certain forms of health care make clear where the societies in which we live are putting their hopes and their trust. (»Where your treasure is, there your heart is also«.) But this trust is clearly misplaced. It is not simply that no feasible health service could deliver the treatments increasingly demanded nor that doctors are trapped in expectations which they cannot meet. There is a still deeper issue to be faced. Our societies seem to have lost faith in any possibilities and powers either beyond human beings or deep within human beings. Instead they put any hopes they have in technical and scientific solutions provided by »them«. So there is a widespread collusion in an idolatry of medicine. As there is held to be nowhere else to turn, scientific medicine, socially organised, is invested with all the hope there is of overcoming unease and promoting welfare. The actual and potential goods of medicine for alleviating suffering and for restoring to people the capacity to seek their own health have been

misunderstood, magnified into a God and given a monopoly over our ideas of and hopes for health. Thus attempts to reach and promote right understandings and creative activities about health are indeed part of preaching the Gospel and of witnessing to God and His power, just as they are part of liberating people from false expectations and dependencies. For they are to do with converting people from false gods to the true God and with setting people free from false dependencies by the establishment of health-giving relationships. The way people seek health is profoundly symptomatic of what they make of life and of what life is making of them.

We cannot therefore separate our attitude to health from our attitude to life. This is why you cannot and, indeed, must not define health. Like life it is an open and as yet undefinable, because as yet unfulfilled, possibility. At least, this is what we can and must say if we see the God who is known to Christians in Jesus as the source, redeemer and fulfiller of life. Health is what we enjoy when we are on our way to that which God is preparing for us to enjoy and when we are collaborating with Him in that preparation. It is also what we shall enjoy when all is prepared and available in the fulfilment of the Kingdom. >Health< is thus a value and a vision word which has both to be brought constantly down to earth and to be related persistently to a promise, an aim and a hope which lies ahead and above us.

Words like >healthy< and >healing< and the judgements which they express, together with the activities which embody them, are to be understood and used as strictly derivative and limited by the particular contexts they are operating in. A >healing< for instance refers to the overcoming and mending of a lesion or wound in a body or a disruption in a relationship or a malfunctioning in a pattern. Something is >healthy< if it is functioning according to its pattern and capacity. Whether or not the healing or the healthy functioning contributes to or is an expression of >health< is a further question. A healing is probably most often the removal of an obstacle to enjoying and contributing to health. Healthy functioning is probably most often the capacity to contribute to health providing wider purposes and relationships are being appropriately responded to. Such an approach further provides a positive way of facing up to and living with sickness where it seems irremovable, suffering where it is inescapable or necessarily



endurable for the time being, limits which make every healthy episode an episode only, and death. Practically speaking health is never reached, it is always to be sought in ever widening circles and it is frequently but temporarily enjoyed. From the faith point of view health is probably best thought of as an «eschatological» idea. That is to say it is what God promises and offers in the end and so what is available now both in foretastes and as the aim and ideal which judges our current activities and structures while at the same time provoking us to more healthy responses and exciting us to a search which is at the same time a seeking of health and an enjoying of health.

So the quest which is reported on in this book is unfinished as it must be of necessity. What is being sought are practical and local ways of making the service of medicine much more widely and directly available to all suffering human beings while at the same time developing and sharing a vision of possibilities which invite us all far beyond the range of either the possibilities or the failures of medicine.

Leeds, U.K.  
July 1981

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## PREFACE

This book describes only a segment of this Quest. Its choice is determined by the experience of a group of people variously related to the promotion of health and/or to the practice of medicine who were drawn together at various times by their Christian commitment and desire to understand the relationship between health, wholeness and salvation and what this understanding, however tentative, would say to the Churches' involvement in medical mission.

For several of them the search for the meaning of health was first prompted by an involvement in evaluating the contribution of Western medicine to the health care of populations in lesser developed countries. It began with surveys of church-related medical programmes in several African and Asian countries in order to measure their effectiveness in meeting the health needs of the people and, also, their appropriateness as expressions of a Christian ministry of healing. There were no ready-made criteria for this latter exercise and this account will attempt to describe the continuing search for them. From the surveys it was found that the churches had concentrated their efforts on building and operating hospital and clinic-based curative services which had a limited impact on the problems. They were, basically, repair facilities which did little if anything to remove the causes of sickness or to promote and maintain health. While they were necessary components of a medical care system their relevance was diminished because of the absence or paucity of other components in the system such as public health measures, primary health facilities, etc., and their operating costs were so high, relative to the resources, that the possibility of meeting more basic health needs was precluded.

Moreover, these church-related institutions together with all the other available facilities of Western medicine were reaching only 20 % of the populations in these countries so that 80 %, and these were usually the poorest and most needy, were deprived of services other than traditional forms of healing where these were available. It also became apparent that the so-called »miracles« of modern technology were largely unrelated to general improvements in health even though they seductively claimed and were granted the lion's share of the scarce resources. Although these findings came as a surprise to the surveyors who were distressed that so many efforts

of good will and commitment should be misdirected by an inappropriate transfer of the Western medical model, it led them to a closer analysis of the model itself.

The obvious disparity between those served and those deprived of medical services challenged the priority, long practiced in Western medicine, of individual care on a one-to-one basis. Human life has a social dimension as well as a personal core and while medicine must be person-orientated rather than disease-orientated it can never afford to neglect the social relationships and demands which shape the person. This led to the formulation of community medicine - a system designed to bring the benefits of medical care in an acceptable manner to as many as possible. This was later amended to correct the unbalanced relationship between professionals and those who bore the burden of sickness, so that the latter fully participated in the development of the system of care and in the therapy itself.

These and other discoveries are described in this book. It would never have been written but for the encouragement of those who participated in the Tübingen studies; especially Dr. Martin Scheel and Prof. David E. Jenkins. Finally, and in a very proper sense of appreciation, I would thank Helga Füllner for all the trouble she took over transcribing the strange sounds she must have heard on so many tapes.

Tübingen, March 1981

## Chapter 1

### THE CHURCHES' INVOLVEMENT IN HEALTH CARE AND ITS PROBLEMS

The Church which is the organized and visible expression of Christian discipleship has always had some difficulty in discovering how it should respond to its Lord's command to heal. In contrast to the other imperatives - to preach, teach and baptize whose implementation presented no problems - the imperative to heal has always created some confusion. The New Testament miracles of healing were so large a part of Christ's ministry and that of the apostles that the Church has always found difficulty in explaining why this particular charisma apparently waned in the second century. The confusion is evidenced by the various groups which claim to have some special insight into what they believe is the unique healing ministry of the Church. So we have faith healers and prayer healers and those who follow St. James's advice regarding anointing and the laying on of hands. There are still others who have established or belong to special orders and societies for the practice of their belief that there is a unique healing power in the sacraments of grace and, particularly, in the Eucharist. The majority, however, have interpreted their response to the healing imperative through the provision and operation of hospitals and clinics to minister to the sick, especially in situations where no other such provision was available. This has been especially true of the medical missionary activity of the Church in the lesser developed countries although there still exist many church-related hospitals in some European countries and in North America. For some reason, there appears to have been less questioning of the rationale for these latter institutions than for those in the Third World.

The Christian Church has probably had a longer history of involvement with health care than any other institution. This is not only because its founder was so much concerned with the practice of healing but, also, because there has always been a very intimate relationship between man's religious beliefs and his concern for health. The word health, itself, comes from an Anglo-Saxon root-HAL, which is related both to the words Whole and Holy. In primitive religions, many rites were initiated to protect men from disease. Since a knowledge of nature's laws was fragmentary it was

assumed that her influence on the person and on the tribe alternated between anger and beneficence. It was therefore necessary to placate the gods which control nature's moods and so insure their beneficence. This became a priestly and, often, a regal function. It is not surprising that a person equipped with such powers, or at least the ability to persuade others that he possesses them, should hold a position of authority in the community and in the nation. Even in the 17th century the concept of the priest-king still persisted in Europe. It was part of the doctrine of the divine right of kings, so they were often approached or placated to use the »king's touch«, as it was called, in order to heal disease.\*

With the diminishing phenomenon of miraculous healing, the Church turned to the provision of facilities where the sick and the aged could be cared for in what we now call hospitals and hospices. The decree of the Emperor Constantine in the year 335 withdrew official recognition from the Aesculapia which had served both as temples and as refuges for the sick. They were now replaced by hospitals founded by devout and wealthy Christians. Thus, Justinian was responsible for developing the great hospital of St. Basil in Caesaria in the year 369. The following year saw the building of a Christian hospital at Constantinople, where two deaconesses nursed the sick. Fabiola, a wealthy Roman matron, endowed a church-related hospital in Rome in 390 and about the same period hospitals were founded in Edessa, Hippo and Ephesus.

By the year 500 most cities in the Roman Empire had such institutions but, already, the medical precepts of Hippocrates and other early Greek physicians were being discarded because of their »pagan« origin, while mysticism and religious rites became more prominent. Records concerning the establishment of hospitals in the succeeding centuries are scarce and we suspect that some of those which were established were really alms-houses sheltering the sick as well as paupers and the homeless. However, there are records of the establishment of the Hotel-Dieu of Lyons, France in 542 and the better known Hotel-Dieu of Paris, founded by Bishop Landry in 660. This latter institution, although it has been rebuilt on several sites at different times, has given continuous service since its founding.

\* (This aura of mystery still clings to the physician of today who does little to disavow it)

During the Middle Ages there seems to have been much more concern for the soul than for the body. No surgery was practiced because the incision of the human body was regarded as sacrilege since man's body was created in the image of God. This was a period in which religious orders created »Hospitia« which were usually constructed adjacent to a monastery and provided food and temporary shelter for weary travellers and pilgrims. The hospital movement grew more rapidly during the Crusades which began in 1096 and it is likely that the impetus for this lay more in the sense of selfpreservation for the Crusaders themselves since far more died from pestilence and disease than by the swords of the Saracens. As a result, military hospital orders sprang up to provide accommodation for sick and exhausted Crusaders along all the travelled roads. One body of Crusaders organized the Order of St. John which established a 2000 bed hospital in Palestine in the year 1099. This Order has persisted to this day. In the 12th century there was a great surge in the establishment of hospitals in England. In London, St. Bartholomew's Hospital was established in 1137, St. Thomas's in 1207 and St. Mary of Bethlehem in 1247. These were much more like the hospitals we know today in that they were specifically designed to care for the sick and were not combinations of alms-houses, resting places for weary travellers and sick-bays. St. Mary of Bethlehem was the first English hospital to be used exclusively for the mentally sick. This institution, whose name was shortened to Beddelem and then later to Bedlam was so notable as to give a new word to the English language.

While the Church may have pioneered in the establishment and maintenance of hospitals it has rarely claimed that its continued operation of these institutions is its unique responsibility. The majority of them were taken over by secular agencies or by the State as public conscience was awakened to its responsibility for the care and treatment of the sick. The religious orders which still operate hospitals in the so-called developed countries use them as channels for their concepts of charity and diaconal service but their number is diminishing. The largest number of hospitals now directly related to the Church is the result of missionary activity much of which began in the early part of the 19th century. By 1910 there were 2100 hospitals and twice that many clinics operated by mission agencies of the Protestant Church alone. The Catholic Church began its medical missionary activity later but soon outstripped the

Protestants in number of institutions and foreign personnel. The Orthodox Churches have established very few medical institutions and their concern with healing has been largely restricted to the sacrament of anointing.

The early missionary doctors were burdened with demands for surgery for it was in this area that indigenous systems of healing were most deficient. In the 1870s the mission agencies of Europe and North America began recruiting nurses for overseas service and they demonstrated a quality of disinterested care and concern which was hitherto unknown except in the immediate family circle. They were pioneers in educating nationals, and gradually achieved a status for nursing service which eventually overcame the cultural prejudices to this profession. At one time, in India, the nurse was considered lower than the menials and sweepers and no self-respecting family would want their daughters to adopt this kind of work. Even as late as the 1940s, 80 % of the nurses in India were Christian girls who had been trained in church-related institutions. Today, that ratio is much lower but it took close to 100 years to overcome the prejudice.

During the past 40 years there has been a steady decline in the number of church-related hospitals and medical programmes around the world, partly because of the increasing financial burden of operating these institutions and partly by reason of the increase in government institutions and services. Kuwait provides a dramatic illustration. In 1949 there was only one hospital and four physicians in Kuwait provided by the Reformed Church in America. By 1967 there were 16 hospitals and 189 clinics with more than 500 physicians. The ratio of beds and doctors to population was the highest in the world and services were entirely free. The mission hospital which had operated on a fee for service basis could not survive in this situation and was purchased by the government although the missionary personnel were invited to remain.

The accelerating costs of medical care became most apparent in the early 1950s when the micro-biological and technological revolutions in medicine not only extended the possibility of treatment and cure in many hitherto incurable situations but, required expensive equipment both for diagnosis and treatment as well as more highly trained personnel. The institutions related to the church could not avoid the effects of these dramatic advances in medical science nor would they have wished to do so but, it placed



them in an increasingly competitive situation as the number of secular institutions grew. They were at a further disadvantage because they were fee for service institutions whereas the government hospitals were heavily subsidized and offered, ostensibly, a free service. In many African countries the governments would subsidize the churches' hospitals to a limited extent but this has never applied to similar institutions in Asian countries.

One obvious effect of higher costs in fee for service medical programmes was the decrease in services rendered to the poor. Since subsidies from the mission agencies overseas failed to match the increasing costs these had to be found from higher fees for services which it was hoped might produce enough income to cover free care for the poor. However, there was a limit to this approach and it troubled many of the hospital staff who, conscious that their Christian vocation directed them to serve the poor, were now forced to cater to the rich in order to do so and even that on a decreasing scale.

Another disturbing factor was that these increasing costs coincided with a process of devolution in which responsibility for these medical programmes was being passed from the overseas mission agencies to the national churches which were themselves the offspring of missionary activity. This process spawned a good deal of rhetoric at the time about self-governing, self-supporting and self-propagating churches which tended to ignore the economic realities of the situation and thus led to many irritations in a relationship which had been optimistically described as "Partnership in Mission". The process of devolution was usually conducted in an atmosphere of euphoria and few of the national churches had any conception of the financial and administrative burdens they were taking on themselves; nor were the mission executives in any position to enlighten them since they rarely possessed expertise in medical care economics and administration. The usual result was that the national church leadership saw in this inheritance of hospitals prestige coming to a minority group; free treatment for church members and available jobs for them also.

All these factors together - the expansion of secular medical services; the rapidly increasing costs of operation and the problems of support relationship led to a questioning of the relevance of Christian medical programmes and a search for »authentic«

expressions of health and healing which would be faithful to the Gospel. The fact that this questioning and search was almost exclusively western in origin led to a great deal of misunderstanding on the part of the national churches which now «owned» these institutions. They felt that they should at least have the privilege of learning from their own mistakes as the westerners now appeared to be doing at a time when they were handing them over to others! While the timing may have been unfortunate it was nevertheless necessary to raise questions about the assumed uniqueness of Christian medical programmes. Were these Christian hospitals different from others, and if so, how? Were Christian medical workers performing a different task in a church-related hospital than in a secular one? After all, these institutions of whatever ownership were following identical techniques of medical and nursing practice and their personnel were trained to an identical curriculum. So, what made the difference?

In reviewing articles written during the decade 1955-65 which were published in the *Journal of the Christian Medical Association of India* one finds a frequent concern to discover the answers to the questions posed above. In seeking a justification for the church-related hospital it was argued that it was a channel for evangelism, »the primary objective of all medical missions is to confront the world with Jesus Christ as our Lord and Saviour.«<sup>1</sup>

In some cases it was felt that a hospital presented a unique opportunity for evangelism since it provided a captive audience! Fortunately, this was a minority view although some institutions did use public address systems for prayer and preaching in the wards and patients had little choice but to listen to them. Others sought an answer through what was regarded as a specifically Christian understanding of medicine which ministered to »the whole man« in body, mind and spirit although this was never spelled out very clearly. As to what made the Christian medical worker different one finds a particular concern about doctors with only rare mention of nurses and other personnel. »By definition a medical missionary is both a doctor and a missionary. The basic motivation for a doctor responding to the call for foreign service is the urge to bring the Gospel message to those who live in heathen darkness. Many of course have motives of social uplift to alleviate suffering and relieve

<sup>1</sup> Scott, W.R.: *Potentials for Ministry in Medical Work. Journal of the Christian Medical Association of India*, Vol. 34, No. 6, pp. 352-357, Nov. 1959

pain. But this lacks the Christian motive. These devoted medical volunteers are not missionaries.«<sup>2</sup> Through hindsight it appears that we all experienced some difficulty in those days in defining our terms and resented having to justify what we believed was self-evident service in the name of Christ. This author uses the inclusive pronoun since he was as guilty as any of using words and sketchy definitions in this fashion. He is not always sure he has improved! On reflection, one strange assumption was that all national doctors and nurses who were Christian should serve as »missionaries« to their own people regardless of the fact that the »foreign« missionary represented a minuscule proportion of his or her fellows in their own countries. Some of this confusion was due to arguments which were advanced to justify the operation of Christian medical colleges which required ever increasing subsidies from abroad. There was disappointment when their graduates failed to meet these expectations. »The supply of Christian doctors is probably nearly adequate, but many hospitals secure a worker for a year or two after qualification, but he then leaves for higher study, for a secular post, or to set up in private practice. The fact must be faced that doubt still remains in the minds of many young graduates regarding the real possibility of advancement in Christian medical institutions.«<sup>3</sup>

Nobody seems to question the relevance of Christian medical service in leprosy institutions nor in remote areas which fail to attract other members of the professions. Did this suggest that the churches' role in the provision of health services was that of a pioneer in meeting human need where no other provision was available but that when secular agencies were willing and able to accept responsibility then the church could withdraw? On the face of it this appears to have been the historical process in the West and now is proceeding in the lands of the younger churches. However, this explanation failed to satisfy many who were convinced that there is a unique Christian understanding of health and healing and that the search must continue. In 1963 the Division of World Mission and Evangelism of the World Council of Churches and the Commission on World Mission of the Lutheran World Federation

<sup>2</sup> Op. cit.

<sup>3</sup> Wilder, E.W.: *The Pattern of Christian medical work in changing India.* International Review of Missions, Vol. 48, pp 190-197, April 1959

decided to sponsor a consultation which would address itself to these issues. In a proposal for such a consultation these bodies reiterated their firm belief that »there is a Christian understanding of the meaning of health and the means of healing which forms an essential part of the contribution of a Christian medical service.«<sup>4</sup> They expressed this »understanding« as follows: »God's purpose for the redemption of man as proclaimed in the Gospel of Jesus Christ is contained in acts that restore man to the wholeness of his life. Man is not himself aware of the real nature of the sickness that infects him - body, mind and spirit. God in human form brings new being to man, restores him to fellowship with himself, offers him hope in the world, and calls him to a service in the world which he as redeemed and healed man can do in gratitude for God's supreme act of salvation.«<sup>5</sup>

So the purpose of the consultation was set. It was to explore this claim to uniqueness in the Christian understanding of health and healing. It also had a pragmatic objective to explore the need for new missionary strategy and planning as the proposal made clear; »The response to the calling of God and of human need which led to medical missions being established as an integral part of the whole Mission of the Church, and which brought about also the planning and building of medical and training institutions with formative influence in the changing societies of Asia, Africa and Latin America, has now to be seen in a new light. The conditions of national welfare and development, the responsibility of missionary agencies for continuing the central purpose of Mission and the indigenous development of younger church life seem to call for a new strategy and planning in Christian medical work in these areas. It also calls for an examination of the motivation of medical missions as well as the means available to carry them out.«<sup>6</sup>

The venue of the consultation was to be Tübingen in Baden-Württemberg and it was to be hosted by the German Institute for Medical Missions under its Director Dr. Martin Scheel.

4 Documentation from Deutsches Institut für Ärztliche Mission (DIFÄM)  
Tübingen

5 Documentation op. cit.

6 Documentation op. cit.

## Chapter 2

### TUBINGEN I AND ITS SATELLITE CONSULTATIONS

In preparation for the consultation which is now usually referred to as Tubingen I, the sponsoring bodies appointed a Norwegian physician, Dr. Erling Kayser, to prepare preliminary documentation some of which was based on his own experience as a missionary doctor in Indonesia. He was familiar with the then current problems of medical mission there and found ample evidence that these were wide-spread as he observed during visits to other Asian and Middle Eastern countries as well as Ethiopia. Dr. Kayser also edited some preparatory material from replies to a questionnaire which had been submitted to a selected group of theologians, mission agency executives and physicians.

In reviewing these preparatory documents it becomes clear that Dr Kayser saw beyond the immediate problems of inadequate funding and devolution of responsibility to national churches with all its attendant difficulties. He was equally concerned about the claims which Christians made for mission medical service and the fuzziness in the meaning of words and concepts which were so frequently used in attributing uniqueness to it. If there is a »unique« Christian understanding of health, healing and wholeness then it should be "different from all others.« It was clear that the impulse which led to medical mission at the early part of the 19th century was in response to overwhelming need. The response was instinctive without any conscious concern about its theological justification. This came later when the response had become organized and institutionalized and, particularly, when the needs appeared to be met also by those who had no pretension to Christian faith. So, the question arose, if the commission to heal is an integral part of the *ministry* of the Church, what kind of *service* is the Church called to give in the performance of its *mission*? The semantic problem becomes obvious when one turns to the New Testament where the same word is used for ministry and service (diaconia). There is no use of the word »mission« in the New Testament except in the Revised Standard Version (Acts 12:25) where it is a translation of »diaconia«. Yet, while *mission* may not appear as a noun (except in the instance above) it does appear in the

verb form, »I send.« Mission is the sending; diaconia is the purpose for which one is sent. Moreover, diaconia in the New Testament sense carries not only the connotation of service which has now become a rather cheap word (e.g. telephone service), it also bears the meaning of servant. Its most »unique« example is Christ himself who came not to be served but to serve even to the point of death. He knowingly and purposely took for himself the title of servant even though it was a term of contempt and he embodied it in his every activity. Christ also made it clear that this kind of service and the ability to perform it were of God's purpose and that it was He who enabled the doing of it. »As my father has sent me« became the commission to His Church to engage in a like service. While many forms of service are listed in the New Testament the service of the Word has pre-eminence. It is the proclamation of the Gospel of Salvation and every form of service should point to that Gospel and glorify God who makes it possible. There should be no distinction here between the act of service in whatever form and the witness which is inherent in it. What is important is not the one who witnesses or the act of witnessing but He who is witnessed to in the act.

In the light of the above one may ask whether there is such a thing as »the ministry of healing« in the abstract aside from the actual function of the *service* of healing. One clue to the answer is given in Christ's own exercise of this service. His acts of healing were conditioned both by the opportunities presented and by the priority of the ministry of preaching. In several of the miracles he forbade publicity, indicating a spontaneous outburst of love, an unconditioned desire to give help by physical healing which, at the same time, is a powerful witness or »sign« to the Kingdom of God. This leads us to think of the service of biological healing as a response to opportunities for the expression of disinterested love which are, at the same time, signs pointing to something beyond, something higher and something permanent. It is hardly love to do such acts as »bait to catch new converts«; it is hardly love to be satisfied merely with biological healing.

In the exercise of Christ's healing power there can be no question of his compassion and his recognition of the evil of disease but why then did he exercise that power so selectively and so seldom? There is the demand for silence from those whom he healed, »tell no man.« There are the occasions on which he disappeared just when the word

of the healing had prompted others to seek him out. Were they no less in need than the others? If we regard the meeting of human need to be one of the highest priorities of Christian service how are we to explain the apparent rejection of this priority by Christ himself? The answer seems to lie in his complete and utter obedience to the will of God and that this is the way God works. It is in line with Christ's rejection of Satan's proposal in the Temptations, for there too he was invited to perform greater works of compassion and of power. As we examine the records we are drawn to the conclusion that while Christ identified himself with man in his need he intentionally separated himself from man's concept of the answer to that need. This is part of the dilemma we face when seeking to evaluate medical services which are performed in Christ's name. Our natural inclination is to make judgements based on human categories such as the volume of services rendered and their quality. But Christ rejects these criteria of evaluation. He healed men's bodies within the context of the salvation which he brought.

So much for the attempt to discover the »uniqueness« of the Christian understanding of health and healing. By implication, it invited a new assessment of the forms of service which the Church had chosen for medical mission. Prior to Tübingen I the normative form was curative medical service in hospitals and clinics. It is not surprising that this should be so because physicians, whether nationals or foreigners, were trained in accordance with an »internationally recognized« curriculum of medical science which generally took for granted the public health situation of western countries and which was one hundred years in advance of the public health needs of developing countries. The church overseas appeared to assume that the prevention of disease was the task of the government even where the government did very little about it. There was also a surprising lack of interest in providing services for the mentally ill or investigating the merits of indigenous forms of healing some of which might be more culturally acceptable than western medicine alone.

In reviewing the then current literature on medicine and theology, Dr Kayser came to the conclusion that if a dialogue did exist it was very one-sided. While theology was interested in medicine the interest was not always reciprocated. Some churches had sponsored such a dialogue during the 1950s and 60s. One of the first of these was the Anglican Archbishop's Commission on the

Church's Ministry of Healing. This was followed by similar dialogues sponsored by the Lutheran, United Presbyterian and Methodist Churches in the United States. Apparently one of the difficulties was to find an agreeable starting point. The churches were inclined to begin from a biblical basis but, here again, there were many differences of emphasis. Some would view health and healing in the context of their interpretation of Creation, the Fall and Salvation; others started from the biblical doctrines of man, the Kingdom of God and the Holy Spirit. Still others stressed the incarnation or the concept of the atonement.

From the medical side, interest was largely confined to a search for resources which gave meaning to life in situations of inner emptiness where patients lacked or had lost a sense of meaning which would make life worth-while. It was natural that such a concern should interest the psychiatrist and the general practitioner. However, the rapid growth of specialization and its higher economic rewards had reduced the ranks of general practitioners in some countries, particularly in North America, and the psychiatrist rarely found full acceptance from his colleagues in other specialties which were based on a mechanistic view of intervention against disease.

The first Tübingen consultation was convened May 19 and adjourned May 25, 1964. In retrospect, its timing was significant. This was a period which saw some innovative thinking about the appropriateness of curative medicine as an answer to the health needs of developing countries. Some of the first to call this into question had been medical missionaries themselves like Dr Douglas Forman in the US and Drs Harold G. Anderson and Stanley G. Browne in Britain. However, the most effective challenge to the transfer of western medical technology to these countries came from a British doctor who, while serving as a locum in a mission hospital in Uganda, conceived the idea of a symposium which should be concerned with the medicine of poverty for he believed that it was a dearth of resources rather than a warm climate which was the main deterrent to a solution of the health problems in the Third World. The findings of this symposium which was held at Makerere University in Uganda were published in 1966 with the title, *Medical Care in Developing Countries* edited by Dr Maurice King who first conceived it. Unknown to most of the participants in Tübingen I was a very significant work by Dr Robert A.



Lambourne which was published in 1963 with the title Church, Community and Healing. The importance of this work only became apparent after the first consultation was ended and reference will be made to it and subsequent papers by Dr Lambourne in a later chapter.

The 18 participants of Tubingen I represented nine nationalities and all but one of them had worked in developing countries. Several papers were presented followed by discussion but few of them were reflected in the final statement which was issued by the participants. This indicates that something happened at Tubingen which went beyond the preparatory material and shows that no one person held a monopoly in directing the discussion. The report which was edited by Dr Frank Davey was published by the World Council of Churches under the title *The Healing Church* (in German, *Auftrag zu heilen*; in French, *Eglise et guérison*). It contains only four of the contributed papers followed by the findings, the closing meditation and an indication of the programmes which might follow as a result of the findings.

The Findings clearly indicate the unanimous opinion of the Participants that the Church does have a specific task in the field of healing which arises from its place in the whole Christian belief about God's plan of salvation for mankind.

»The Christian understanding of healing begins from its place in the ministry of Jesus. There it was a sign of the breaking into human life of the Powers of the Kingdom of God, and of the dethroning of the powers of evil. The health which was its fruit was not something static, a restored equilibrium; it was an involvement with Jesus in the victorious encounter of the Kingdom of God with the powers of evil.

A concept of health which is merely that of a restored balance, a static >wholeness<, has no answer to the problem of human guilt or death, nor to the anxiety and the threat of meaninglessness which are the projection upon human life of the shadow of death. Health, in the Christian understanding, is a continuous and victorious encounter with the powers that deny the existence and goodness of God. It is a participation in an invasion of the realm of evil, in which final victory lies beyond death, but the power of that victory is known now in the gift of the life-giving Spirit. It is a kind of life which has overcome death and the anxiety which is the shadow of death, Whether in the desperate squalor of overpopulated and underdeveloped areas, or in the spiritual wasteland of affluent societies, it is a sign of God's victory and a summons to his service.

The Church's ministry of healing is thus an integral part of its witness to the Gospel. In the exercise of this healing function the Church must never

be indifferent to the patient's spiritual condition, his religious faith or unbelief.

The Christian ministry of healing belongs primarily to the congregation\* as a whole, and only in that context to those who are specially trained. If healing is understood as above, it will be clear that the entire congregation has a part to play in it. By its prayer, by the love with which it surrounds each person, by the practical acts which express its concern for every man, and by the opportunities which it offers for participation in Christ's mission, the congregation is the primary agent of healing. At the heart of this healing activity lies the ministry of the Word, Sacraments and prayer. The specialised work of those who have been trained in the techniques of modern medicine have their proper place and will be fruitful in the context of this whole congregational life. We have to recognise that a rift has developed between the work of those with specialised medical training and the life of the congregation, so that the congregation often does not see how it can take a real responsibility for the work of a healing institution. One of the most urgent needs of to-day is that Christian congregations, in collaboration with Christian medical workers, should again recognise and exercise the healing ministry which belongs properly to them.

The Christian ministry of healing as exercised by the Church is subject to him who is the Lord and Head of the Church, and to the continuing guidance of the Holy Spirit.

It follows that the form and expression of the Church's ministry of healing must be kept under constant review particularly in relation to the mission and ministry of the Church in each generation. For this purpose the Church must seek and follow the continuing guidance of the Holy Spirit in the exercise of its healing ministry.«<sup>1</sup>

Other »findings« stressed the conviction that all healing is of God whether it occurs through what we call natural laws, some of which we know, whether or not it appears to have been brought about by medical means, or whether or not it has been accomplished by means of spiritual healing. This should be accepted even to the extent that all the achievements of modern medicine ultimately are to be understood as signs of the healing power of God. There is frequent reference to the special role of the congregation which has itself become a transformed community. It is not only a worshipping community but it is a serving and spending fellowship. The professional medical worker is seen as a member of such a fellowship strengthened by its corporate support and using special skills which are enhanced by practical acts of love and service and

**\* By >congregation< in this Report is meant the corporate fellowship of the People of God wherever it manifests itself.**

<sup>1</sup> The Healing Church, World Council of Churches, Geneva 1965, pp 35-36

sanctified by the ministry of the word, prayer and the sacraments.

The participants expressed their regret that there was so little evidence in theological education of concern for or explicit teaching about the Christian understanding of healing. Courses in pastoral counselling tended to regard it as a specialty and thus shifted responsibility from the congregation to individuals although they could never compensate for the corporate expression of support, care and healing which was the role of the congregation. While nothing is said about whether the Church had discharged its duty in the field of healing through the maintenance of hospitals and clinics or through the witness of Christians in secular institutions, the consultation urged the complete integration of existing institutions into the life and witness of the Church since both institutions had tended to have a life of their own. There was a recognition that the Church could obviously never meet all of human need for health care but it should always regard new avenues of service as demonstrations of how need should be met. To this end, it called for an integrated witness in which medical work could be correlated with social work, nutrition and agriculture and community development and thus recognize that medical care was only one component of a diversity of disciplines all of which were necessary to promote and maintain health. The conclusions of this consultation were summarized in the closing meditation.

»In our search for a Christian understanding of healing we have considered compassion in response to need; we know that compassion is a Part of a Christian concept of healing, but it is not distinctive. We have recognized in much medical work a motivating sense of the dignity of man. This too in a special sense is true of Christian healing, but even a particular sense of the dignity of man is not enough. We have noted that a disciplined Practice of the medical arts is a part of responsible work, but this also is not distinctive to Christian healing. We have seen a noble dimension in the willingness of those engaged in healing to suffer. This also is fundamentally a Part of Christian healing, but this too is not entirely distinctive.

We have been led to hold our search against the background of the New testament drama of salvation. The first element in the drama is the emptiness of man, his confusion, his anxiety, his sense of insecurity and often the meaninglessness of much of life. Against the emptiness of man the New Testament speaks, first of the fullness of Christ (in whom the Godhead dwells) but, also the emptiness of Christ who poured out himself and became obedient unto death, even death on the cross.

We know therefore that health in daily life can never be a static **Wholeness**; rather it must be understood as a constant encounter with

sickness and with all the powers of evil. A constant encounter which, through God's grace, can be victorious. We have been led to hold our search against the question of who it is that heals and we have seen that no man heals alone. Healing demands a variety of talents, gifts and disciplines, through which the richness of God's grace brings true healing to a total brokenness of man. We have been led to hold our search against the background of the corporate life of the people of God which is a compassionate, sympathetic fellowship of a sharing of the burdens and the joys of life. We know that the healing of bodies apart from life in this fellowship is as incomplete as launching ships in dry harbours, or sowing seeds on stony soil.«<sup>2</sup>

While the consultation did not devote much of its time to the problems of financial support of institutions or whether curative programmes were the most effective form of service in situations of massive need, it did recommend to its sponsoring bodies that a careful analysis be undertaken beginning with an extension of the surveys of church-related medical programmes at a national level already initiated by the World Council of Churches Committee for Specialized Assistance to Social Projects (SASP). It also recommended that a further consultation be organized to discuss the subject of »Health and Salvation«. The results of these recommendations will be reviewed later.

It may appear strange that a consultation called to deal with some of the difficult problems arising out of the Church's involvement with medical care should have had so little to offer in the way of analysis of or solutions to these problems. Instead, it concerned itself with the Christian understanding of healing in a much wider dimension for which the hospital and the clinic were no longer the required components. It recognized that the Christian gospel was more concerned with the sick person than with the particular sickness and that the sick person was part of an environment and a community which also stood in need of healing. The Church can never relegate its healing service to professional medical and nursing workers in isolation. Its »unique« task is to restore men and women to fellowship with God and with one another and to restore communities to a righteous order characterized by mutual dependence and support for one another. If this may appear a strange task of healing for the Church it is because it has too frequently failed to be a healed and healing community itself - a

**2 The Healing Church, World Council of Churches, Geneva 1965**

Society in which men and women who have been forgiven learn to forgive and so build up a fellowship of reconciliation which operates in all aspects of the world's life; the relationship between management and labour, between ideologies and races and between the hungry and the well-fed. Yet, if the Church is to obey its Lord's command to heal then it too must first seek healing for its own wounds of disunity. It is not possible to obey where the world can look at the Church and cry in derision, »physician, heal thyself. « An essential task of healing is to restore the unity which God requires of the Church.

### *The Satellite Consultations*

After the publication of »The Healing Church« a number of satellite consultations were called in various parts of the world. Some of these were initiated by those who had participated in the Tübingen meeting; others were organized independently to examine the implication of the »Findings« in a national or regional context. One of the first of these took place in Coonoor, South India, in March 1967. It was sponsored jointly by the Lutheran Church - Missouri Synod and the Wheatridge Foundation and had the advantage of long and careful preparation.

The participants at Coonoor recognized that the crisis in overseas medical mission was, essentially, a question of identity. One needed to know if there was anything distinctive about the healing which the Church provided. They thought they would find an answer in a much more inclusive vision of the Church's healing task but the operation of medical institutions was not the most essential element. They recognized that their conclusions had a much more significant application to Christian congregations set in a western culture which were not involved in any form of medical service and, indeed, they found it strange that the Church in the West should invest a high percentage of its overseas missionary budget in medical work while remaining almost totally isolated from medicine at home.

The Study Director of the Coonoor Conference, Dr Thomas Droege, who had prepared much of its preparatory material, summed up its conclusions as follows: »It can be described as a search for renewal within the Church, an attempt to rediscover its

essential nature and function. That the Church should be involved in healing was taken for granted. More fundamental was the question of what forms that involvement should take, what meaning it should have. The commitment of Christ and of the early church to healing was evident. Most of the forms, however, have been superseded. The question now, was how to combine the insights of the past and the advanced medical practices of the present? If the Church is mission, and healing is one aspect of that mission, then a renewal of that aspect is urgent. That concern dominated the thoughts of the conference participants.

The first step in renewal for the Church is self-understanding. A first step toward understanding its healing nature was made at Coonoor, but only a first step. Self-understanding must precede a concern for logistics, principles of administration, long-range goals, re-examination of existing facilities, guide-lines for relating to other healing agencies. An exercise in self-understanding must precede a dialogue with other healing agencies, public or private. Such dialogues must follow if the Church is not to live in isolation, but they dare not precede the prior question; how the Church is to understand itself as a healing community.«<sup>3</sup>

As might be expected from the sponsorship, the Coonoor Conference was deeply concerned with the theological rationale for the healing mission of the Church and sought this through frequent reference to biblical passages. The participants concluded that although they were willing to concede that the era of »medical missions« was at an end, they were not sure, precisely, what would succeed it. They liked the concept of the healing church which suggests very much broader involvement in healing than medical care alone and placed it close to the centre of the Church's mission but they were not sure what organizational patterns would emerge from this development. On one point they were quite clear however; that only a healed community could ever become a healing community.

(In retrospect, it is a tragic commentary on man's seeming inability to follow even his own good advice; this Church was soon to become deeply split over accusations of heresy levelled by some of its members against others.)

3 Droege, A.T., *An Evaluation of the Coonoor Conference*, Concordia Theological Monthly, Occasional Papers No. 2, p. 7 (1968)

The remaining consultations were convened in Africa, East, West and South. Chronologically, the first of these took place in Makumira, Tanzania in February 1967. Its focus was primarily theological but it did recommend a sympathetic study of traditional medicine to see how far its practices might be used as an effective means of promoting health. It also drew attention to the need for a survey not only to review existing involvement in medical care but to assess needs which were not yet met and it recommended the establishment of an ecumenical planning body to co-ordinate the churches' activities in medical work. Recommended standards for staffing hospitals were also proposed. The final recommendations were addressed to theological colleges and seminaries which were urged to study and give instructions regarding the healing ministry of the church and assist in the proper training of hospital chaplains who would be responsible for the pastoral care of hospital staffs as well as patients.

The next consultation was held in Legon, Ghana on the other side of the continent in April 1967. It was particularly significant because it was not only preceded by the consultation in Tübingen but also had the advantage of a survey of church-related medical Programmes in the country, both Catholic and Protestant, which had been completed in 1966. As a result, the participation was fully ecumenical and, for the first time, included representatives of the government and the medical faculty of the national university. The meetings began with a description of the indigenous healing Practices of the people of Ghana with a plea for recognition of the herapeutic value of some of these which could well be incorporated into the practice of Western medicine. Of particular value were the close personal relationships which existed not only in the extended family but also in the tribe as a whole which resulted in a strong supportive and caring element which promoted therapy. The insistence in the Western type hospital of strict adherence to visiting hours, for instance, could not be understood in this culture and, moreover, would impede recovery from illness.

The recommendations of this consultation were most significant.

The hospitals operated by the churches in Ghana represented, in terms of occupied beds, more than 30 % of the whole but, this statistic had little meaning while each hospital existed as a quite separate entity. It was therefore resolved to form an Association of church-related hospitals and clinics which would co-ordinate all

church-related medical programmes both Catholic and Protestant and would employ a full-time administrator to promote this. This body would present a united voice in negotiations with the government and would make a concerted effort to employ Ghanaian doctors in its hospitals and give high priority to the training of nationals for all positions of authority. There was also a resolve to aim at getting church-related medical work in Ghana into the hands and the hearts of the Ghanaian churches since it had largely become a domain of the professionals who saw their task as being done in the »name« of the church rather than as an integral part of the local churches' witness. There was also a strong emphasis on the concept of a »therapeutic« team which would incorporate the non-professional employees of the hospital as well as members of the local congregation.

As a measure of the degree of ecumenical cooperation achieved at this consultation it was agreed that all the churches should contribute to the establishment of one higher grade training programme for nurses which, though based on a Protestant hospital, would be supported in staffing and funding by all. It was also decided that after full consultation with the Ministry of Health the churches should explore new avenues of service in community health as distinct from their previous preoccupation with the individualistic approach through curative medicine as practiced in hospitals.

The remaining meetings were both held in South Africa. In May 1967 the Division of Mission and Evangelism of the Christian Council of South Africa convened a conference in Johannesburg with the theme, »The Church and the Ministry of Healing«. This was followed in September of the same year by a conference held in Mapumulo, Natal, under the sponsorship of the Lutheran Church.

Both of these meetings were concerned to define, if possible, a Christian understanding of health and healing which they saw in the context of God's intent for man in creation. Thus, Healing was seen as the restoration of a dynamic harmony between God and man, within man himself and in his relationship with his fellows. This restoration results in a new attitude to sin, sickness and death which manifests itself not in freedom from them but in a freedom within them. This freedom is only made possible by Christ's victory over death by His resurrection.

Both meetings gave emphasis to the valuable insights within



traditional African concepts of healing which reflected a new awareness of the values in indigenous culture. These had been shrugged off in the past as manifestations of paganism. Now there was a growing awareness of the need for humility in approaching other cultures and this was especially true in regard to medicine since the practitioners of allopathic medicine were particularly arrogant regarding the supposed superiority of their methods.

In reviewing the after effects of all these consultations including that of Tübingen itself, one finds it difficult to point to any radical change in the attitude of churches to their ministries of healing. Yet it was to the churches that each consultation addressed itself; calling for renewal exemplified in the practice of a mandate given by the Lord of the Church. The lack of response may have been due to the fact that the participants in these consultations were not church leaders but the majority were professionals engaged in medical and nursing services. Their original intention had been to address themselves to the problems of their service and to discover a cogent rationale for the churches' involvement in medical care. Yet, in every case, they found themselves concluding that the church had somehow lost its capacity to heal partly because it had chosen to define this role too narrowly in terms of medical practice, addressed especially to those in sore need, and, partly, because the church had lost its sense of corporateness and community through a pre-occupation with individual salvation. In this sense, the church suffered the same imbalance as medicine which was most frequently practiced on a one to one relationship between physician and the individual patient.

The consultation in Ghana did have some practical results in the formation of a coordinating body supported by all the churches, Catholic and Protestant, which gave them a common voice in negotiations and cooperation with government. The higher grade school of nursing was also established and a full-time administrative secretary was found for their organization. However, it is probable that these results came more from the survey of medical facilities in Ghana rather than from the theological discussions. In fact, a Proposal to combine child immunizations with the rite of baptism which had been proposed at the conference was never adopted.

The consultations never resolved the problems posed by language and, to this extent, failed to provide a true dialogue between the two disciplines of medicine and theology. Although, as has been pointed

out, the majority of participants were medical people yet their vocabulary was more familiar to theology than to medicine. As Dr Anthony Barker pointed out in one of the South African meetings, the word »heal« is rarely used by the physician. »The doctors look on it as a presumptuous word, an unscientific word, a word which implies a certain emotional environment in something which it's better to keep emotionally neutral.«<sup>4</sup> On the other hand, the doctor's use of the word »scientific« leaves much to be desired because there are so many factors which have an impact on therapy but which cannot be measured or tabulated in any scientific way.

Yet, even while it is difficult to pin-point the specific results of Tübingen I and the regional meetings which followed from it, there can be no doubt at all that they introduced a new dimension into all subsequent discussions about the church's role in healing and into its engagement with medical practice as will be shown in later chapters. The concept of the Healing Church is a glorious one and one which is close to the heart of the gospel. That there are so few healing churches is an indictment of the Church, not an invalidation of the concept.

4 Barker, E.A., Priest and Doctor, A. Synthesis. Consultation on the Church and the Ministry of Healing. Christian Council of South Africa, Johannesburg 1967, pp. 11 - 17

## Chapter 3

### TUBINGEN II

One of the conclusions of Tübingen I was that the Christian understanding of *health* derives from the Christian belief about God's plan of *salvation*. This led to a specific recommendation that a further consultation be convened, under the same sponsorship, to discuss the validity of that statement and to explore the relationship between health and salvation. There was an obvious etymological connection since the word »salvation« was derived from the Latin root *salus* which means health. However, this was not to be merely an academic exercise in semantics but it should speak directly to the needs of the Church and of the medical professional. It was to explore whether an understanding of the relationship between the concepts of health and of salvation would make any difference in the way that the medical professional, the clergyman or the church member should behave in his respective role. Put in another way the issue was whether the physician's view of health is complete and sufficient without a contribution from Christian theology, and whether the theologian's view of salvation would be complete and sufficient without the contribution of the scientist.

In preparation for this consultation several preliminary meetings were held, particularly in the United States but, also in the United Kingdom and Germany. It was a time when the questions raised by this proposal appeared to be related to a growing interest in the wholeness of man in society. In different ways, the doctor, the theologian, the sociologist and the psychologist were concerned with this theme and anxious to discover whether differences of approach and terminology were actually concealing a common Pursuit. There was much interest in what the psychologists termed the »integrated personality« which while it was a woolly and imprecise expression carried with it some of the attributes surrounding the concept of wholeness.

As the proposal for this consultation became more generally known it attracted attention from individuals and groups working independently on this and similar concerns. They were willing and anxious that their findings be available for study. One of these was an investigation into the effect of acceptance and belief on the speed of healing which was reported by hospital chaplains working with a

professor of ophthalmology in a teaching hospital in New York. This investigation showed that patients require a conceptual framework for making sense of sickness, providing an explanation of the illness and what is required to alleviate it and find healing (salvation). Within this framework is an expectant faith in the healer which had been shown to shorten the period of convalescence. Unfortunately, this element of faith or trust is not always reciprocated by the physician. By the euphemism of the »cooperative« patient the physician usually means the completely docile patient. This and other similar studies made it clear that both theologians and physicians needed to be broader than their respective disciplines. The first step in achieving this would be to discover, firstly, whether they were talking about the same things in different vocabularies and, secondly, whether they were looking at the same person or, in other words, whether their views could be reconciled in a single view of man.

When one treads on the frontier between the disciplines of medicine and theology one is aware that while some of the signposts are still legible it is quite easy to lose ones way and, however much one might desire to disregard the barriers which denote the frontier, they are, unfortunately, still there. Some of these barriers can be traced back to the work of Descartes in the 17th century. His dichotomy between the mind and the body gave rise to a mechanistic interpretation of the physical world. The body was conceived as a machine which might be taken apart and reassembled if its structure and function were fully understood. Thereafter, medicine gradually adopted the engineering approach which relied on intervention in the working of the machine. The fact that it so often worked successfully blinded its users to its serious deficiencies as a conceptualization of the problems of health.

Those who are concerned with salvation know what stands in its way: it is sin and man's sinfulness. Yet the rational view of man which is dominant because of the prestige of science leaves little room for such a concept of sin. It is much easier to hold to the deterministic assumption that what we cannot help doing is hardly a sin. Even our own sense of guilt we attribute to maladjustment, malfunction or inadequacy and this kind of guilt can be alleviated by showing that it is irrelevant.

If we are to lower the barriers which demarcate the frontier then we must discover in the medical realm analogues to the Christian

sequence sin - guilt - repentance - forgiveness - redemption. We must also discover whether the physician who is successful in the mediation of healing to the sufferer from guilt is doing something essentially the same or very different from what is accomplished when the gospel is proclaimed and accepted unto salvation.

The most significant contribution to the preliminary preparation for Tübingen II came from Dr Robert A. Lambourne who, as a physician, had already crossed the frontier and made a study of theology. His book titled "Community, Church and Healing"<sup>1</sup> was published in 1963 and was followed by a series of papers and lectures until his untimely death in 1972. He reminded us that the structure of a health service with its clinics, hospitals and professional workers is only the visible tip of an iceberg. Supporting it but largely ignored is the vast army of relatives, friends and neighbours who care for the sick at home. While the hospital provides an aseptic environment it also isolates the individual Patient from family and community, in fact, those who are most likely to care for him. Moreover, the growth of medical specialization has tended to break down the patient into Pathological parts so that less and less is he regarded or treated as a whole person.

Lambourne saw in the act of healing a close parallel to the sacrament of the eucharist by which the Church sustains itself and its members through the body and the blood of its Lord. In every act of healing, Christ regarded himself as representative of the community which participated with him then and still should through his Body, the Church. So it is the Christian congregation as a whole which is *meant* to be the healing Body of Christ among men and *can* be when it has effectively become a community knit together in Him. When the Christian community serves the sick Person in its midst it becomes itself healed and whole. »The sick visitation is no isolated action of an isolated individual at a particular moment of time. It is a doing of a memorial of what God did when he visited his people. Thus in the sick visitation the Church offers itself in word and deed with the life of Christ, including his healing work, and the sick man who is visited is confronted by love sent from God to heal and to save. A sick person is joined to the Body of Christ. He is joined to the fellowship of Christ, the fellowship of

**Published by Darton, Longman-Todd (now out of print), London 1963. A French translation only is available.**

the holy spirit, and the fellowship of the saints. He is joined by the fellowship of love. This fellowship of love which is to be found in the local church, and which, embracing the suffering of its own members and the suffering in its own neighbourhood, is to be a therapeutic community . . .« (page 120)

His most radical idea departed abruptly from our usual concept of healing as a lifting of burdens and a liberation from suffering and pain. For Lambourne a man is only whole when he is joined to the suffering of others. »Here indeed is a mystery which is proclaimed in the life of Christ. He who would save his life must lose it. He who would be made whole must suffer as he joins the suffering of man in Christ.« (page 72)

One of Lambourne's most interesting papers which was distributed to the participants in Tübingen II had the strange title »Hospital Salt, Theological Savour and True Humanism.«<sup>2</sup> In it he considered the treatment of the individual patient in the hospital in order to discover whether Christian faith and life had anything relevant to say to clinical medicine in this situation. He did this in the context of his thesis that the hospital was a powerful humanizing instrument which combined personal commitment with the use of modern technology and had become the »temple of the 20th Century« - a place which reflected and to some extent shaped our ideas about what life is like. To this institution in whose daily life occurs everything from new birth to death he applies the central thesis of his book »that healing works are meant to be social experiences of the power of love which authenticate what they display. In this act of curing disease all those who participate by responding and acting and believing in the primacy of sacrificial love as the ultimate grounds for order and the recreation of persons become themselves reordered and recreated.«

The hospital is a place where this could happen and had largely replaced the Church which now had difficulties in communicating the gospel in action. Now it was the hospital where the »miracles« happened but, this discovery came at a time when the hospital itself was threatened by its sheer size and the complexity of specialization as well as the growth and power of its inanimate technology. As a result society is fed not with freedom, but with the conviction of having been delivered from death by things.

**2 This hitherto unpublished paper is likely to be included in a collection of Dr R.A. Lambourne's papers now being edited by Dr Michael Wilson.**

Further, he argues that clinical medicine was the natural enemy of extreme objectivism or scientism on the one hand and extreme subjectivism or existentialism on the other because its diagnostic method was a mix of objective signs with subjective explanations contributed by the patient. Yet here again the enemy enters in the form of technology and research to dehumanize what should be a very personal approach. The results of a battery of tests becomes more important than the relationship of persons in a therapeutic encounter. Translated into institutional form the hospital now becomes a factory for the repair of things rather than a hospice for the care of souls.

Some of this has happened by the adoption, whether conscious or not, of a hierarchy of values which excludes the incurable, the dying and the mad from teaching hospitals and so shapes clinical interest of the future doctor but leaves him inadequate to deal sympathetically with a considerable segment of human experience. "Medicine becomes more and more a matter of elimination of disease and less the care of the person with or without a disease. Surgeons top the list, public health doctors and those who care for the incurable and the mad share bottom place. Another reason is medicine's concept of health as the absence of disease - a concern for rooting out objectifiable defects in isolated individuals.« Moreover, Lambourne felt that medicine »had no doctrine of salvation except b an immediate and total removal of evil. Anxiety, pain, suffering and sacrifice which in Biblical mythology and Christian belief hold a paradoxical position, being totally opposed to God's will and yet the very means of its ultimate triumph, are in orthodox medical Philosophy things for isolation and eradication by power.« This is illustrated in medicine's attitude to the care of the dying for death denotes failure. But not all the blame for these attitudes is attributable to medicine. The Church has too often tried to confine medicine within narrow ethical boundaries based on a pre-Darwinian cosmology - the so-called natural law and it is medicine's experience with such moral philosophy which makes dialogue still difficult and this will only be resolved when medicine and theology can come to terms regarding the nature of man.

Finally »salvation does not consist in man being freed from disease or achieving whatever sets of psychological standards we believe to be the measure of mental health. Health and salvation are not equivalents though health is a concomitant of the service of

God.« Just as the anthropology of the Gospel permits of »no division in principle between salvation of body, mind, soul and the whole physical order« so, medicine must discover this anthropology if it is to survive and be a real giver of life, a salt of true humanism. So long as the concept of curing illnesses continues to be identified as the goal and triumph of medicine in contrast to the concept of seeking and preserving the wholeness of man in -a whole society as the purpose and triumph of God; then the concepts of health and salvation will remain unrelated for all practical purposes.

There was a common theme in the preparatory papers submitted and distributed prior to this second consultation and that was the need to overcome the dualism between material and spiritual reality which fails to do justice to either the biblical or contemporary view of man and of his sickness and healing. While there may be different interpretations of the nature of illness from the perspective of the viewer whether he be physician, theologian, psychiatrist or sociologist; the error is to assume that any one interpretation is exhaustive or rules out another.

The Tübingen II consultation was again held in the delightful and convenient facilities of the German Institute for Medical Mission from September 1-8, 1967. Participants came from Australia, Britain, Denmark, Germany, Holland, India, Japan, Sweden and the USA. An introduction attempted to state the problems and pressures generated by contemporary health and medical services - that while, in varying degrees, man lives longer than he used to; his stay in hospital is shorter and he has a much greater hope of recovery from diseases which were once considered fatal; in the process, he has been reduced to an impersonal object. Because of the focus on his localized pathology he tends to lose his identity and individual uniqueness. Housed in the aseptic atmosphere of the hospital he is far removed from the familiar locus of personal care given by family and friends. Further, the increasing cost of these services due to technological advances widens the disparity in their availability so that more than half the world's population has no access to them. Yet this is only one of the moral dilemmas in which medicine has become trapped. While it points with pride to an extended life expectancy it shows little concern with what this extended life is for. Its inferior provision for the incurable and the dying makes explicit a value system which emphasizes clinical success and in which death becomes the ultimate failure. One might suppose that the Church



would be able to supply the answer to these problems. She exists to serve God by serving man and transforming his anxiety into hope. Yet the Church must stand under judgement for she has usually opted out of any confrontation with the biological sciences and has used this medical system uncritically for her own purposes. Would it be possible to recall the Church to her appointed task in enabling man to find that true health which is related to salvation?

The above is a summary of the problem posed to the participants of the consultation but the response was not what one might have expected. Bishop Ian Ramsey explained why and his statement is quoted in full because it points to a methodology which became normative for this and subsequent discussions up to the present time.

»It might have been expected that in order to give (as we were asked) an exegetical and systematic theology of health and salvation, passages from the Old and New Testaments and perhaps from the Fathers would first have been quoted, broadening out into some highly generalized discourse about man's health and salvation. But such a procedure may well fail to make any creative contact with problems and issues which are being currently raised, in this case, about health and salvation. To avoid this difficulty, a rather different procedure has been attempted. This follows situations, such as the introduction delineates, when we grapple with the problems and issues which they raise, that new insights will emerge; that our understanding of the Gospel will thus be illuminated, and that this illumination can then in its turn be brought to bear on the particular problems before us.

We hope to show how, for example, faced with certain interpersonal Problems, we can be led to a new understanding of the significance of the Crucifixion which, revealing anew to us the Gospel, will in its turn enable us to bring a Christian judgment to bear on the problems, for instance, in the doctor: patient relationship, with which we started. Or again, certain Problems confronting hospitals and doctors which point for their solution to a consultative group may thus be hinting at a new understanding of the Church as a Christian community! and when that has been disclosed to us, we will be enabled to bring to the hospital something of the resources available in the Church of Christ.

There, at any rate, are two examples of the procedure as it is found in subsequent sections. It may be seen as a liberating approach designed to avoid the dangers of a stereotyped theology, which does justice neither to the complex and far-reaching pressures of the contemporary situation, **Whether** in medicine or theology, nor to the living Christ and the character of Christian revelation. *Empirically* speaking, failing to start from where we **are** may generate theological fantasies of service neither to God nor man;

*theologically* speaking, our procedure is an expression, in terms of method, our belief in a living Christ who is the living Word.

Some might say, »But why, then, start with the problems? Why not start with Christ?« However, we must beware here of confusion, for there are ambiguities over this matter of 'start'.

Undoubtedly, the *logical* start for all Christian theology is with Christ. In this sense »the saving work of the living Christ« must be the key-phrase for Christian theology. But the *logical* start need not necessarily be the *practical* start in any particular situation. These starts would only coincide if we were in heaven where theology, like much else, would hardly be needed. Meanwhile, however, we may well have to begin our theology practically in the basement or at least on a side-balcony. Pastoral or medical concerns alike may well point us to a start with the secular world, even though »the saving work of Christ« is *logically* the key-phrase, the apex, from which a theology, when finally constructed, will spread. Such a start with problems is no denial of Christ. For not the least significant of our present medico-theological discussions is that when they encourage us to practice - and even demand that we practice - this approach, we find that it is one by which the living Christ may be disclosed anew, and being disclosed in the context of genuine problems, He speaks to them.

In this way we are being called to a new theological modesty which matches ever deeper insights which man has into his finitude as he comes to know more fully the infinite God with whom he is confronted. These are the background convictions against which our present theological studies have been broadly developed.«<sup>3</sup>

As a result of this approach the discussions of Tübingen II were much more concerned with finding a role for the Church to play in the total healing process than with defining a relationship between health and salvation." Yet, in searching for this role it could not avoid criticism of some prevalent assumptions behind the practice of medicine in the West while, at the same time, expressing gratitude for the many benefits which that practice had brought. So it is not surprising that the final report of this consultation bears the title, »Health - Medical and Theological Perspectives.«

Unlike the first Tübingen consultation, this one produced no formal findings although it did offer suggestions regarding the role of the Church as a healing community. It also suggested some correctives to western medical practice particularly through the use of interdisciplinary teams for consultation and therapy. Some extracts from the Report are given in Appendix I.

Finally, one might have thought that these two consultations

### 3 Report on Tübingen II, pp. 4-5

\* Prof. Seward Hiltner of Princeton University had prepared two basic papers on this topic which were used as study material prior to the consultation; »Health and Salvation; Analysis of the Terms«, and »Salvation's message about Health.«

which attempted to bridge the gaps between the Church and Medicine **would** have resulted in some significant changes within the life of the Church for, after all, it was the Church which was being addressed and being recalled to her own mandate. It might be argued that insufficient publicity was provided for these reports or that they were too narrowly addressed to missionary situations. Yet, even if they had been widely read by clerical leadership it is still doubtful that their recommendations would have been implemented. For, of late, the clergy have largely lost their nerve in confrontation with the biological scientists and the medical Practitioners. In this area they have thought to legitimize their status by using the language and adopting the methods of the medical and psychotherapeutic professionals and, in the process, have become secondary members of the health team. The public expectation of the clergy role, no doubt due to observation, is that of reacting in relation to other professionals. They have almost been forced into being reactors to world views and life-styles which are shaped without any theological initiative or prophetic insight.

Beginning in the United States and then spreading to Europe and other continents we have seen the emergence of a new phenomenon known as the Pastoral Counselling movement. It has developed a new kind of professional within the clergy who, while acting Presumably on behalf of the Church and its members, tends to remove from them the obligation to be part of a healing community themselves. When Christ commissioned his disciples to heal. He was not addressing the graduating class of a healing profession. He was laying an obligation on all who would follow Him.

Fortunately, the Christian faith is not dependent on its institutions or professionals. The gospel still proclaims a God of love and justice who overwhelms all technologies and offers a quality of life which alone can provide that health and wholeness (salvation) which is God's intent for his people. And for those who cannot fathom the »mysteries« of theological formulations there still remains the invitation of Christ himself, »come, enter and Possess the kingdom that has been ready for you since the world was **Made**. For when I was hungry you gave me food; when thirsty, you gave me drink; when I was a stranger you took me into your home, when **naked** you clothed me; when I was ill you came to my help, when in prison you visited me . . . I tell you this, anything you did for one of my brothers here, however humble, you did for me.« (St. Matth. 25:34-36, 40)

## Chapter 4

### THE SURVEYS OF CHURCH-RELATED MEDICAL PROGRAMMES

The surveys of church-related medical programmes at a national or regional level (see page 16) began towards the end of 1963 with an exhaustive study of institutions related to the various Protestant churches in Nigeria, Uganda and Kenya. The National Council of Churches in each of these countries had appealed to the World Council of Churches for assistance since many of their member denominations had recently inherited responsibility for medical programmes initiated and previously maintained by missionary societies. The surveys had two primary objectives: (1) To discover the relevance of Christian medical work as a professional activity within the context of the existing health and medical needs and in relationship to other agencies, governmental and private, which were also seeking to meet those needs; and (2) to seek the relevance of Christian medical programmes to the life and mission of the church particularly on the national and local level. It should be noted, that this was the first time in which surveys of church-related medical programmes had been conducted inter-denominationally. Prior to this each denomination and each Catholic religious community had evaluated only its own institutions.

One of the surveyors in these initial evaluations had largely anticipated some of the subsequent findings of Tubingen I and introduced to both church and medical leadership the concept of the Church itself as a healing community. However, it was a measure of the misunderstanding of professional roles and common objectives that while a few individuals responded enthusiastically, there was little evidence of this characteristic in the churches or even attempts to experiment. This is all the more surprising in Africa where health and illness are so often understood in their community dimension. In fact, in each of these countries there had been a rapid growth in independent churches in all of which this concept of healing was particularly important. Many of them were started because they missed this healing dimension in the western-style churches which were the products of missionary activity.

By the time the fourth country-wide survey had been requested

an initial attempt had been made to standardize the questionnaires which were to be used for this and all subsequent national surveys. It gradually became refined on the basis of use and experience. The fourth survey was requested by the National Council of Churches of Malawi in Central Africa. By a happy turn of events it became a fully ecumenical exercise since it included the Roman Catholic programmes as well. When the surveyor arrived at the national airport in Blantyre he was met by the Secretary of the National Council of Churches and informed that the roads leading from the airport were temporarily closed while they awaited a state visit by the Emperor of Ethiopia, Haile Selassie, whose plane was expected within an hour. During the enforced wait there was a chance meeting with the Bishop of Mzuzu who had flown in from his diocese in the north of the country in order to attend a meeting of the Episcopal Conference of which he was chairman at that time. When he learned the purpose of the survey he requested that it be extended to cover Roman Catholic medical programmes also and, with the approval of the National Council of Churches, this was accepted. So began a series of ecumenical undertakings which not only included all future surveys but several other activities as well, some of which will be described later.

The survey began with an examination of the Government's development plan for health services. In it there was no reference to church-related programmes even though they constituted 40 % of the existing national facilities. The reason for this omission was not as strange as it may appear. There were 26 church-related organizations operating these institutions but they had no common voice. As the Life President of Malawi expressed it, »they are all playing in their own back yards and they never look over the wall.« In such a situation, planning becomes impossible. At the conclusion of the survey, those whose institutions had been examined were asked to assemble in order to hear the results of the study and its recommendations. The first of these was that they disregard the labels on their doors which never cured anybody but, instead, tended to inhibit dialogue, and that they should form an association to coordinate their activities and engage in joint planning amongst themselves and, collectively, with government. This they agreed to do and the association was offered accommodation by the Life resident within the Ministry of Health.

There were many convincing arguments for such coordination.

The Government had raised the requirements for nurse education and no one church alone could meet them. One hospital had independently started a training programme for laboratory technicians, while the hospital of another church 60 km away had heard nothing of it, even though its own laboratory facilities and manpower were woefully inadequate. Still another institution had an excellent programme for training physiotherapists but trained only its own, whilst the Government and the other churches were in desperate need of such personnel. Through this new association, the churches resolved to carry out the following objectives: 1) To develop the highest level and distribution of health care through mutual cooperation of all the members; 2) to facilitate cooperation with the Government's Department of Health and Medical Services and to speak as the official voice of the private sector in liaison with the Malawi Government for the furtherance of programmes, which would be constructively related to the Government's health services; 3) to develop and coordinate training programmes appropriate to the health needs of the country; 4) to engage in regional planning.

When this association and its programmes were reviewed 10 years later it was found that while the initial focus of activity had been centered on the development of uniform administrative practices and a sharing of personnel for more effective programmes, this later shifted into a broader concern for public health activities and outreach programmes. Malawi, with a population of approximately 5 million had and continues to have one of the lowest per capita incomes in Africa, and expenditure on health care fails to reach the total population. A concern to correct this situation occupied the attention of both the Government and what was now called the Private Hospital Association of Malawi, but the latter, representing the private sector, had a greater flexibility in which to develop innovative programmes. It began by placing the highest priority on the development of community health and fully integrated preventive services. At the beginning of 1968 its committee on public health decided to concentrate on the development of under fives clinics, which would reach the large population of mothers and children not normally seen in the outpatients' departments of hospitals. It obtained printed weight-charts from Kenya and began training programmes for middle-level health workers to staff these clinics. Within a few months of the inauguration of this programme,

the Ministry of Health started a similar development and weight-charts are now printed for both sectors at the government press in Malawi. It is estimated that 35 % of Malawi's child population under five years of age is seen at least once in such a clinic, where weights are checked and the majority are given DPT and polio immunizations as well as BCG. Mothers are introduced to health education and nutritional advice including a practical cooking demonstration. Some of the integration and the scope of this new interest in preventive measures can be seen from the increase in immunizations in the private sector - from 29,735 in 1967 to 234,283 in 1972.

In contrast to other countries where the private sector continued to develop hospitals as the focus of health care, the association in Malawi added only one small new hospital and upgraded a few existing ones in the period under review. Primary attention was given to the establishment of rural clinics and nutritional rehabilitation units. It pioneered in pre-school feeding Programmes, publication of health education literature, and in the development of refresher courses for rural health workers. Dental prophylactic programmes were started in the northern region of Malawi under the direction of a Canadian dentist who was supported by the United Church of Canada but based at a Catholic hospital operated by the Medical Missionaries of Mary from Drogheda in Ireland. This is a further example of the ecumenical cooperation which was pioneered in Malawi.

As a result of this coordination in the development of integrated health services many denominational barriers were breached. Thus, the dispensaries and clinics were related to hospitals for supervision and referral services and the determination of which relates to what was based on convenience, geographical factors and population densities. Yet, in all these activities, the identity of each institution and its relationship to its founding organization was never lost.

This rather lengthy account of the Malawi experience was included to show that cooperation amongst the churches led **inevitably** to a more responsible awareness of national health needs, **reaching** beyond the preoccupation with individual institutional problems. The church-related hospitals in lesser developed countries too often worked on the assumption that the prevention of disease and the promotion of health were the exclusive responsibility of the government. This is understandable when

national health care systems are inappropriately modelled on Western countries and much of the church-related sector was, and in Africa, still is, under expatriate direction. Therefore, it is of special significance that the Malawi programme for national coordination and planning of services together with those which followed it should have given the highest priority to integrated programmes designed to bring more effective health care to the maximum number of people in the population. In the case of Malawi, the complete cooperation of the government itself was an important factor in bringing this about. The government also benefitted from the arrangement, since it dealt with one organization housed in its own Ministry and representing more than 150 separate units.<sup>1</sup>

Not all the surveys had as useful an outcome as that of Malawi. Some of them, as in the cases of Indonesia and Cameroon, resulted in the collection of statistics but little else. The recommendations, including the proposal to coordinate the activities of the church-related medical institutions, failed to gain approval. It was also found that where some degree of cooperation had been previously established such as a Protestant Hospital Association, a Catholic Hospital Association or both it was almost impossible to achieve any further meaningful cooperation between them such as the level achieved in Malawi. Some of these organizations were created for the specific purpose of bargaining with governments for larger grants in aid. Since they were successful with this limited objective they were reluctant to risk further cooperation for joint action as this might threaten their individual and limited cooperative identities and might prove fatal to the vested interests of their officers.

On the other hand, the results which followed the surveys in Zambia and Ghana were similar to the Malawi model. Coordinating agencies were established under full-time executive officers and more effective cooperation with government resulted in participation in national health plans. These two countries were later followed by Botswana, Lesotho, Nigeria and Sierra Leone.

There were five regional surveys within the sub-continent of

<sup>1</sup> The above account of the development in Malawi is taken from this author's previous description which was published in CONTACT No. 26 »Health Care for All«. »CONTACT is published by the Christian Medical Commission of the World Council of Churches.



India and even though it was impossible to visit all the 620 hospitals and 570 clinics operated by the various churches, Protestant and Catholic, a series of selection processes was put under way to identify certain areas and certain institutions which together would give a representative view of the situation. The first of these surveys was conducted in North East India in 1965 and was followed through to the latter part of 1967 in Punjab, Haryana, Uttar Pradesh, Madhya Pradesh, Andhra Pradesh, Mysore, Kerala and Madras, with brief excursions into some of the neighbouring states.

The reports of these surveys were collated and studied by the staff of the Christian Medical Council in New York who then called a consultation with representatives of church agencies involved in medical work in India in order to arrive at a consensus regarding future strategy as a step towards discussions with Indian leadership which would make the final decisions. Some of the findings of this consultation represented conclusions which were applicable to all the countries which were surveyed and, for this reason, are noted here. They are taken from a »Consultation on the Strategy of Christian Medical Work in India,« dated March 22, 1968 and sponsored by the Christian Medical Council of the Division of Overseas Ministries of the National Council of Churches USA. They will be supplemented by a brief review of the final conclusions which were common to all the surveys covering 18 developing countries. But, first, with regard to India, an independent observer **With** several years experience of secular medical work in that country reviewed the survey and had this to say: »I do not believe that it is an unfair evaluation of the situation to say that the medical work of the Church in India is an unplanned, uncoordinated operation without clear objectives, trying unrealistically to meet needs which have not been properly assessed and in the face of a severe limitation of resources. There do not appear to have been any clear-cut goals to determine what the Church is trying to do nor any **real** effort made to assess the needs of the community in which it works.

Why should the Church operate a hospital in India? Should **Christians** be doing the hospital work or should the **hospital** work be done by Christians? Should the emphasis be on rural work where Medical care is unavailable or in urban areas where the witness is conspicuous to a greater concentration of people? Should it be the goal of the Church to establish a model hospital with a high standard

of Christian medical practice or should it be the goal of the Church to raise the standard of total medical care in the community? It would seem that the Church is focussing on the former, although from a Christian point of view the arguments are probably much more in favour of the latter. Perhaps the worst aspect of the hospitals is not their obsolescence but the fact that the bricks and mortar may have physically imprisoned us, obstructed our vision, and narrowed our horizons.

The Church must recognize the fact that it is humanly impossible for it to meet all the medical needs of India. Under these circumstances it would seem reasonable for the Church to assess the needs of the community, to set certain priorities and be satisfied to live with them. When it does this, it will most probably find that its 95 % emphasis on curative medicine cannot be justified in a country like India.

In the financial area I cannot really see any logical or Christian reason why a church hospital should be self-supporting. I contest the argument that the wealthy patient is >just as deserving and in need as the economically disinherited<. The fact is that in India as in other countries the middle-class and well-to-do have the economic power to deprive the poor of much of the non-government medical manpower and services, and the Church should not be used as an instrument to strengthen that power. I can see a logical and Christian basis for deciding on grounds of illness, but not on economic grounds. When preparations are made for private patients as a means of balancing the budget and enabling the Church to take care of the poor then I believe the rationale for the Church being in the medical field is somewhat distorted as both the rich and the poor are being treated as >it< rather than >thou<. I recognize that the financial problems may have created many headaches but I am sure that it has caused the Church to be scandalized and I do not think that the obsolete buildings or lack of financial resources present the greatest problem for the Church. The greatest problem is in the shortage of dedicated personnel. It is easier for us to be impressed by what we do but I think that India would be far more impressed by what we are.«

Other observations which came out of this review of the Indian surveys were as follows: - »Everybody is overwhelmed by the claims of curative medicine, with more clinical work on the doorstep than can be handled with the result that less is done for

more and more people. This has effectively prevented both a long-range plan for the future or any approach to comprehensive health care.«

»Administrative relationships between the Church and its hospitals were generally bad. Medical Committees were catering far more to the exigencies of church politics and power structures than to securing the disinterested expertise which these complicated institutions such as hospitals required. Denominational control of hospitals had effectively prevented regional and functional planning which is absolutely necessary if the hospitals are to serve the community adequately as an expression of Christian concern. There are several instances where church-related hospitals could be effectively grouped together for a more functional coordination of their activities by complementing each other and, in turn, complementing government and secular services within the same area. Instead of this they are related to other hospitals of the same denomination which may be many miles away and serving entirely different population areas.«

An interesting fact which emerged from the surveys as a whole was that the churches collectively were making a considerable contribution to the total medical facilities of these countries. In terms of ratios of hospital beds and clinics the churches were responsible for 43 % of the national total in Tanzania, 40 % in Malawi, 34 % in Cameroon, 27 % in Ghana, 26 % in Taiwan, 20 % in India, 13 % in Pakistan and 12 % in Indonesia. However, one should not read too much into the above ratios because, at the time of the surveys, this church-related sector was a very disparate group which, with few exceptions, had no collective existence. The following comment in an official report to the Government of Tanzania concerning its health services, published in 1964, would be typical for most countries. »At least 21 separate voluntary agencies operate medical services in Tanzania. The number and variety of these agencies present many difficult problems of developing an integrated service. There is no central organization to which these agencies owe allegiance; individual hospitals are supervised by their own parent organization. There is little coordination even among the voluntary agencies themselves, or between the voluntary agencies and the public sector. A Mission Medical Advisory Committee exists to foster medical co-ordination centrally between representatives of the agencies and

representatives of the Government, but the decisions of this body are in no way binding on individual agencies.«

The surveys also revealed a considerable increase in the cost of operating the hospitals in these countries due to the increasing technological complexity of modern medical practice and to a rise in salary costs because of the necessity for employing a more highly qualified staff which the technology required. A spot-check of 25 hospitals in 20 countries showed an increase in operating cost of between 100 and 150 % within a period of 10 years. The upgrading of nursing education to a higher level had had a mushrooming effect. Not only did it cost 10 times as much to train such a nurse in comparison with the previous level; but such a nurse expected and could command a much higher salary. In church-related hospitals these higher costs were traditionally passed on to the patients in the form of higher fees, but they were now approaching the point of diminishing returns since the rising costs of care far exceeded the growth in per capita income.

One other factor relating to finances must be mentioned. While increasing costs of operation were making it very difficult to maintain the bilateral relationships between a church or mission agency and »its« hospitals, a new phenomenon had come upon the scene in the form of donor agencies which had considerable funds at their disposal but most of which were only available for capital items such as construction and new equipment. The requests addressed to these donor agencies for assistance were largely initiated by individual medical directors whose ambitious dreams for their own institutions may have had very little relevance in the larger context of a nation's health priorities. While such requests were supposed to be screened by National Councils of Churches they rarely had expertise available to them for this purpose.

Finally, one might summarize the findings of the surveys through the following disturbing facts:

1. 95 % of the churches' medical activities were focussed around curative services in hospitals and clinics. Very little was being done to promote health or prevent disease.
2. This type of curative activity was becoming increasingly the acknowledged responsibility of governments. Nevertheless, the activities of both churches and governments in this type of institutionalized system was rarely available to more than 20 % of the population in these developing countries. Thus 80 % were

deprived of health care or had to use the traditional practitioners.

3. The cost of operating these institutions was increasing annually at about 4 times the rate of increase in per capita income. The need to recover costs through a levy of patient fees had necessitated a shift in the clientele they served. The very poor could no longer afford to go to them and the hospitals were finding it increasingly difficult to admit them.
4. The location of the institutions was frequently determined more by ecclesiastical considerations and historical circumstances than by an analysis of health needs. As a result there was frequent overlapping and duplication.
5. Government development plans for health care tended to ignore the contribution of the churches and explained this by pointing to the fact that these churches usually tended to ignore each other and to ignore the results of government planning. Therefore it was impossible to involve them in the planning process. It is obviously very difficult for a government to deal with a large number of unrelated church institutions.

All these conclusions pointed to the very urgent need for closer cooperation among the churches involved in medical care so that they could more wisely use their limited resources by co-ordinating their activities and engaging in collective planning with governments. The alternative was to continue the pattern of unilateral relationships between churches and mission agencies with "their" hospitals and with the inevitable consequence that many of them would have to close. Either rising costs, lack of professional staff, or irrelevance to government planning would make this inevitable.

It was in response to this situation that the World Council of Churches created a Christian Medical Commission beginning in June 1968, and charged it with responsibility to promote the national co-ordination of church-related medical programmes and to engage in study and research into the most appropriate ways by which the churches might express their concern for total health care. So it was to be the focus of two converging interests, one functional and the other theological with the hope that the findings and recommendations of the two **Tübingen** consultations might find practical implementation through the Commission's programme.

Its members were chosen »ad personam« in order to secure the competence necessary for this task but with the understanding that the membership would be acceptable to the churches.

## Chapter 5

### THE BEGINNING OF THE CHRISTIAN MEDICAL COMMISSION - ITS EMPHASIS ON COMMUNITY HEALTH CARE.

The mandate of the Commission called for it to promote the more effective use of resources for medical work through the establishment of structures for joint planning and action, (a) between the churches themselves, whether WCC members or not, and (b) between the churches collectively, other voluntary agencies and the Government. Such regional planning would have the following objectives:

1. Establishment of joint training programmes;
2. The re-alignment of resources to avoid overlapping and the promotion of complementary services;
3. Facilities for the exchange of personnel;
4. The development of common strategy in joint planning with government health agencies;
5. Assistance in the development of uniform practices in internal administration and fiscal procedures;
6. Assistance in the development of projects for Joint Action for Mission in medical work, offering advice to those agencies concerned with their establishment.

The Commission was to engage in, and encourage, the study of the nature of the Christian ministry of healing and the problems which confronted it in a changing world. To this end its activities would embrace all six continents for the establishment of relationships with other agencies similarly engaged. In the light of these studies it would permit the development of, and channel funds to, selected experimental programmes of strategic and catalytic significance; particularly in the fields of comprehensive and promotive health and in the training of personnel to conduct these.

The Commission was to collect information on existing health and medical programmes; conduct surveys on request, and develop channels of information concerning the availability of expert resources in the planning and operation of medical institutions; their internal administration and external administrative relationships. While it was understood that requests for resources to erect or extend medical institutions would continue to be directed

toward agencies available to assist in their establishment, the Commission would be in a position to extend advice to Divisions of the World Council; to National Councils of Churches and to churches and mission agencies both with regard to specific projects and to strategic needs and relative priorities in particular situations. To further its effectiveness in this activity it was to establish liaison relationships with appropriate agencies of the United Nations, health departments of governments, and foundations and other agencies engaged in international health activities.

The first draft of the above mandate was referred to a number of international agencies engaged in medical activities which provided helpful suggestions and this was particularly so in the case of the Rockefeller Foundation whose Drs. J. Weir and J.H. Bryant gave generously of their time. The latter became the first chairman of the Commission. At that time he was writing his book, »Health and the Developing World«<sup>1</sup> - one of the most definitive resources for all engaged in health care in the lesser developed countries.

After several revisions the mandate was referred to the appropriate committees of the World Council of Churches which finally submitted it to an external committee of experts which recommended it for adoption. Since the WCC did not have funds available to launch such a commission it gave its blessing and Proposed that it be a »sponsored agency« of the Divisions of World Mission and Evangelism and Interchurch Aid and that it should have an initial life span of three years to be followed by a second stage of five years. It was then commended to the member churches of the Council for funding. It was felt that the success or otherwise of such an appeal would clearly indicate whether such an activity was what the churches wanted! Within a few months it had received cash and pledges to the amount of 500000 Dollars for its first stage of operation.

Some may wonder why it was called a »Medical« Commission when its chief concern was to be with health. When the original Proposal to create a Christian Health Commission was announced it attracted an immediate response from various spiritual and divine healing groups which felt that, at last, they were being provided a forum within a world-wide ecumenical body. Since the Commission was intended to assist the churches which were

<sup>1</sup> Cornell University Press, 1969

engaged in medical services around the world it was decided that it would be more appropriate to designate it as such. However, it was always hoped that this would not in any sense preclude an interest in non-scientific forms of healing.

The membership of the Commission was appointed by the Executive Committee of the World Council and was representative of five continents. Of the 25 members, 18 were health professionals including two national directors of health services, two senior officials of the World Health Organization and 4 heads of departments in University Medical Schools with a special interest in international health. There was also representation of church and mission agencies and two ex-officio members from the related divisions of the WCC. There was an executive staff of three together with three assistants. All these appointments had been completed during the first half of 1968 and the staff were at work in offices rented from the WCC in Geneva as from June 1 of that year.

Prior to the first meeting of the Commission which was held in Geneva in September 1968, attempts were made to secure Roman Catholic participation although it was not easy to ascertain the appropriate counterparts within the structures of the Vatican. Yet the success of ecumenical cooperation at the national level made it imperative to seek similar cooperation at the international level. This was not simply a bureaucratic necessity but clearly intended to enhance the contribution of all the churches towards those whom they most wished to serve.

Through the helpful direction of a member of the Secretariat for Unity in the Vatican contact was established with SEDOS an organization of missionary communities which agreed to send observers to the first meeting of the Commission. At its conclusion they expressed their earnest hope that a more permanent relationship could be established. As one of their members said, » We are all searching for solutions to common problems and there is no reason why ecclesiastical allegiance should prevent or weaken our common effort in witness and service. In view of the need to serve a common goal, it would not be advisable to establish a separate Roman Catholic Medical Commission. Therefore, it was necessary to find a way to work together in one Christian Medical Commission.« In view of this, the Commission resolved to develop proposals for facilitating the fullest working relationship with Roman Catholic agencies.



At this first meeting several papers were presented describing the inheritance - theological, developmental and medical - which necessitated the Commission's creation. We were reminded by Archbishop Anthony Bloom, Metropolitan of Sourozh (Russian Orthodox) of the need for theological humility, »I think the trouble with us Christians is that we imagine that we are a healed community because Christ is whole and that we can heal others although remaining sick ourselves, perhaps without noticing it while everyone else does notice. I wonder whether it would not be a great deal healthier if we thought of ourselves a bit like >alcoholics anonymous< and were prepared to recognize the fact that we are not well ourselves and to tell this fact to others, we could come to a point which was made before - that of compassion. You don't need to be whole to be compassionate with one that is not whole. In this new relationship there would not be this very shocking divorce between what people see in us as sickness, and a claim we offer to heal others, . . . We could then fulfil what was said before, that Christ did not give us permission to heal everyone indiscriminately, but to love everyone indiscriminately. If people could see this, they would first respect us a little bit more and, because compassion is healing and indiscriminate love is healing, our attitude could give to others more than we possess. Then we could achieve, inadvertently so to say, the conversion of others to more than we possess.«<sup>2</sup>

It was at this first meeting that the Commission's style of operation and its priorities were established. There were so many things that needed to be done that the staff could easily dissipate their time and energies in patching up operations for survival because of emotional attachments to the past. They **could** also spend most if not all their time responding to the requests of others who **Would** then set the Commission's agenda. After much discussion, a consensus clearly emerged which expressed the Commission's **Understanding** of its task. Because this shaped the style of the Commission's **operation** for the next few years it is quoted in full: -

"While we are justifiably entitled to pride in reviewing the legacy of Christian medical work, we realize that some of the earlier initiatives are no longer open to us and that we must search for a new relevance today. Part of what was distinctive in Christian medical programmes was its pioneering

<sup>2</sup> Proceedings of the Christian Medical Commission, first meeting, September 1968,  
Page 37

nature - in offering medical care to those who otherwise would be destitute. However, today, governments and other secular agencies are increasingly offering such services, and we must discover how our programmes can be co-ordinated with theirs. This is not to say that the pioneering aspect of our services is over. There are whole new dimensions of pioneering possibilities which are still open to us. Yet, in the discovery of them we must always be aware that relevance is always relative. What is relevant today may be quite irrelevant in the days to come, and so we must always be open to renewal as we search for the appropriate ways in which the Church can bring healing and wholeness to man.

A review of the problems which face individual institutions makes it abundantly clear that we lack adequate mechanisms for planning. The majority of these institutions operate in isolation from others and their priorities and programmes are determined within the narrow context of their institutional walls. Thus, appeals for financial assistance go to the agencies with which they are historically related or to Donor Agencies. Yet such projects may have little relevance within a regional or national assessment of priorities. Because we lack mechanisms for planning, our present goals for the delivery of health services are largely undefined and they may be inappropriate in terms of community health needs.

The most important new dimension in the field of health care today is the element of planning, and most national governments are now engaged in it. Such planning seeks to define overall objectives and to identify the resources which are or may be available to meet them. It is now incumbent upon the churches to engage in such planning themselves if they would exercise stewardship with their resources. Planning is necessary to all levels - national, institutional, and even at the level of dispensaries - and there must be a correlation at all these levels. Stewardship is required not only to achieve the optimum health care within our resources, but equally to see that the results are economically viable in the local context. We must always beware lest we advocate a system for the delivery of health care which is beyond the reach of patients who are asked to pay for it. Modern technology is making hospital care more and more expensive. Yet, most Christian hospitals seek to demonstrate the highest professional level of care believing this to be an effective part of their witness. It is ironic that in doing so, they often price their services beyond the reach of the very poor who most need them. In such a situation, these institutions may have an aura of affluence and an image of indifference. We were asked to consider the disturbing question »can we exclude from our mortality and morbidity statistics those we could not afford to care for?«. Thus, it may be appropriate for the Church to develop experimental programmes directed toward minimal cost medical care, facing realistically the issue of cutting costs without too much increase in the risks.

One theme which recurred again and again was that the focus of care must change from the individual to the community which includes all individuals. This was one area where theologians and health planners found

common ground. While the Church had emphasized personal (individual) salvation, it was now coming to recognize that the uniqueness of the individual most frequently lay in his relationships in community. So, there was a need to recapture the Hebraic concept of corporate salvation and the Pauline version of it as the New Community in Christ. Likewise, health planners were now aware of the deficiencies of a hospital-centred, disease-orientated system which focused on the individual who came to the hospital, but tended to neglect those beyond its walls who might be in greater need. Often we were reminded of the Tubingen consultation which saw the ministry of healing vested in the congregation which moved out to engage human need beyond itself. And in seeking this role, our Chairman reminded us of the great danger - that in seeking to do things *with* people our patience often runs thin and so we tend to do things *for* people which easily gives way to doing things *to* people.

As an element in the planning process, we were reminded that modern bio-medical technology which requires expensive hospitals and equipment for its implementation can have only a limited impact on the serious health problems that are before us. The vast efforts of personnel, money, buildings and equipment, which are required in the modern hospital, may have only a minimum effect on the total health need. The child with malnutrition and diarrhoea awakens in the night with earache and is brought to the hospital; he receives penicillin and eardrops and returns home again. The suffering of the moment is relieved and that is very important, but the effect on the child's life and probable early death is not minimized by this contact with modern bio-medical technology. An auxiliary nurse visits a home and there is contact between mother and nurse but nothing happens. This is the interface between what we know about disease and what we have to learn about health care. But the fact that we have limited effectiveness in this area does not seem to deter us from continuing with this enormous and at times unavailing effort - building evermore and ever-larger institutions.

Considerable discussion centred on the suggestion that our planning should involve a fearless appraisal of what we can and cannot do. This was coupled with the urgent need to work with governments in the development of priorities and programmes. This echoed the now familiar concept that we should work within »the world's agenda«. There is a sense in which these health problems are the world's agenda, and the question is to what extent or in what way does the Church accept them without question. Dr. Tavior made an earnest plea that we must not simply react to this agenda, but that we should lead in its development of priorities and methods of meeting them.

The discussion following the presentation of case studies which represented problems of church-related medical programmes made the delineation of road blocks to planning especially clear. There is an urgent need to evaluate the best use of resources. How can donor agencies become a part of the planning process so that their gifts provide the optimum of

health care and giving does not destroy the integrity of those national churches which ultimately become the owners of these prestigious institutions. It was recognized that one of the complications of our present situation is that we have on the one hand a system of relationships with agencies and churches who have resources, and on the other with churches and agencies that have needs. If change is to come, it must be at all levels of these relationships - the institutions requesting aid, the donor agencies which are in a position to give it, and the national churches which have ultimate responsibility for the institutions. And to make the interaction of these relationships all the more difficult we have the complicated problems of ecclesiastical identity which always appear to be so important, even though they have never been an instrument of healing.

We were reminded of the frequently inappropriate adaptation of western styles of hospital-centred care and the educational systems that have been developed to support them which are often impossible to adapt to local situations or cultural factors. In such cases, while the Church must retain a degree of freedom to experiment, if it has adequately assessed the needs, it is also imperative that it engage in consultation with governments and not simply develop its own programmes for the sole purpose of keeping its institutions running at the cost of an impossible social burden on those whom it trains.

For example, in our church-sponsored educational programmes there must be adequate thought given to the maintaining of government standards, as well as the need to plan that the person trained will be always employable, - i.e. not beyond the capacity of the economy to absorb at any particular time, nor frustrated by being trained at a level that permits no further advancement.

We must seriously consider whether the Commission could make a significant contribution not simply by finding ways to adhere to standards that are often too inflexible and not completely relevant to the national situation, but by exploring the wide open field of community health nursing, a field in which everyone is eagerly seeking help.

In reacting to the presentation of these problems, Drs. Chandy and Ademola reminded us that while we may be able to reach objectives within an international framework of accepted values, we must never forget that the solutions must always be developed within a local context. These solutions have to reckon with local economic factors, local personalities, and local colonial heritage. The per capita expenditure on health within different developing nations varies considerably, and this forces us to reckon within different contexts in which solutions must be found, but also warns us that requests for answers cannot be quick answers if they are to be good answers.

While much of the previous discussion appeared to indicate a downgrading of institutional hospital-centred care, we must never forget that the hospital has a vital role within a comprehensive community-orientated health programme. People in communities have a

very wide range of health needs. Some of these health needs are best met in the home situation - things that have to do with situations that happen in the home, relationships between people, the care of children, living Patterns, relationships to environment. But there are other things that cannot be taken care of in the home - simple things perhaps, such as a boil, a red eye, attacks of malaria, a cut; and perhaps these can best be taken care of in a simple centre by a person with simple training. But there are other things that neither of these situations take care of, such as the woman in obstructive labour. There is only one place for her and that is in the hospital where someone is competent to take care of her need. In order to give comprehensive medical care we must carefully assess all the needs of all the People and recognize that these can best be met in various institutions, each in careful co-ordination one with the other. It is when they are separated that things begin to fall apart; when the hospital in isolation only meets part of the problem and complicates the issue by sometimes meeting problems that could easily be taken care of elsewhere, in a less expensive and less sophisticated establishment.

Having reviewed some of the major problems facing Christian medical programmes today in all their complex relationships, we recognize that but a few of them can be responsive to individual solutions, while behind the majority lies a fundamental need for change. From these discussions there emerged a consensus that the direction for change points to the adoption of a central concept in health care which recognizes the total needs of man in the community. This resulted in the document which follows: »The Commission's Current Understanding of Its Task«.

### The Commission's Current Understanding of its task

#### ***Production***

We are aware of the privilege of meeting together in the Christian Medical Commission, representing the world-wide Christian ministry of healing. Every member of the Commission is fully identified with that ministry in one aspect or another. Although we are deeply conscious that what we can say together at this time must inevitably be somewhat tentative we have been led to certain insights concerning the crisis in the Church's healing ministry with which we are faced in most parts of the world.

*The Christian Calling*

Christ's command to love our neighbour commits us to the compassion

He

has shown for all who suffer, demands that we see in our neighbour the

dignity of one who is created in the image of God, and leads us to serve our fellow man in the imitation of Christ.

In this healing ministry the whole people of God are committed to reflect Christ the Saviour in the fullness of His divinity (cf. Col. 1, 19-20) and in the servanthood of His being man (cf. Phil. 2, 5-11). Through this healing ministry the congregation witnesses to the salvation which Christ offers to man whether in health or in death and testifies to the unshaken hope in the resurrection in Christ.

No man alone can heal the total brokenness of the human condition. Rather through a variety of talents, gifts and disciplines the whole man is healed with God's grace. For both, individual man and the community, Christ has brought salvation. In this healing ministry both the individual and the congregation live by God's mighty power working in Jesus Christ.

### *Need for Change*

The medical work of the Church historically has been oriented toward individual care in a hospital setting. Over 90 % of medical mission activities are hospital-based. The quality of their work is undeniable. Thousands of dedicated and highly skilled workers have given their lives in a healing service to others. Church-related institutions have frequently pioneered a medical service for vast numbers of people, saved countless lives, and reduced human misery. Yet, today, many of these institutions suffer from multiple problems: steeply rising costs, limited staff, inadequate administrative systems, and obsolescence. There are crippling limitations of resources with which to meet those problems. These institutions often function in isolation, not co-ordinating their activities with one another or with government. Governments meanwhile develop plans for providing universal health care, but neither do they take into account nor benefit from a representative voice from the churches, because there rarely is such a representative voice.

Mission boards and related donor agencies share the same orientation and problems. They receive multiple requests for hospital-based programmes but have inadequate information and limited competence for judging whether or not the request is realistically related to either local or national need. The division of responsibility between national churches and mission agencies abroad may lead to a paralysis which makes it well-nigh impossible to make a new assessment of the task.

But financial and organizational problems are only a part of the difficulty of programmes dedicated exclusively to hospital care. There is the more basic issue of the extent to which such programmes, despite their unique achievements, meet men's actual needs. First, the orientation of hospital work toward the service of only those who come to the institution, rather than reaching out to serve all in a surrounding community, has meant that many in need have not been served at all.

Second, hospitals can provide only a part of the care necessary to meet the

health needs of people and often fail to touch the greatest needs. The causes of ill health have a wide range which include a hostile environment, malnutrition, poverty, ignorance, social deprivation and overly-large families. While hospital treatment is essential for the care of some Problems, it offers little for others. It has limited influence on the pattern of diseases and their causes.

### *New Directions*

A re-orientation of Christian medical work is obviously required. We call the churches to turn their attention in the direction of comprehensive health care of man, his family and his community. The needs are great - to relieve suffering and heal disease; but, no less, to prevent disease and promote general health - but resources are limited. Yet, we are responsible to use those resources in ways that will bring the greatest benefit to all. We must grow in our ability to see man as his total self and to meet his needs in that context.

Any individual church or institution must recognize that it can respond to that total complex of needs only on the basis of close and careful co-ordination with other institutions and with government. This will require fearless appraisal of what the Church can and cannot do, and a willingness to join with other Churches - Catholic, Orthodox and Protestant - and with government, in joint planning; setting priorities according to the needs of the people, and selecting from among these Priorities those most appropriate to the distinctive resources and conscience of the Church.

An essential step in implementing these recommendations is the development of competence in national churches, mission boards and donor agencies for planning and evaluating health programmes which meet wealth needs in ways that reflect the best use of resources. At national and focal levels it is imperative that there be developed organizations that delude the representation of churchmen both in and out of the health field, deluding those in government, drawing on the skills of whoever can contribute to the study of the nation's health problems, and the development of co-ordinated plans for meeting them.

### *Specific Objectives*

As the process of change in the direction of the Church's healing ministry is initiated there will be need both for a long range view and patience in implementation. The above broad goals and new directions lead now to the identification of the following specific elements in the new orientation.

Movement toward these specific objectives must be based on selective strengthening of established institutions and services and, where appropriate, through reduction of some present emphases.



A general principle underlying our proposals for new direction is that immediate progress toward all the objectives and in all areas is unrealistic. »Felt needs« for change in institutions, areas or activities must provide appropriate local involvement in the transition process. An eagerness for new programmes of greater relevance is sufficiently evident to suggest that progress toward the total conceptual action presented below may quickly permeate all Christian medical work.

### *1. Comprehensive Health Care*

Comprehensiveness in development of services can be viewed in at least three dimensions:

- a) A spectrum in types of service ranging from treatment and rehabilitation to prevention and health promotion (including health education and improved nutrition).
- b) The health services network ranging from specialized institutions and general hospitals to health centres, sub-centres, community-wide services and the home.
- c) The human resources available for health care ranging from the involvement of concerned church members, whether professionally trained or not, in home and community and the extremely important and urgently needed auxiliary and middle level health workers, to generalist and specialist professionals.

### *2. Community Orientation*

- a) In the new healing ministry the community is the patient. In treating the whole man each individual can be cared for only within his community ecology. Disease prevention and health promotion can be effective only when there is as much concern for the healthy as for the sick.
- b) Among the several target populations with high priority needs we identify particularly mothers and children under five. The health quality of future generations is largely conditioned by total care provided in these critical years.

### *3. Co-operation with Governments and Other Agencies*

- a) Most countries now are actively engaged in national and regional health planning. The Church should fit its health activities into general plans and co-operate with the planning process.
- b) Institutional services provide multiple opportunities for a working collaboration within the regional framework. Hospitals may establish two-way educational and referral relationships with government health centres or community services or vice versa.

- c) Manpower development and educational programming must be consistent with locally accepted categories. In view of the need of experimentation in new areas, such as community nursing, we must be fair to the trained personnel in providing career opportunities. Quality must be judged according to local criteria rather than rigid international standards.

#### *4. Inter-church Co-ordination and Co-operation*

The opportunities for improving Christian witness by better relations between Church groups is probably better in medical work than any other group of mission activities. The advantages of sharing personnel, facilities and responsibility within a regionalized framework has already been demonstrated to be eagerly welcomed in some countries such as Malawi.

#### *Planning Mechanisms Appropriately Structured in Regional and Local Organizations*

New understanding of the planning process is rapidly changing the international approach to development. Responsibility for planning and evaluation must be separate from but should strongly influence the direct administrative framework. The planning process is dynamic and continuing with effective implementation being directly correlated with the amount of local involvement in planning. Priority setting especially must be locally determined but within guidelines and norms established by the donor agencies.

#### *6. Re-orientation of Personnel*

The Commission attaches its own highest priority to the need for providing opportunity for all individuals involved in the healing ministry to have a chance to develop the new orientation outlined here. Through short courses and conferences emphasizing case studies and by working jointly on specific local problems we urge an intensive effort to reach all health Personnel, the local churches and staff of donor agencies.

#### *7. Need for Administrative Re-organization*

Among the greatest obstacles to effective change are rigid administrative structures and traditions. If the new emphasis on planning and evaluation is

going to be effective a willingness to modify administrative patterns will also be needed.

## *8. Data Systems*

Limitations of actual information severely limit our ability to communicate effectively or increase understanding. But data must be gathered only to fulfill specified objectives otherwise it will detract from and confuse the new developments proposed. Perhaps the most needed data are comparable economic analyses.

## *9. Facing the Problem of Population Dynamics*

Few world problems are as important or as poorly understood as the unprecedented rate of population growth. Because of ethical implications, the potential total impact on the health of families, and especially the care of children, Christians have a particular responsibility to provide imaginative leadership in the search for solutions. Our Commission places high priority on providing opportunities for Church medical programmes to lead rather than follow in developing new ways of meeting this worldwide need. Wherever family planning is offered the choice of methods must be according to individual conscience of all concerned.

## *Conclusion*

These suggestions will fall on some institutions and agencies that will have difficulty responding to them. For example, while some hospitals may be fully utilized as part of a comprehensive health programme, there are others where beginning such a programme may require entailment of established activities that are less relevant to health needs.

Despite these and other difficulties the Christian Medical Commission is utterly convinced that we face a radically new and changing situation and that our Christian calling demands that we find effective means whereby the ministry of healing might be directed toward the wholeness of man in his community.«<sup>3</sup>

**3 Proceedings of the Christian Medical Commission, first meeting, September 1968, pp. 60-68**

## Chapter 6

### THE DISCOVERIES - NEW APPROACHES TO HEALTH CARE

Once the priorities of the Christian Medical Commission were established the staff began the search for existing programmes which conformed to the concepts of community health care as described in the previous chapter and also let it be known that assistance would be available to those who wished to undertake such programmes. It was felt that examples of community health care would be more helpful to the Commission's constituency than theoretical descriptions although the Commission did eventually publish a booklet "Community Health and the Church« which was published under the auspices of the World Council of Churches in 1971.

The Commission functioned as an enabling organization without specific programmes of its own. It thought to commend the results of

its own studies and observations on their merit alone although it soon became clear that the Commission was developing a bias which was away from large curative institutions and towards low cost comprehensive community based programmes. The fact that the vast majority of church-related medical services were hospital-based made it necessary to stress the relatedness of one type of medical facility to another as part of an integrated whole and thus avoid a polarization between one emphasis and another.

The missionary doctors who had established these hospitals were predisposed to this type of facility by their training and because, when faced with such a vast amount of suffering, the immediate reaction was to alleviate it without too much concern for its causes.

Moreover, the quality of their service, frequently rendered at great personal sacrifice in harsh circumstances, made one hesitant to criticize its effectiveness. Only gradually did the economic consequences of hospital-based programmes become apparent in the lesser developed countries. The economic growth of these countries was relatively minimal and what growth there was frequently became absorbed by an increasing population. To adopt

standards from western countries of providing a high ratio of hospital beds to population became impractical and this, eventually,

led to serious doubts about the application of a western-orientated system to the problems of health in a developing country. In contrast to the prevailing trend a few dared to match the health problems with the meagre economic and manpower resources by means of cost-benefit analyses and presented options which seriously challenged the existing medical priorities.

The surveys had revealed that up to half the admissions in hospitals were for preventable conditions. Government statistics showed comparable figures. Yet few had made the deduction that hospital care of preventable illnesses was very much more expensive than the eradication of such conditions or, at least, their early treatment in less expensive facilities. But it was not only the economic factors which led to these doubts about the effectiveness of hospitals and clinics alone to meet the wide spectrum of health needs. These institutions depend upon a clientele which comes to them for help but they do nothing to help those who, for one reason or another, have failed to come. It may be a matter of distance or expense or fear but nevertheless these need help and the hospital or clinic is unable to reach them. Mobile clinics were rarely an effective substitute since they had to follow an established routine and itinerary which did not necessarily coincide with illness episodes.

It was not easy to challenge the prevailing system. The governments of these countries assumed that a considerable expansion of curative services would result in a marked improvement in the health of the population to be served. The development agencies of western governments did nothing to discourage this view. Grants they made were primarily for expanding hospital facilities especially teaching hospitals and these introduced more and more western technology which the recipient countries then adopted as the desirable goal of their own aspirations for medical services. Thus Britain «assisted» Uganda by providing funds to build Mulago Hospital, the teaching hospital of Makerere University Medical School and which was to be the apex of the medical care system of that country. Yet because Uganda lacked the filtering infrastructure to deal progressively with illness from the simple to the more serious episodes it was inevitable that this sophisticated hospital should become the district hospital of Kampala with a similar ratio of admissions for preventable conditions. It also absorbed a very large proportion of the national health budget for its maintenance which prevented the required

expansion of village health services. The United States made a similar mistake in Liberia where the John F. Kennedy Memorial Hospital absorbed the bulk of that country's health budget.

In the late 1960s and early 70s there were very few developing countries which had resisted the current trend to build more and more curative facilities as the necessary answer to meet their health needs. Then came news of the revolutionary approach adopted by the Peoples' Republic of China which, literally, turned the health care system's triangle upside-down. Instead of starting with the apex of the triangle - sophisticated and highly specialized services which satisfied the elite but rarely reached the rural areas where the majority of the population lived - the Chinese started at the base of the triangle to make sure that medical care would be available to all in accessible and acceptable forms. Moreover, this was a medical system which was community-centered with health workers chosen for this role by the community itself thus breaking the dominant and possessive role of the professional. However, it was still not known whether the adoption of this system necessarily implied the adoption of the Maoist political ideology also! Nevertheless, it clearly indicated the need for change and suggested some of the requisite steps to achieve it.

During the survey in Indonesia in 1967 at least one new approach to health care had been discovered. Dr and Mrs (Dr) Gunawan Nugroho had been assigned to a small (20 bed) maternity clinic on the outskirts of Solo in Central Java. They gradually converted it into a base for comprehensive health care for the community but in spite of several innovative approaches the cost of the services still excluded the very poor who were in most need of help. Dr Gunawan then resolved to try a different approach after analysing the basic causes of the high incidence of disease in the community. One obvious cause was malnutrition and the answer to this lay in a major improvement in agricultural production through better rice strains and the use of fertilizers. The increased production had a major impact on infant and under five morbidity and mortality. Some of the surplus could now be sold to purchase other food stuffs and household necessities. Another health hazard was the smokefilled bamboo houses in which the villagers lived. Through the purchase of a simple brick making machine and the construction of a »model« house, Dr Gunawan was gradually able to convince the villagers to abandon their disease-generating homes and build hygienic and



more comfortable ones for themselves. While one rarely associates rice farming and brick manufacture with medical practice it was obvious that these activities had a greater impact on the health needs of that community than the interventions of surgery and chemotherapy. To a large extent the success of this programme was due to the fact that the decision making was left in the hands of the local people themselves with Dr Gunavan supplying the various options open to them so that they understood the consequences of the choices they made.<sup>1</sup>

Another »discovery« emerged when the Commission was approached by Dr John Sibley, an American missionary surgeon serving in South Korea who was becoming increasingly disturbed by the high cost of hospital care excluding large segments of the population which were frequently at risk. In 1967 the cost per patient day in the hospital where he was serving was 7.10 Dollars while the average daily personal income was about 40 Cents. Dr Sibley needed assistance in developing a new type of project which would be community based, have a strong emphasis on health education so that people might take some reasonable responsibility for their own health and it should become viable within the financial resources of the community. Kojedo, an island off the south coast of Korea was chosen for this experiment. It had a population of 120000 of whom 30000 were chosen as the primary target group. 72 % of this population had a per capita income of less than 80 Dollars per annum so the amount they could afford to spend on health care was very little indeed.

If health care was to be brought within reach of these people the most stringent attention to costs was necessary and this required a series of demythologizing experiences for Dr Sibley. From his training and past experience he had assumed that a national physician would be required to run the programme since he would provide the entry into the system for all those needing help. But no physician was willing to work in such an isolated place and, in any case, his salary would have overburdened the programme's budget. This realization challenged the traditional role of the physician to be the only person qualified to diagnose and treat illness. Yet this was required by the strict medico-legal code of South Korea and fortified by law. Unfortunately, the law did not also stipulate that

**1 A fuller description of this project is to be found in »Health by the People edited by K. W. Newell and published by the World Health Organization, Geneva. 1975**

these physicians should make their services available wherever people chose to live. The physicians were inclined to settle in urban areas which offered rich rewards and good social amenities so that the rural people who became sick had to travel, if they could, to the places where the doctors chose to live.

For the next few years the Kojedo project experimented with the training of various new types of health worker in an attempt to find an effective method of insuring basic services for those who previously had been deprived of them either by location, lack of financial resources or the »standards« of a western type medical system. Dr Sibley's account of these experiments is not only modest but reveals the liberating experience of being able to make mistakes in the development of services if these are shared with the community which is hoping to be served. For the physician dealing with the individual patient mistakes are to be avoided so one senses the surgeon's relief when he realized that the community was less critical and more cooperative!

It was found that girls selected from the villages even though they had no more than primary education, could be taught basic skills in health care, family planning, health education and first aid. Thus they became the first-line resource in each village and were linked up to more sophisticated services through a readily available referral system. While this approach had been previously initiated in Africa, it was new in those Asian countries where the western system of allopathic medicine prevailed.

The Commission was able to assist in the planning of such Programmes as Kojedo and similar ones which followed it because in its membership were several outstanding experts in the field of international health. Among these were Dr David Morley of the Institute of Child Health of the University of London who, while working in Nigeria, had pioneered the first Under Fives Clinics which had proved to be very beneficial in combating malnutrition and child disease. These clinics relied on nurses, para-medical workers and mothers for their effectiveness and thus extended the health coverage which no doctor alone could possibly manage.

Another member was Dr Carl Taylor, Chairman of the Department of International Health at Johns Hopkins University, Baltimore. Both he and his colleagues were engaged in experimental health projects in several countries and, particularly, in the Narangwal Project in Northern India in which several innovative

approaches to health care had been introduced. The Chairman of the Commission, Dr J.H. Bryant, had spent several years in Thailand with the Rockefeller Foundation, introducing community health into the curriculum of a new medical school in Bangkok and was now Dean of the School of Public Health at Columbia University in New York. It was this galaxy of talent which brought the Commission a degree of respect from its constituency as well as from Ministers of Health and, eventually, from the World Health Organization.

In 1970 Dr and Mrs (Dr) Arole from India visited the Commission's offices to describe their proposal for bringing medical facilities to approximately 20000 people in the Jamkhed area of Maharashtra State. In their own words, »We were both concerned about the medical care of the rural population of India, and so after graduation we both went to a hospital situated in a rural area and worked there for about five years. To our amazement, at the end of five years, we found that all we had done was to take care of patients who came to the door-steps of the hospital, but we had done little for the general health of the community around us. To give you a simple example, we served a population of about 100000. There must have been 4000 deliveries each year, but we were taking care of only 300 of them. We asked ourselves, >what happened to the remaining 3 700 deliveries?< There was nobody besides us in the area. Examples such as this made us realize our need for public health training to enable us to reach out to the community. Therefore, we went to Johns Hopkins University and took a public health course. A lot of material that we read there came from the Christian Medical Commission. The books and articles written by many members of this Commission helped us to formulate a programme.«

Their proposal was to select an area deprived of medical facilities, invite the people's cooperation to participate with them in achieving the following objectives:-

1. To reduce under-fives' mortality by 50 %.
2. To reduce the birth rate from 40 per 1 000 to 30 per 1 000.
3. To identify and bring under regular treatment leprosy and tuberculosis patients.
4. To train indigenous workers and offer field training to health workers.

The staff of the Commission were impressed both with the

personalities of the Aroles and the content of their proposal and promised to seek funding to subsidize the first three years of its operation. The Aroles then returned to India eager to implement their plan. However, because of the delay in securing the necessary funding, they spent the first few months visiting the villages where they hoped to work, talking to the local people and above all, listening to them as they described their felt needs. This experience led to several major modifications in the original plan. To the Aroles's surprise, health care was not a major priority in the minds of the local people. They were more concerned that their crops had failed because of drought in the two previous years and so they needed more and deeper wells to provide irrigation. They also needed better housing, schooling for their children and feeder roads to take their produce to the local market when they had a surplus to sell. They were concerned about the health of their children - half of them died before they reached the age of five but this had been so for so long that they were almost fatalistic in their acceptance of it.

The Aroles realized that if they were to help these people it would first be necessary to respond to their priorities. For too long medical workers had seen the priority needs of a village community only on their own medical terms. First, it was necessary to build a clinic, give immunizations, treat minor ailments and provide food supplements to malnourished children. Rarely had anybody thought to ask the village people what it was *they* wanted. In this case the Aroles took these people seriously and secured well digging equipment for them and then first used part of the delayed grant which eventually came to them in order to purchase a tractor to be loaned to the villagers. Very soon they earned the respect of the local people who were then prepared to listen to their advice on health care and participate in securing it.

As irrigation enabled them to increase agricultural production they used part of the surplus to provide a communal meal for all the children of each village. They were taught how to weigh the children regularly as a warning against malnutrition and they kept the records. The school teachers or the village leaders were provided with simple drugs and taught their specific usage. The Aroles deliberately avoided the use of separate clinics for leprosy patients and taught the villagers the etiology of the disease and its reluctant transmission. By this simple act they prevented the social segregation which must be as painful to the leprosy patient as the disease itself.

Another example of the Aroles's sensitivity to the wants and needs of these village people was their observation that when a nurse addressed a gathering of women in the ante-natal clinic they would later seek the advice of the clinic sweeper or watchman who were illiterates like themselves. There was a bond of community and understanding among illiterates so that an educated person like a nurse, even though she came from that area, could not find a bridge of communication to them. As a result, it became necessary to train illiterate village women, chosen by the villagers, to be the local health workers. Each week-end they would travel to Jamkhed to share the experiences of the week with their fellows from other villages and so enjoy a new learning experience.

Although the area served by this project had no western type medical facilities prior to the Aroles's arrival there did exist an infrastructure of indigenous practitioners who would normally be rebuffed by allopathic practitioners and whom they would see as a threat to their own livelihood. The Aroles overcame this difficulty by establishing a rapport with them; regarding them as colleagues and serving them as consultants so that, eventually, the indigenous practitioners became part of the total health team.<sup>2</sup>

It was discoveries such as these and others similar to them which were given wide publicity by the Commission through its publication »Contact« which began as an occasional paper in November 1970 and, later, was published regularly every two months. It was distributed free of charge and its readers were invited to republish any part of it as they desired. While, initially, it was published in English only, it soon became necessary to provide French and Spanish versions. Later, it was discovered that it was also available in Portuguese since a Brazilian editor was reproducing it in a national journal. As could be expected, the publication of these experimental forms of health care not only encouraged more experimentation with local modifications but also encouraged others to describe their own »discoveries« of which the Commission had previously been unaware.

The discoveries were not only exciting in themselves but they were illustrative of the growing awareness that health care systems must respond to the basic needs of people for social justice. While

**2 A fuller description of this is to be found in »Health by the People«, edited by K.G. Newell and published by the World Health Organization, Geneva 1975.**

the so-called developed world of the industrialized nations was concerned with the ethical issues involved in the care of individual patients - issues such as abortion, euthanasia and the sustaining of life by artificial means - few had yet appreciated the moral issues involved in providing medical services for large numbers of people when financial and manpower resources were severely limited. These moral issues were brought into focus for the Christian Medical Commission through a series of dialogues between its chairman, Dr John H. Bryant and Prof. David E. Jenkins a theologian, which became a feature of the early annual meetings.

Dr Bryant set the stage by describing a typical situation in the medical services of a lesser developed country. »A young physician arrives at his first assignment to a rural district of a less developed country. This district contains 70000 people. He is the only doctor. The hospital has 70 beds - some beds hold two patients, and other patients are on the floor between the beds. The out-patient clinic is choked with patients. His health team includes one nurse and a variety of paramedical and auxiliary personnel. Four health centres are scattered through the district, each serving 10000 - 20000 people and staffed with auxiliaries who handle the problems that are within their competence and ask for help from the doctor and nurse for the more complex problems. Of the patients who come for care, some are in desperate need, such as women in obstructed labour and men with cerebral malaria, but most have minor problems, such as the common cold. Many of the district's people do not come at all. Why? A man may have tuberculosis but not know it. A child's intellectual potential may be eroding from malnutrition, but the mother may not be aware of it. Or they may know of their sickness but choose not to seek help because it is too far, or the wait is too long, or the cost is too high, or the manner of the health personnel is offensive. Or they may sense through untaught intuition that the care they receive does not answer the problems they have.

Confronting the physician is a question that leads us into the substance of our enquiry: For whom am I responsible? We are brought to appreciate the importance of defining the population for whom (or to whom) the physician and his health team are responsible. If they establish their major objective as improving the health of all the people in the district, it is immediately clear that those who do not come for care >count< in calculations of health improvement as much as those who do come.

Having accepted responsibility for all, the physician is then confronted with the disturbing realization that he cannot actually provide care for all - the problems are too numerous, the resources too limited. He must decide therefore who within the population should be served. In deciding who should be served, he is at the same time deciding who would be deprived. How should these decisions be made? Currently, with rare exceptions, they are not made. Traditions of medical care determine that those who come to health facilities and those who live nearby are served, and those who do not are neglected. What help does the young physician have in this situation? It is unlikely that his education will have prepared him for making these decisions, indeed, he may have been steered away from recognizing that the decisions are there to be made. He may have been taught preventive concepts and participated in a community-based health care programme, such as family planning or child care. While these are important approaches, they are usually limited in scope and aimed at small groups of people, and it is highly unlikely that he would have learned to struggle with the larger questions before us because the medical profession itself has struggled with them so little.«

Prof. Jenkins responded by reminding us that this situation of having to face hitherto unexperienced questions and challenges is normal for the people of God who, in the Bible, are always portrayed as being on a journey. Our resources for this journey will depend upon our understanding of ourselves in relation to one another, in relation to the world, and in relation to God. Theology cannot be expected to produce simple answers for all our problems but it does help us to live with them and so face the questions in the faith that God holds things together and has given man the privilege of joining with Him in revealing the Kingdom. Moreover, the Christian understanding of men and their situations is that while we are to be aware of responsibilities *to* all, we are not responsible *for* all. The Cross shows us that only God is capable of fully accepting responsibility for all. Yet where does this help us or the young physician in making decisions?

»The Christian Gospel helps us clearly with one priority, that of serving the poor. It makes us ask, »who are those who are not cared for and to whose care no prestige is attached ?« These are not necessarily the poor in any simple economic sense, but rather the neglected, the ignored, the unimportant, the rejected, the outcasts

and drop-outs of society at all levels. The fact that any society produces them is itself a judgement upon that society and its priorities, and our priority is to get these priorities changed. — For instance, we have to be clear ourselves and make it clear to others that no amount of health care will stop people from dying either now or then. Therefore, our decisions have to be made about how we help people to be human in the light of (1) their need for health care, and (2) the need to treat them as human beings who live *and die*. Something has to be brought to them here and now, whether or not we can change their overall condition. There is need to remove malnutrition and to face the problem of caring for undernourished people who will die. No amount of development will give people *human* life. I think, incidentally, that this criterion of the »poor« should directly help us about our Christian priorities with regard to the setting up of a comprehensive health care service. Where there is a pioneering need to do this, because nobody else will give attention to it, then it is a Christian calling.«

Prof. Jenkins then proposed a second criterion which is the need to question that which is taken for granted. An example would be the regulations in a hospital and whether they were motivated by concern for the care of the patient or the convenience of the staff. Is the use of medical manpower and resources directed by a traditional prestige which has developed? Is it important to have more and more equipment and be able to do more and more complicated operations for example? Who is going to bear the burden of constantly challenging this sort of thing? This is a very important part of the calling to follow the suffering Christ and to challenge and correct priorities. Further, there is a need to question assumptions about the very idea of health, especially the notion that you can deliver or impose it. Who are we to take decisions about health and especially to impose our notions of health? We are always in grave danger of serving ourselves and our image of ourselves rather than those we claim to serve. Who would be the voice of those who suffer and find no health? Health is something to do with the wholeness of all

men and cannot be imposed from above or from outside. We are not concerned to produce health but to enable health so that the Giver of health may give it.



In continuing this dialogue Dr. Bryant and Prof. Jenkins addressed themselves to the questions; of what value are those lives We are deciding about; what is human life for and what are the

decisive questions to be asked about it? They agreed that the following words were meaningful in this context; Belonging, Caring, Counting, Sharing, Becoming, Being on the Way. These words expressed the fact that human values are intricately associated with things personal, not in isolation, but as part of a family or community. They are active and process-oriented rather than static; and they connote uncertainty (belonging to whom? being on the way to what?) While the uncertainty is worrisome it also leaves room for hope. One is not subject to either whimsical or deterministic forces but can participate in the direction and process of change.

Dr. Bryant then proposed a methodology for setting priorities among health problems using the criteria of prevalence, seriousness, community concern and vulnerability to management and then reviewing these in the light of those human values previously agreed upon. »The community can be involved at every stage of this problem-solving process, as they are introduced to it, come to understand it, develop the capability for making decisions about it, participate in its application, observe the successes and failures of their decisions, and change it as they decide it needs to be changed. To that extent they are sharing in being on the way. The initial objective might be to involve the community in deliberations that would lead to a particular health care programme but the greater objective would be to establish as an ongoing community process the problem-solving cycle, which might also be called the cycle of self-determination. The decisions made as a result of a community and health team turning through the cycle would be less important than the fact of their involvement in the cycle, less important than the community's deciding what it was becoming.

David Jenkins said earlier that technology is to do with problem-solving, but theology is to do with living with problems.< I wonder if the two are not brought together in this concept of the community's using the problem solving process as a way of living with its problems and for shaping its own destiny, at least to the extent that men have control over such matters. Much has been made of the dichotomy of hospital-based programmes serving individuals and out-of-hospital programmes serving communities. The former are criticized for spending too much on too few, the latter for neglecting the needs of individuals and losing the personal warmth inherent in the one to one relationships of healing.

Doubtless, much has been lost through the mistaken narrowness of these views. There is the middle-ground of comprehensive health care through which both individuals and communities can be taken into account as needs are balanced against resources. - Does this discussion help us with the problem of the young physician and the decisions he has to make? I think it does, and at several levels of the problem.

Visualize this young man driving a Land-Rover over a dirt tract in the back of his district. He has accepted responsibility for the entire population of that district and has turned from the endless stream of people who come to his hospital, leaving them for a time with other members of the health team, so that he can oversee the development of programmes in the district as a whole.

In the beginning he and his health team may have sorted out the leading health problems, set priorities and chosen some target populations that could be managed within the slim resources available. In making the choices of whom to serve he may have been helped to recognize the limitations of more purely technical criteria. Here, our concern for the value of life, born from a Christian concern and developed in a theological context, provides an example of an alternative set of values to be considered in making decisions about health care priorities. While this approach to setting priorities may have helped him to take into account a wider range of human values, the difficulty, in a purely human sense of one man choosing whom among other men to serve, has not been lessened. Here, he may be helped to recognize that there is a class of decisions that should be shared with those who will be affected by them.

Thus he turns to the community. As he shares decisions with them, he sees the long and complex process of their finding their Way to effective participation. But he is also helped to see that, apart from the health problems at hand, participation is an important part of the process whereby individuals, families and communities rise in their capability for self-determination. As the young physician approaches a village and as he walks toward the midwife from his health team, who stands with the village leaders waiting for him, he knows that his purpose is to share a process with them that is essential in terms of their health and at the same time humane in terms of their fulfilment as men.«

Dr. Bryant concluded by saying that he had found the dialogue intriguing and useful; but, was it theology? Prof. Jenkins responded

by setting the words which were meaningful for considering human values (belonging, caring, etc.) in the context of the Gospel and its offer of God in Jesus Christ.

»And so when Dr. Bryant asks whether we are doing theology, the answer is that we undoubtedly are because theology is about God. There is a very important practical point here that follows because the >something< is God himself, because the range of the belonging, becoming, sharing, and so on, is as wide as I have indicated. For what one is concerned with is not primarily delivering medicine. Of course, we agree about this, our concern is with health. But in fact, it is not even that. What one is concerned with is the business of the intercourse, of the dealing, of God with man and of man with God, under the forms of, through the processes of, through the opportunities of medical work. And the primary point does lie in this being and becoming.

In this light we have to consider further the matter of the Christian differentia. Consider therefore the Incarnation, consider Jesus as the embodiment of God, consider Jesus as the man who is the divine member of the series which is concerned with the becoming divine of all things. Jesus shows that within the historical series the distinctive identity of God is expressed towards us in the identity of a man. But with regard to this notion of identity, it is important to note further that this God is not the same as man. That, indeed, is the source of our hope. The distinctive identity of God is expressed towards us, in the historical series, in the identity of the man Jesus. And it is a human identity which this divine man has. Thus we have the most exciting offer and suggestion, namely, that it is literally true that we have divine possibilities.«

Finally, Prof. Jenkins wondered whether commitment to this kind of enquiry and the action which it called for might not lead us along a revolutionary path.

»But in a way this is incidental. What we are basically concerned with in Christianity is the celebration of change. This is so because we are concerned with entering into this newness developing into the infinity of Himself which God offers. This, however, brings us to what has been a major point in all our discussions. Change threatens our identity. - The more I am involved in systems analysis, in changing the running of institutions, of asking questions about how attitudes which have been institutionalized can be changed, the more crucial question seems to be: Where do people

find their identity? For the Christian the theological answer is that the identity is not in myself as I am now, not in myself for instance as a doctor, an administrator, a worker in a medical school etc. That is how my identity is expressed and embodied at the moment. But identity is not in the medical profession or whatever else we happen to have solidarity with for the reasons of our training and so on. The identity of each and every man is in God and in us all as in His image, and we are becoming his image. The great problems of change seem to me to be institutional problems. But the institutional problems are those which trap human beings and to which human beings respond. And unless we can become ourselves persons who are free for re-identification and help others to become such, all this talk about re-orientation and so on is quite hopeless. It may well look pretty hopeless anyway, but that is where we go back to belief about the fact that the mission is God's so that we are free to go on trying.«<sup>3</sup>

With this call to seek renewal under God coupled with the practical examples of those who had been willing to lose their identities in order to serve the needs of men and women more effectively, it was no wonder that the Christian Medical Commission should have embarked on a crusade for social justice in the promotion and distribution of health services. It also renewed its concern to discover an effective understanding of health and healing which could be implemented in practical forms.

All references to this dialogue are taken from CONTACT No. 4, »Moral issues and Health Care«, March 1971

## Chapter 7

### THE WORLD HEALTH ORGANIZATION AND PRIMARY HEALTH CARE

The Christian Medical Commission's involvement in experimental projects aimed at a more effective and wider distribution of resources for health care had attracted the attention of the World Health Organization. At the end of 1973 the Deputy Director General of WHO, Dr. T. A. Lambo, approached the Director of the Commission to explore closer cooperation. On March 22, 1974 Dr. Halfdan Mahler, the Director General of WHO, called together his senior staff for a joint meeting with the senior staff of the Christian Medical Commission (all five of them!) and this resulted in a proposal to appoint a joint committee which would explore the possibilities of coordination and cooperation in matters of mutual concern.

Among the recommendations of this Joint Committee were the following: It is accepted that the building of a relationship takes time and that this building can best be done by the joint involvement in common endeavours. The mechanism for this may well be a small standing committee which could meet regularly and report to the appropriate persons in the two organizations. The first role of this standing committee would be to suggest mechanisms for joint action during 1974 and to propose common endeavours over a limited time period (1-2 years). It may well be that initially such programmes will involve mainly the CMC and Headquarters WHO and a limited area of interest. It would seem necessary at an early stage for WHO and CMC to be more frequently represented at a technical level in meetings of their various technical and executive bodies. This already occurs to some extent, but it could be extended considerably. The CMC must face difficulties because of its size. It would seem that, if its programme parallels so closely some parts of the WHO programme, WHO should make it easier for the CMC to use the expertise available in various technical units of WHO to further its projects. While it has formal access as a Non-Governmental Organization, a joint standing committee may make it easier for this to happen in practice.

While the above recommendations were enthusiastically received

by the Commission it was thought necessary to clarify the respective mandates of the two organizations. While WHO was constituted to exercise concern for the health care of all peoples, its primary relationships are with Governments, some of which might suspect from its title that the Christian Medical Commission held a predominantly sectarian interest and could engage in activities which were contrary to Government policies. The Commission made it clear that its own activities in promoting health care were also directed to total populations, irrespective of colour, creed, sex or national origin. It recognized the constitutional and moral responsibility of Governments for the health care of their peoples. While it reserved the right to be critical of Government health policies where these were failing to meet the needs of total populations, it did not and would not engage in overt anti-government activities. Rather, it sought to organize the voluntary sector of medical care, a large proportion of which was church-related, in order to provide a forum for joint planning with Governments so as to avoid overlapping. It also encouraged the churches to undertake innovative programmes in health care in which the Governments might find features worthy of adoption as national policy, especially if these were directed to alleviating the plight of the poor. In September of 1974, the Director General of WHO expressed his agreement with the recommendations and a Joint Standing Committee was formed.

One of the first fruits of cooperation with the WHO was the inclusion of some experimental programmes in health care which were associated with the CMC in a joint WHO/UNICEF study with the title "Alternative approaches to meeting basic health needs of populations in developing countries." This was followed in 1975 by WHO's publication of the book, »Health by the People« which, again, included descriptions of these and other experimental programmes. This ensured the widest publicity for some of the concepts mentioned in chapter 6 and which thus reached an audience far larger than the Commission's constituency. However, the most significant result of this cooperation between the two organizations was the formulation of the principles of Primary Health Care for which WHO must take most credit. It resulted in a proposal which was introduced to the Executive Board of WHO meeting at Geneva in December 1974. The proposal began with a definition of the problem which the Board itself had adopted the

previous year and which drew attention to the maldistribution and the inadequate coverage of existing health services.

»The Board is of the opinion that in many countries the health services are not keeping pace with the changing populations either in quantity or quality. It is likely that they are getting worse. Even if this is looked at optimistically and it is said that the health services are improving, the Board considers that we are on the edge of a major crisis which we must face at once as it could result in a reaction which could be both destructive and costly. There appears to be wide-spread dissatisfaction of populations about their health services for varying reasons. These dissatisfactions occur in the developed as well as in the third world. They can be summarized as a failure to meet the expectations of the populations; an inability of the health services to deliver a level of national coverage adequate to meet stated demands and the changing needs of different societies; a wide gap (which is not closing) in health status between countries, and between different groups within countries; rapidly rising costs without a visible and meaningful improvement in service; and a feeling of helplessness by the consumer who feels (rightly or wrongly) that the health services and the personnel within them are progressing along an uncontrollable path of their own which may be satisfying to the health professions but which is not what is wanted by the consumer."<sup>1</sup>

In offering a solution to these problems WHO advocated the adoption of Primary Health Care at the community level as the only way in which health services could be developed rapidly and effectively. In so doing, it acknowledged that the prevailing system of transferring health technology from the economically developed to the developing world had failed to meet the problems. What was now required was a radical departure from conventional approaches through the adoption of the following basic principles :-

- (i) »Primary Health Care should be shaped around the life patterns of the population it should serve;
- (ii) A local population should be actively involved in the formulation of health care activities so that health care can be brought into line with local needs and priorities;
- (iii) Health care offered should place a maximum reliance on available community resources, especially those which have hitherto remained untapped, and should remain within the stringent cost limitations that are often present;

<sup>1</sup> World Health Organization. Official Records. 1973. pp. 103-115



- (iv) Primary Health Care should be an integrated approach of preventive, curative and promotive services for both the community and the individual;
- (v) All health interventions should be undertaken at the most peripheral practicable level of the health services by the worker most simply trained for this activity;
- (vi) Other echelons of services should be designed in support of the needs of the peripheral level, especially as this pertains to technical, supply, supervisory and referral support;
- (vii) Primary Health Care services should be fully integrated with the services of the other sectors involved in community development (agriculture, education, public works, housing and communication).

To implement these principles it was recommended that the basic health workers be selected by the community and trained locally in a continuing manner, supported and administered where possible by the community itself.«<sup>2</sup> The acceptance of the above principles in 1975 by the World Health Assembly marked a radical shift in WHO priorities. One delegate thought that it was interesting that after 25 years WHO should have arrived at such simple ideas based neither on modern disciplines such as sociology nor on computer technology but simply by concentrating on the problems. In the past, health service planning, which is still a relatively new discipline, had been too much concerned with the reallocation of resources within the prevailing system rather than with the burden of sickness in the total community. Thus, it had relied on the information available within the existing system which was bound to be deficient since it rarely touched more than 20 % of the Populations in the lesser developed countries. Even in developed countries which rely so much on the myopic individualistic focus of much of medicine the information fails to reckon with the sick who do not present themselves to the facilities provided by the system and are not, therefore, observable phenomena with any statistical importance.

Moreover, health services planning like most other forms of planning tends to become systems-orientated rather than People-orientated. There is no question that the adoption of a national policy to redress the present imbalance in facilities and

<sup>2</sup> World Health Organization. Promotion of National Health Services. Doc. EB 55/9. December 1974.

health manpower between the 20 % now served and the 80 % deprived is a desirable goal but it does not go far enough. The provision of more facilities and more personnel does not guarantee that all the people will use them or that they will provide the right answer to the problems. Health systems are usually constructed in the form of a pyramid. Ideally, this should begin at the base with the provision of primary health facilities and appropriate manpower selected by the community. This would probably take care of approximately 65 % of illness episodes in the total population. Above this is the secondary tier of district hospitals which should be able to handle 25 - 30 % of more serious cases and, at the tertiary level, there should be a sophisticated facility with specialist manpower to take care of the 5-10 % of cases requiring specialty care. However, the majority of health systems in the lesser developed countries have done the impossible. They have started to build a pyramid from the top down and have usually failed to reach the bottom. The intention of the pyramid design is that all illness episodes should proceed through a filtering system with only the most complicated reaching the apex at the level of the university teaching hospital. But, of course, it doesn't work that way because there is no adequate filtering facility at the base.

The greatest difficulty with the system's approach is that it simply transfers one Western type system with all its deficiencies to another culture with a different economy and when this is facilitated by bilateral aid the result is the development of underdevelopment. The »trickle down« theory, whereby the increasing financial rewards that accrue to a country are supposed to trickle down through all sections in order to relieve the plight of those at the bottom of the pyramid, is now under attack and certainly is no longer universally accepted. It appears that those at the bottom of the pyramid and who are waiting, never in fact get the goods, and the gap between rich and poor grows larger. Similarly, if health care resources are added to the system as it is organized in its present patterns then it is likely that the majority of people in the lesser developed countries will still be denied access to what should be regarded as a basic human right.

The greatest fallacy perpetrated by the system's approach is the assumption that health is a commodity which one individual can bestow upon another instead of a quality which each individual and community must learn to pursue. The assumptions of this fallacy

are apparent in the health planner's vocabulary. He talks about consumers and providers of health care and about health *delivery* systems as though these were made up of packages coming in different sizes. The chief merit of the Primary Health Care approach is that it attempts to deal with the above problems in a realistic way by bringing health nearer to people where it belongs.

The first principle of Primary Health Care that it should be shaped around the life patterns of the population it is to serve is a necessary corrective to the arrogance of allopathic medicine which, for so long, has rejected any integration with traditional medicine or, indeed, with any other form of healing. Yet, the traditional healers are still the preference for millions of people because they appear to answer the questions if not always the needs of those who go to them. The traditional healer is more likely to understand the patient's »world view« of the causality of his sickness and thus see him as a total person in the social setting to which he belongs. To be shaped around the life patterns of those it serves would enable medicine to recall its social mandate which it receives from a society which bears the burden of illness. This public accountability would require an honest and objective appraisal of what medicine can and cannot do in the preservation of or the restoration to health. This would also encourage a reciprocal responsibility from the community as suggested in the second and third principles. They might thus avoid the trap of addictive dependency on medicine which is becoming prevalent in the West.

The choice by the community of the person who is to be trained as the primary health care worker/enabler reflects the successful use of the »barefoot« doctors in the Peoples Republic of China who not only serve the immediate needs of the people but have been instrumental in improving the quality of life in that country. It challenges the assumption that the doctor must be the entry point into a medical system. Moreover, the sheer impossibility of training enough doctors together with growing doubts about the relevance of some of this training makes the case for the primary health care worker imperative.

The inclusion of the community in the planning and management of these basic health services has the advantage that those who have contributed to the betterment of health through their own Participation are likely to apply the knowledge and motivation they have acquired to the solution of other community problems.

Moreover, most poorer countries are rich in people who by their participation in health care can provide a resource for their own improvement which is better than being objects of pity and of chanty.

The seventh principle recognizes that health is only one aspect within the total spectrum of development. Part of the problem is that health cannot always be expressed in quantitative terms.

One can measure the number of immunizations given or the number of attendancies at an outpatient clinic or admissions to inpatient facilities; but these statistics do not always indicate a measurable index of better health. Health is not a single quality which can be assessed and stated to be present or absent. It must be seen in a qualitative sense as a dimension in the quality of human life which is a precondition for total human development. No longer can we assume that economic development alone will eventually improve the health of a community. The improvement of health on the other hand, contributes to human skills, imagination and vitality which are essential to creativity and the attainment of a higher quality of life.

The inclusion of health as a dimension of total development thus makes it necessary to see the relatedness of health to other factors, dimensions and disciplines. Thus, health and poverty have a two way relationship. If an individual or a community is very poor they are unlikely to be healthy. If they lack resources for adequate food or protected water, no medical intervention will improve their over-all health development. Conversely, poor health can be a major factor in preventing or making it difficult for a poverty group to rise above its existing economic level. In many situations better agricultural production and nutrition, better housing, sanitation, education and communication will have a greater impact on health status than medical care alone. While medical technology can influence the effects of disease it has virtually no impact on its incidence.

It may appear strange that such emphasis is given to the World Health Organization and its priority in promoting Primary Health Care. What has happened to the churches' response to these basic needs which Primary Health Care attempts to supply? It must be admitted that, by and large, the churches in the lesser developed countries, although they now held the power of decision, rarely considered the problems of health care outside the institutional

forms such as hospitals and clinics which they had inherited from Western missions. Some of them, regrettably, saw these institutions as prestige symbols which were important to a minority group. If their guidance came from the few medical professionals among them, whether nationals or Westerners, they were likely to be encouraged to continue as before. The few »discoveries« recorded in the previous chapter were the result of an imaginative and acutely sensitive approach to the needs of the poor initiated by highly motivated individuals with Christian conviction. These projects required, as did others like them, a rejection of the normative standards of Western medicine. Yet, this created a problem since these innovative programmes depended so largely on the input of their originators and, so, were difficult to replicate.

The merit of the primary health care approach and its adoption by WHO was that it attempted to develop a methodology which would be replicable and also put a respectable stamp of approval on it. It was adopted as national policy for health services by the Government of Sudan which immediately sought to implement it in its Southern region. It was followed by Guinea-Bissau and Cape Verde with local modifications. Meanwhile, the Christian Medical Commission made every effort as did several other non-governmental organizations to promote Primary Health Care as the priority within the private sector. For the CMC, Primary Health Care seemed to vindicate its own progressive search for viable alternatives to the injustices and inequities which were inherent in the Western system of medical care which the churches had unwittingly propagated and practiced. It was clearly necessary that the emphasis on vertical programmes in Western medicine which concentrated on a cluster of diseases or even on one, must give way to the horizontal and integrated approach if the poor were to be served and cared for as though they mattered.

While Primary Health Care, at first sight, may appear as the solution to many of the health needs of third world countries and even have much that is worth-while to offer to industrialized societies; it still faces the problem of integration into a medical system which has a well guarded hierarchical structure of professional domination. Another problem is that it has not yet provided for the upward mobility in both skills, ranking and rewards which people generally demand. It would be unrealistic to suppose that every primary health care worker would be content to

remain so until retirement. Many will wish to become »Professionals« themselves and some will even aspire to that lofty social attainment of being addressed as »doctor«. Such doubts are prompted by reflection on the history of similar movements designed to help the poor which always seem to become bureaucratically institutionalized just as much as the systems they were supposed to liberalize.

From the Christian point of view we are back to the sinfulness of man and his inability of himself to be and to do those things which he knows to be right.

In July 1975 the Christian Medical Commission invited Dr. Charles Elliott, a priest and an economist, to address its annual meeting in Zürich. He chose the subject »Is Primary Health Care the New Priority? Yes, but . . .« In questioning the extent to which Primary Health Care had become a new form of professional domination and whether it will become institutionalized in a way that prevents it from effectively reaching those who need it most, he had this to say: -

»Both as dispensers and recipients of health care, men-in-community are severely limited in their ability to give or receive health. The fundamental problem that faces us, therefore, is to enlarge that ability. The process by which that is done can be ascribed a variety of different labels according to ideological or ethical positions. It can be called conscientization. It can be called liberation. It can be called cultural revolution. Or it can be called salvation. I am not suggesting that these are either the same or even roughly

equivalent: I am suggesting that we are all looking for ways in which the delivery of health care does not become subverted into the protection of a profession; and for ways in which the receiving of health care does not become distorted into a process by which my neighbour is robbed.

Here I think we glimpse something that CMC has always emphasized, even if sometimes obliquely - namely, that health and salvation are mutually interdependent in every human society, irrespective of culture, political allegiance or level of gross national product. That interdependence is worked out, not only at the individual level, but also at the macro or social level. The personality of professional and patient is determined by what a passing generation of theologians called the state of grace, and the social milieu in which the personality is formed and lived. Thus, salvation does not, cannot and must never be allowed to have a purely personal reference. Salvation is a social process as well as an individual liberation.

The question remains: In operational terms, how can we make real this dawning perception that, in all our societies, rich quite as much as (perhaps

even more than) poor, the processes of being healthy and making others healthy have to them the dimension completely ignored by traditional

thinking, - a dimension that acknowledges that the people (both healer and healed) and the institutions are in continuous need of liberation, renewal and at-one-ment - a need that the biblical tradition calls salvation, but which could often be equally well translated wholeness or healthfulness? In developed and underdeveloped countries, how do we bring healing and wholeness, not only to the sick, but to those who purport to cure the sick? When we do that, what are the implications for the relationship between the practitioner and the patient, the curer and the cured? This will doubtlessly need much further investigation but one implication is clear. That relationship ceases to be a relationship between the sick and the healthy. It becomes rather a relationship between two people or groups both of which know that they are less than whole and both

of which are seeking to find a greater degree of wholeness.

I know that some of what I have said is contentious and may spark challenge and even fundamental disagreement. So be it. But at the risk of seeming to confound confusion, let me make one final comment. If what I have said is even roughly right, there is clearly a limit to the extent to which the *Christian Medical Commission* can collaborate with agencies which deny to the concept of health the element of transcendental wholeness as expressed in the last paragraph.«<sup>3</sup>

While Dr. Elliott expresses some serious reservations about the ability of the primary health care methodology to achieve its purpose of bringing health care within reach of the millions who are now denied it, its implementation will certainly be an improvement upon the »elitist« system now prevailing and, to that extent at least, enables us to »be on the way«. The crisis is likely to come over the adoption and implementation of the sixth principle e.g., that »other echelons of services should be designed in *support* of the needs of the peripheral level.« This requires far more than logistical or supervisory support if it is to work. It will demand a critical reappraisal of the present hierarchical structure within the medical professions with the »higher« deferring to the »lower« in the service of the sick who will need to be deferred to most of all. This is extremely difficult to achieve and some would argue that only the most fundamental political and economic changes could effect it. While the member governments of WHO have accepted the priorities of primary health care there is still little evidence that this has changed the budgetary allocations to their health services. If they do not do so the likely result is a two tier system with a minority having access to sophisticated high cost technology while the rest have primary health care.

<sup>3</sup> CONTACT 28, August 1975



Commitment to the principles of primary health care would also require a demystification of medical jargon with ordinary people permitted into the inner sanctum with the probable exposure of professional fallibility. All that should provide enough of a revolution to begin with but it is one which becomes increasingly necessary. Any attempt to bring health by and to the people where it should belong is a step on the way to wholeness. The next logical step in the progression of primary health care was the call to use its methodology in order to make health care services available for all by the year 2000. This was advocated by Dr. Mahler, the Director General of WHO, in his address to the 30th World Health Assembly in 1976. He suggested using the facilities of WHO to analyse the health problems and resources in each country, rich and poor, so as to enable the development of health policies and targets which could be adopted at the national level and would lead to the achievement of this goal. He saw it as a moving target and not simply as filling the gaps. As one stage in the process is reached there would be other and higher targets to attain. The proposal was later adopted and became the subject of an International Conference on Primary Health Care which was held in Alma-Ata in USSR in September 1978.

The idea that health care policies should be adopted and implemented progressively requires some concept of what the final step in the progression should be. It would surely not be more of medicine for it seems that as more possibilities for curing appear the less likely are people ready to accept responsibility for their own health and the health of their communities. Instead, they are more likely to become dependent on a medicine which they believe can repair the consequences of their own self-indulgence. So the end might well be worse than the beginning in which we have exchanged the diseases of poverty, malnutrition and of parasites for lung cancer, increasing accident rates and suicide.

Dr. Elliott is right to remind us that health is more than medicine and that the ultimate answer to dis-ease lies in a way of life - a life of surrender and obedience which leads to wholeness.

THE EXPANDING VIEW OF HEALTH

A review of this quest which began in search of a Christian understanding of health and healing shows that whenever we have taken a few steps towards a greater understanding of our aim or toward achieving a practical goal in the field of health we have had to replace our initial aim or goal by one which is more comprehensive. In fact, we have discovered the necessity of an expanding view of health - a process which is likely to continue. It is as if every step we climb up the mountain makes the horizon appear more extensive. It also brings into focus some commonly held assumptions about health which need correction.

Since the first Tübingen Consultation of 1964 our concept of health has changed considerably. Prior to that consultation very few had questioned the assumption that the availability of more medical services would ensure a greater measure of health. It is an assumption which still persists today and not only in the lesser developed countries. It formed the basis for the National Health Service in Britain. In introducing it, the then Minister of Health, Aneurin Bevan, stated that «Medical treatment and care . . . should be made available to rich and poor alike in accordance with medical need and by no other criterion.»<sup>1</sup> It was assumed that there existed a measurable quantity of ill health or morbidity in the society and if this were treated there would be a marked reduction in illness rates. However, the free availability of services simply increased the demand, partly, because of new expectations raised by advances in medical science and, partly, because the public brought to the health services a whole new spectrum of disorders such as family problems and job dissatisfaction for which medicine could do little except to offer palliatives such as tranquillizers. Certain »illnesses« became Popular, particularly, those which could be related to stress. It became socially acceptable to stay home from one's job with the sanction of the Health Service even if the real purpose was to paint the house! Moreover, the confusion which equates medicine with health had become further compounded by shifting into the category of illness such problems as attempted suicide, some forms

<sup>1</sup> The National Health Service - the first thirty years. Abel-Smith, B. (HMSO 1978)

of criminality and homosexuality. Like obesity and alcoholism, these problems became more »respectable« when viewed as illnesses in the guise of genetic and psychiatric disorders. Together, all these examples show that medical self-indulgence can defeat the best intentions of health care planners.

It is obvious that medical care is related to the maintenance and promotion of health although its primary concern is with sickness through the treatment of disease and the relief of symptoms. For this reason, it would be more appropriate to talk about sickness services rather than health services. Much of the confusion is due to our preference for the idea that health is something which can only be restored by treatment of the disease which attacks it and, so, diminishes it. The alternative notion that health is something which is preserved by a way of life requires too much discipline and the exercise of responsibility. These two alternative views are found in the ancient myth of Aesculapius and Hygeia with the former gaining the ascendancy and his sign being adopted by the medical profession as its emblem.

The idea that health is restored by attacking disease is predominant in the present model of medical practice. It frequently entails an engineering approach which regards the body as a machine and offers protection from the attacks of disease and recovery from them by using interventions through drugs or surgery. It applies, particularly, to the treatment of the individual patient with the doctor relying on a diagnosis which sometimes requires expensive technology in the form of scanners, X-rays and laboratory equipment which can only be housed conveniently in a hospital. For these and other conveniences which it offers to the doctor and his allies, the hospital becomes central to the structures of medical care and also tends to perpetuate the approach we have described above since it provides the locus for the training of future medical and nursing personnel.

The predominance of this model of medical care and the confused notion which equates it with health has a significance beyond itself. Just as the provision of a well not only ensures a water supply; it also carries a message to those who use it which changes their view of life and expands their expectations. So, the adoption of more and more medical techniques based on the mechanical concept of the body and relying on an increasing use of technology which is obscure to those affected by it, results in a meaninglessness which either

alienates the patient or makes him unhealthily dependent upon the professional providers.

As it was shown earlier in this account, it was the scarcity of western style medical care resources in the lesser developed countries and the impossibility, financially, of extending them which brought into focus the disparity between those few who were served and the majority who were deprived. So our concept of health became radicalized by matching it to the dimension of social justice which raised ethical and political questions of resource allocation. The search for a more equitable distribution of »health« services raised the inevitable question of whether what were supposed to be distributed more equitably e.g. medical services were, in fact, the most effective measures for promoting and maintaining health. This led to an historical review of the factors which had most promoted a higher general level of health in western societies. These were found to exist chiefly in the physical and social environment in which people lived and in their personal and social life styles. Protected water supplies, sanitation, nutrition, housing, education and communications were all important factors which led to the sharp decline in mortality and morbidity in western countries during the 19th and early 20th centuries. It was the introduction of these services rather than medical care alone which had the most profound effect on health. So, our view of health has to be enlarged to include disciplines other than medicine. It is apparent that if priority were given to their introduction in lesser developed countries the resulting impact on health would be equally dramatic. Transferring the medical technology of the West to a developing country which lacked a basic sanitary environment and adequate nutritious food was not only inappropriate but morally wrong since the cost of transferring and maintaining that technology would absorb all the resources some of which might have been better spent on potable water supplies and agriculture.

As for the West, it had replaced its former environmental deficiencies by such unhealthy practices as industrial pollution and personal indulgence in smoking, drinking and over-eating! So, knowledge of the factors which promote health does not necessarily mean that priority will be given to their implementation. The lack of them is frequently due to poverty and the economic system which produced it and prefers to tolerate it rather than be changed. Similarly, efforts to change life-styles which are injurious to health

are tolerated provided they do not bring into question the system which promotes their use under the guise of exercising personal freedom of choice. So people are constantly subjected to the wiles of advertising which encourages them to want and consume more and more, including those things which are injurious to their health. In this situation, the distinction between what people need and what they desire becomes blurred with the result that desires become needs and life-styles tend to reflect this.

Our view of health is further expanded as it moves from concern for the individual to the community of which the individual is a part and to the relationships he will have with others in that community. Experiments in promoting health to whole communities which culminated in the development of Primary Health Care were based on the view that health belongs to people both as a right and a responsibility. It is not something »delivered« by one person to others nor by a professional group to its patients. The patient actively participates in the health team and is both knowledgeable about and intimately related to the treatment. We find, also, that whereas some health problems can be tackled on a short-term basis our expanded view of each man's relatedness to others within social space means that the significance of the problems extends over an ever increasing span of time. It takes longer to grow new crops than to eat a meal; it takes longer to dig wells and build latrines than to treat a case of dysentery; and much longer again for villagers to learn the necessity for them and how to use and maintain them. So, our view of health expands in time as well as space.

Health has also a political dimension which reflects our values and the social structures affected by them. The fact that millions of people in Asia and Africa suffer from malaria and severe malnutrition is frequently written off as »a fact of life«. Our distance from them blurs our sense of responsibility and the fact that these conditions have existed for a long time blunts the will and initiative of those legally responsible to do anything about the situation commensurate with its seriousness. Thus, the questions of »Who is sick?« and, » Who is my neighbour?« are intimately related. One is reminded of Lambourne's account of this relationship, »Human nature is such that there can be no full health without the sharing of the burdens of sickness . . . He only is whole who is joined to the suffering of others.«<sup>2</sup>

2 Community, Church and Healing, page 162

Our concept of health also expands through listening to those we seek to help. This not only requires the active participation of the patient in his or her treatment. It requires a modesty which is willing to listen and learn from other cultures which have produced their own indigenous forms of healing. While these differ from country to country and even among the tribes and castes within countries they have two outstanding differences from our western scientific approach. Firstly, there is the overriding interest of the patient and the relatives in the reason for the sickness or disorder and the explanation must fit into their world-view of causation. Secondly, while we tend to use analogies drawn from the world of inanimate things which have some order and predictability about them, they use analogies drawn chiefly from the world of people and their relationships. We use what we call common sense - putting two and two together - to deduce the connection between snails and bilharzia; between mosquitos and malaria. They find it reasonable to attribute disease to unseen spiritual forces and disturbances in relationships such as jealousies and hatreds. The former must be placated and the relationship must be restored if healing is to take place. These relationships can involve the extended family and even the community as a whole.

A willingness to learn about and to understand these indigenous systems has interesting results. It reveals the importance of making care comprehensible to those who are being served on their terms, involving them and their families in the therapy. It also requires a willingness to discard some »rules« in order to accommodate the Patient's need for supportive relationships. Thus, strict adherence to visiting hours in a hospital will have to go and other »rules« be re-examined to see whether they were imposed in order to suit the convenience of the staff or that of the patients.

The very expansiveness of our current perspective on health Points up the problem of finding a satisfactory definition for it which would include the attributes already discovered. The most common definition, until recently, was to give health a meaning only in confrontation with its opposite - disease. Thus, health as defined in several medical texts, is the absence of disease. However, People can adapt to sickness and learn to put up with the fact that their body is performing in a less than optimum way. They have what we call a »healthy attitude« to their diseased condition. Moreover, as the meaning of health extended beyond biological and

psychological phenomena to include social and cultural conditions of communal as well as personal import, so the definition widened. Today, the most notable definition is that of the World Health Organization which regards health as » . . . a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.« At first sight, this may appear to satisfy our expanding view of health but a closer look suggests that it is a bottomless conceptual pit which sees health embracing every human condition. Its emphasis on complete well-being gives both medicine and society an unattainable objective.

As our understanding of the dimensions of health grows and we fail to find a satisfactory definition which includes them all we are bound to ask whether we have not extended the meaning of health too far or, at least, beyond the comprehension of those who commonly use the word. Our quest would be meaningless if it only ended in alternative definitions and failed to articulate the necessary steps required to achieve our goal. The word health has already become suspect by its misuse. We have already pointed out that so-called health services are, in reality, sickness services and, for most people, health is equivalent to medical care. This is one of the reasons why we turn to the use of wholeness to describe what it is we seek. It indicates our conviction that matters of health do influence and are influenced by the whole of life whether it be in terms of individual or corporate life. But, there are implications in the word wholeness which are not usually connoted by the word health. Since wholeness is inclusive of whatever is partial it takes in both health and illness. Our search for wholeness recognizes that, humanly speaking, pain, suffering and death are not to be eradicated or abolished by health care or health enhancing measures; though we may hope that these elements within the totality may be subordinated to the whole.

Another connotation of the word wholeness is methodological. We find that as we participate in the search for the meaning of healing events we pay increasing attention to the context in which they are set. To view such an event »as a whole« requires a response which discriminates as to which part to focus attention on in order to be most effective in promoting the health both of the whole and of that part of the whole which first drew our attention. In the medical field this perspective must entail a comprehension not only of the facts of disease but also the sufferer's experience of the illness.

Wholeness also suggests a cohesion of parts and a unity of all the dimensions of life in the person. It is akin to the Hebrew concept of Shalom which brought together the ideas about health in the wider sense we have discovered and also the idea of social harmony in which people should live together - a state so desirable that it became a wish conferred on another in the form of a greeting (Peace). To look at all these dimensions enables us to separate out those to which medicine has a very appropriate relationship and where it can make an effective contribution and others where it can not. This approach was first suggested by Paul Tillich in an article in "Perspective in Biology and Medicine«, Autumn 1961.

The first dimensions then, are biological, mechanical, chemical and psychological. The biological dimension is partially affected by that branch of medicine known as public health. Political and economic factors will limit the extent to which public health measures are permitted to control such environmental problems as pollution of air and water and the squalor of inner city slums. The mechanical dimension is concerned with the physical structure of man and regards health as the adequate functioning of the parts both separately and in relation to each other. Inevitably, this leads to an engineering approach in which surgery removes or replaces the malfunctioning parts. The chemical dimension is concerned with the biochemical functioning of the human body which, when diseased, may respond to intervention by drugs. The psychological dimension is concerned with self-awareness and relationship to reality and, as in the other two physical dimensions above, therapy is especially applicable to the cure of individuals.

In addition to the above dimensions which are appropriate for the exercise of medical care there are others in which people can be healthy and/or sick which bear no relationship to medicine as such. These are the societal, relational, and spiritual dimensions of life. Each presupposes and relates to the others. The societal and relational dimensions of a man's life have an effect on his health. Whenever resources are limited, as they usually are, the resources claimed for one man's health may well deprive others of health opportunities. The insensitivity which is so evident in a racist society makes it impossible for either the racist or the victim of racism to know and appropriate that health which would otherwise be available for them. These examples raise the question of whether



personal and communal health is ever possible in what we increasingly tend to call a »sick« society.

Lastly, there is the spiritual dimension of a person's life in relation to health. This has been interpreted in such a variety of ways and with so many exclusive claims that one is required to define one's meaning here. For some it is restricted to »spiritual healing« as distinct from the curing of physical or mental illness which is offered by medicine. As such it is frequently regarded, esoterically, as a special kind of healing akin to the miraculous which operates outside the space-time world which assumes that life is part of a mechanical and closed rational system which is understood in the light of experience and reason and where there can be no room for the breaking into human experience of what is regarded as Divine intervention. While many people are aware of or have heard or read about such »healings« as in the case of a complete remission of an advanced carcinoma or the occasional restoration to health of a pilgrim to Lourdes; there is an apparent randomness about such events which are difficult to match against the Christian claim that God is equally concerned for all his creatures. Moreover, such events are not confined to those who claim to be Christian. When these rationally unexplainable events do take place many would regard them as a coincidence or attribute them to some natural phenomena which are not yet understood. The appropriate response to such events should obviously be one of gratitude and adoration of the God who makes all healing possible.

However, it is not this special dimension that we are concerned with here but rather with that dimension of man's life as expressed in Christian faith and practice - or in response to Christ's invitation to follow him and it is here that we discover a concept of health which is akin to wholeness for it is a sign or a glimpse of the Kingdom.

The Gospel sees man's basic problem in terms of his separation from God and from his neighbours and being at cross purposes with himself. Salvation and health consist of the restoration of man to harmony with God, his neighbour and himself. When this harmony is restored in any episode, God's Kingdom becomes visible and partially realized. It is only in this context that man catches a glimpse of that wholeness which is related to holiness. It is a wholeness which is far greater than the sum of its parts.

Just as the healing acts of Christ embraced all the dimensions of

human experience so are we impelled to discover a unitary understanding of health and wholeness. Just as man is a product of his total environment so is dis-ease a product of the whole man. It is much more than a matter of invading germs or hardening of the arteries for many other factors are involved in the production of disease and we desperately need an new approach to health and healing in order to deal with it. Medicine has pre-empted so large an area of involvement that we have become blinded to the other dimensions. Medicine's division into specialties and subspecialties has provided detailed knowledge of the mechanisms of some diseases but has delayed our recognition of the deeper factors which underlie all disease. Yet, medicine cannot be held entirely responsible for this. It is because the other dimensions demand change in us - in our attitudes, our beliefs and our behaviour - that we lack any comparable system or body of knowledge and practice which could not only supplement medicine but delineate the boundaries of its appropriateness.

To implement such a new approach to health and healing we would first need to unify the prevalent dualism of body and spirit. For most of us, to speak of the spirit signifies something which is unreal and allegorical. To act or live in a spiritual way means to live in any way except a real one. On the other hand we have good evidence to believe in our bodies and that we are surrounded by material objects which appear solid enough to be noticed. What we find it hard to accept is that God is the God of matter just as much as he is the God of the spirit. Yet, this is what the Bible makes clear - that there is nothing in the creative world which is unrelated to God. Why else would God choose to meet us except incarnated in a human body? This is why St. Paul tells us that the whole creation is groaning and waiting for the revelation of the children of God. He does not separate matter or the body from the spirit. It is the total created universe which has been led astray by the fall of man - by his chosen separation from God. In the incarnation the unity of all created things was made visible. So we must learn to see that things are, in reality, together and that even material things and our bodies are capable of bearing the divine nature. At the core of healing is the restoration of this incarnational unity in which we become whole because, if only incipiently, we become subjects of God's Kingdom and partakers of his nature.

Obviously, this goes far beyond the scope of present attempts to

practice what is called holistic medicine.<sup>3</sup> These are little more than a visible partnership of doctor, nurse, psychiatrist and priest or pastor. While this is a belated recognition of the multi-dimensional aspects of healing, it is still related to the individual patient and has little if anything to offer to the community and the society which stand in need of healing and are frequently the cause of the individual's sickness. While it is the church which has sponsored this approach in parts of North America, it is, in no sense, the collectivity of the Church and its members as a healing community which participates. Rather, is it an association of professionals, each seeking to cure from his or her perspective of the meaning of health. If the incarnational means of healing are to be realized it would call for a renewal of the Church itself and the active participation of each member in the process.

3 The use of the word »holistic« here applies to its appropriation by those associated with Dr. Granger Westberg in the United States. It should not be confused with the emergence of a "holistic health practice« which is a mishmash of colourful characters from psychic healers to shamans offering a variety of "alternative" therapies.

## Chapter 9

### THE PRESENT STUDIES

In a preface to the report of the first meeting of the Christian Medical Commission in 1968, the Director wrote: »The CMC came into being as a focus of two converging interests, one functional and the other theological.« The functional concern was with church-related hospitals and church medical agencies in a changing situation of countries becoming independent and of freeing themselves from imperial and colonial domination. The theological concern was with new insights into the interconnections between healing, the Gospel and the mission of the churches. In reviewing the activities of the Commission after the completion of its first mandate - a period of eight years - it was evident that a great deal of progress had been made in the functional concern but, without any comparable advance in clarifying what was different and, possibly, unique in the Christian understanding and practice of health and healing. It was partly to rectify this imbalance in the Commission's activities that its second mandate laid greater stress on the need to «explore new insights into, and promote theological reflection on, the Christian understanding of life, death, suffering and health that these may find expression in the church's concern for health care as a healing community.« Because of its world-wide relationships, the Commission was in an excellent position to undertake such a study for it could draw upon its network of churches in different cultural settings, not only to avoid a western bias to the study but, to enrich its own understanding of its task.

Meanwhile, as a contribution to the ongoing study of the Commission, a small group of participants<sup>1</sup> drawn chiefly from Europe, was meeting, occasionally, in Tübingen, at the German Institute for Medical Missions which had hosted the previous consultations on the healing ministry of the Church. Their concern focussed on three issues. Firstly, they felt it was necessary to explore what would happen to western medical services if one adopted those principles discovered in the promotion of Primary Health Care in the lesser developed countries. If the principles were universally applicable then their adoption should correct some of

<sup>1</sup> For membership see Appendix II

the errors in the western system and would, also, go far to commend this approach to the developing countries themselves for it was unlikely that the latter would accept Primary Health Care with much enthusiasm unless the industrialized countries, which they were so inclined to imitate, set an example by applying to themselves the principles they were advocating for others.

Secondly, the participants had in common a deep commitment to explore Christian insights into the meaning of health and healing, believing that the way to a true and full health and wholeness lay in the salvation offered in Jesus Christ. Yet, they felt a deep disquiet that the churches were failing to engage with people in their present problems, uncertainties and sufferings; and that the actual systems of parish and congregational life, worship and training failed to make that salvation, which subsumed health and wholeness, self-evident. It became clear that the Church was in no position to make judgements about the dehumanizing effects of technology, the impersonality of institutions and the medicalization of death unless she was willing to effect radical change in her own life and institutionalism.

Thirdly, because medicine touches intimately on all our lives, our attitudes to it reflect widely accepted values and beliefs which are not susceptible either to speedy or easy change. This is to say that medicine and our attitudes to it reflect, in microcosm, the kind of society in which we live. Therefore, we felt compelled to seek new approaches to, and new methods for, seeking and promoting health while believing that we have a similar call to develop new approaches to, and new methods for, proclaiming the Gospel and for living Christian lives of discipleship, service and witness. We see a close connection between these two demands because of the connection since New Testament times, between the service of the Gospel and ministries of healing. Moreover, as Christians, we cannot only be concerned to reform our search for health unless, at the same time, we are part of reforming the life of the Church and our response to the Gospel. In this connection it was felt necessary to discover better ways of communication or building bridges between the »medical« or »scientific« world and the »theological« world. The objective of this process would be to ensure that an effective debate is carried on about the relationship between the search for health and the struggle for human wholeness offered by the Gospel.

As might be expected from such a group which included University Professors in the disciplines of Medicine and Theology there was an initial debate about the starting point and whether this should not be the Biblical understanding of Health. However, we accepted a theologian's view that »We are being neither biblical nor theological in seeking to base our approach on something we call a >biblical< or >theological< approach to health. The Bible does not portray the discovery of God's will and calling by being >biblical<. It portrays such discoveries through facing up to problems in the contemporary history and experience of society, responded to in the light of insights derived from the tradition and life of the people of God. Thus it is wholly unbiblical to start from the Bible. God works on us through what is going on in the world, not through what is repeated in Church when it is so repeated out of touch with the world.«

This was not taken to mean that we could afford to ignore what the Bible has to say about sickness and healing and, particularly, the insights about the nature of man derived from the Bible and the life of the people of God. One such insight was that health is not to be regarded as the summum bonum of human life and that it cannot be possessed by itself alone. It is both collective and social. Thus it is not regarded as an individual possession but derivatively from the community and this community has a cohesion and strong sense of belonging about it - not like marbles in a box. Nor is health regarded as something separate from religion since the Bible does not recognize »religion« as an optional choice.

It was agreed that the task of this study group would be to focus on the existing situation in medicine and health care and scrutinize it in the light of a Christian understanding of man and of what the Bible has to say about sickness and healing. Consequently, it was thought appropriate to prepare an interim position paper which would summarize the participants' views. It was titled »The Mission and Service of the Church in Sickness and Health Care« and is reproduced in full.

»From the beginning of her existence, the Church has been concerned with responses to what human beings experience and understand as sickness, disease and disorder. She has done this because Christians believe that Christ came »that we might have life and have it more abundantly« (John 10:10) and that in His ministry He gave signs of this by His activities of healing and by His confrontation with the evils which hold men and

women in their grip. Thus, a commitment to activities designed to assist in the healing of persons and in the treatment of diseases has always been part of the services of the Church, of her proclamation of the Gospel and of the exercise of particular spiritual gifts by her members.

The form of these activities has changed over the years. From the early preoccupation with healing as the exercise of spiritual gifts, the Church's concern began to take on a more institutional form following the Emperor Constantine's adoption of Christianity as a state religion in the 4th century. Then began the Church's long involvement in hospices and hospitals. These hospitals have tended to become, like their secular counterparts which emerged later, more concerned with the treatment of diseases than with the healing of persons. It must, however, also be remembered that the church has always maintained some form of ministry to the sick which was directly addressed to them as persons through such matters as prayer, sick-visiting, and the laying on of hands etc. but it may be held that this became more and more separated from >medical< treatment which was more oriented to diseases rather than persons.

As more hospitals became secularized, particularly in the 18th and 19th centuries, the Church shifted its major involvement to the areas of overseas mission activity so that by 1910 the Protestant Churches alone were maintaining 2 100 hospitals, chiefly in Asia, Africa and Latin America. Yet, even today, there exist, in some European countries and in North America, a considerable number of church-related hospitals, many of them located in areas which are also served by state-owned institutions. Even in the lesser developed countries where governments are increasingly adding to the national health services, it is becoming more common to find church-owned and state-owned institutions within the same locality. This, inevitably, raises the issue of comparison. What is it that makes the Christian institution different? The question becomes all the more grave when asked in the context of the very costly institutions which modern technology demands for the practice of medical care.

Both types of institutions, whether church-owned or state-owned use the same medical model. Their practitioners are trained according to an identical curriculum. They use the same techniques of nursing and medical care. If it be argued that the distinction is to be found in the quality of service offered by the Christian institution - the unique relationship in which the patient is treated with dignity, and sickness becomes transcended in the mutual quest for wholeness, then one must ask how far the modern technical model of medical care is conducive to these objectives or whether it actually hinders or even prevents them. This is a question which the Church must face not only in relation to its own institutions but it must challenge the same model in secular institutions when it finds that it has distorted the image of health and robs men and women of their opportunity to be truly human as God intended. It is these distortions in the structures and presuppositions of medicine which obscure and even thwart its enormous achievements for good.

Of late, there has been a growing disquiet about the organized methods of responding to sickness and the means of pursuing health and healing which are dominant in Western countries and which have been shared with, or imposed upon, the countries of the Third World. Concentration upon the science and practice of medicine as the effective means of seeking health and the sole means of responding to sickness has led to both a picture and a pursuit of human health which is dangerously narrow, makes both human beings and their communities unnecessarily dependent, and leads to a monopoly of professional power which is both exploitive of others and wasteful of resources.

The focus of this disquiet centres around those aspects of the dominant model of medical care which have resulted in false expectations which must be challenged.

Some of these are *impossible expectations* - e.g. health cannot be »delivered«. It is not a commodity which one individual or profession can bestow upon another. It is rather a quality which each individual and community must pursue. Moreover, the resources for health are strictly limited; human life cannot be exempted from suffering and death nor is it rendered meaningless by suffering and death.

Some are *inappropriate expectations* - e.g. it is not the practice of highly developed medicine which contributes most in determining the healthiness of individuals and societies. The greatest improvements in health have come

from an understanding and modification of those factors in the environment which favour the occurrence of disease. It is improvements in housing and food supplies, the introduction of safe water supply and waste disposal systems and, particularly in the developed countries, the elimination of pollution and the strict observance of speed limits which have the greatest impact on our health. In short, the biggest factor affecting our health is our life-style.

Some are *harmful expectations* as people become greedy for scarce resources (e.g. more and more technology for a few individuals such as heart transplants and renal dialysis.) These expectations lead to an addictive dependency on medical care as though it would relieve all our sickness. Then, people are depressed into additional misery when services fail or are not available.

In addition to these false expectations we recognize that the current provisions for health care have led to a gross maldistribution of resources. The adoption of high cost, technologized medicine by the Third World has served only their elite so that 80 per cent of the populations are deprived of health services. Moreover, there is maldistribution among the various strata of society in some of the developed countries so that the poor can no



longer

afford to be sick. Meanwhile, powerful groups within the health care enterprise exercise great control and amass considerable wealth, especially the medical profession and the international drug companies.

This "domination of the medical model« (as it is sometimes called) in the human understanding and the social pursuit of health is coming more and

more under challenge. Christians who are working in the fields of medicine and of health care as an expression of the witness of the church to Christ and to the Gospel have, perhaps unwittingly, been caught up in (or seduced by) this medical model, together with the societies from which they come and in which they serve. Christian medical work and Christian concern for health and healing thus face the same central challenge and Christians are called to share the same disturbances and disquiets about current methods and future plans in the field of health care. The critical question for them, however, is how to perceive the hand of God and His judgment in these disturbances so that they may effectively renew their sharing in the human struggle to alleviate sickness and to develop health, as part of their service in the name of Christ and in their desire to share the Gospel.

The human pursuit of health and responses to sickness need to be set free from the domination of the medical model as it has developed. Others may and will work at this need in ways which have nothing directly to do with the practice of medicine. (For example, through developing community action or through working on social and economic conditions.) We, however, choose to remain concerned with what we have called »the medical contact area« with human and social life. By using this phrase »medical contact area« we intend to draw attention to the fact that the practice of medicine developed as a way of getting into contact with the sphere of disorder, disquiet and disease in human experience. Medicine is an applied science which gets its mandate from those who bear the burden of sickness. Yet it has grown from modest beginnings into almost a way of life which calls the tune about what is regarded as healthy and holds the key to the pursuit and achievement of such living. A public which has been justifiably excited by the major technological breakthroughs in modern medical science is now increasingly concerned that the technology is becoming an end in itself justified by what is technically possible, rather than applied to the social mandate which gave it sanction. The medical practitioner and those associated with him have correspondingly grown from servants and carers to masters and even to substitute demi-gods. It is increasingly clear that there is very little that is health-giving about this and much that is sick-making, both for individuals and for society.

We wish to remain with this medical contact area as our sphere of operation for the following reasons:

- 1 Firstly, there is an immense investment, both of resources and of expectation, in medical practice as the main approach of the problems and distresses of human disorder and disease. Further, no widely accepted alternative approaches as yet exist. Therefore the medical contact area constitutes a main battle-ground for the struggle for a more realistic and a more just use of human and social resource in promoting health and happiness.
- 2 Secondly, as Christians we are clear that sin need not have dominion over us. We know, therefore, that abuse and distortion in a sphere of human activity need not invalidate that sphere and should not lead to its

undiscriminating rejection. Commitment to and development of medicine has been an important channel of human compassion, inventiveness and service. The real achievements of this must not be lost to future and broader human uses.

3 Thirdly, the various manifestations of medical practice and attempts at the provision of health care provide us with a multitude of persons, groups and organizations who are in intimate (even if sometimes distorting) contact with men and women in the stresses and struggles of their lives. Also, there are many Christians and Christian organizations active in this sphere. Thus, there are many living opportunities available for experiment, innovation and hope.

For us, therefore, it is the medical contact area which constitutes the arena in our search for a wider health and a deeper service. We do not enter this arena with the belief that we have or shall produce fresh and good models to be substituted for medical models which have become stale and the source or sustenance of much that is bad. We look rather for ways of working with other concerned people and groups to develop a more realistic awareness of what the role of the doctor and the practice of medicine actually achieve or fail to do today. As we believe that facing up to realism and judgment is a necessary step on the way to receiving practical repentance and the renewal of opportunities for creativity and service, we expect such developing awareness to lead us also to mutual discoveries of re-interpretation, reorganization and change which are necessary if medical practice and health care are to become part of human collaboration in the struggle for more healthy living in a more just society. We do not know in advance how far these changes must go nor what demands will be made of us or what possibilities offered to us. What we do know is that God in Jesus Christ offers us resources and promises which can sustain us in facing criticisms which challenge our present identities and practices to their very roots, and can maintain us in a hopeful and joyful search in the face of all obstacles. We expect also to learn more of what faith in God through Jesus Christ means by our involvement and for our involvement in this exploration and struggle. By this learning we hope also to discover and develop hints about those forms of ministry from the Church and for the Church which will recreate, for our times and circumstances, effective mission and service in the fields of medical practice and the pursuit of health.

Thus, we are seeking to develop an *analysis* of what has been learned from critical involvement in the practice of medicine and the attempts at the provision of health care. We propose to relate the understanding built up by this analysis to the *traditions* both of human service which originally inspired the development of medicine and of Christian understanding and which has sustained the Church in confronting sickness and seeking

healing. We shall attempt to put together the results of this analysis and this reflection on tradition in a practical way by seeking *entry-points* into the

field of medical practice and health care where we find opportunities, consonant with the approach outlined above, to develop experiments, change attitudes and multiply the resources for widening the human search

for health and deepening the understanding of what is implied in this and offered for it. We thus seek to be part of a rediscovery of the living links between health, community and salvation.«

In this analysis and in this search the study group could draw upon several resources such as the activities of the Christian Medical Commission and the experiences of its own membership. Prof. David E. Jenkins had been intimately associated with an analysis of the National Health Service in Britain<sup>2</sup> which had been submitted as evidence to the Royal Commission which from 1976-1979 had been reviewing the operation of the Health Services. For the purposes of this quest the following points from that analysis are relevant.

(1) Expenditure on Health Services bears little or no relationship to the levels of health found in the community. Curative services - especially those relying on costly technology - get the lion's share of available resources in spite of the fact that the treatment of illnesses amenable to such technological intervention represents only a small fraction of total illness.

(2) The pressure points on the service are due to insatiable demand on strictly limited resources. Many of the demands are inappropriate and many of the treatments offered are of doubtful effectiveness.

(3) The dominance of the medical model of health is self-defeating because it is expected to deal with an ever increasing number of ills and uneases in society. The »Health Services« become entangled with the »social services« and the latter are expected to deal with social problems on the medical model.

(4) It is not that the medical model with its emphasis on attacking disease is evil in itself but, rather that we have invested too much hope and too much power in it. Yet there is no substitute model for the practice of medicine. The urgent task is to cut it back to its appropriate size lest we obscure the necessary role of that model and those who work by it.

(5) To reform the medical model we need a vision or at least a glimpse of the wholeness of man and human society as it should be

2 Restructuring the Health Service. Tom Heller (Croom Helm, London 1978)

and can become; a willingness to surrender power; the development of a new identity to replace the power and pride of professionalism and, finally, a readiness for risk because we do not yet know what will work only what will not work.

Dr. Jürgen Bierich of the Medical Faculty of Tübingen University applied the above analysis to the situation in Germany where only a few had ventured to criticize the prevailing medical model. He attributed this to the continuing fascination with technical and scientific advances as well as pride in the national industrial and economic achievements. Moreover, there was a bureaucratic rigidity which made change difficult to accomplish. The curriculum in medical schools in Germany follows the line of pure natural sciences. There are no lectures on anthropology, sociology or discussions about human values. An attempt to introduce the teaching of medical sociology had recently been defeated in the Bundestag. However, there was now some evidence of disquiet and an increasing interest in the writings of Viktor von Weizsäcker who had raised some fundamental questions about the relationships between patients and doctors in the 1920s. Some teaching hospitals were now introducing ethical committees which might go beyond the examination of risks in clinical cases to a questioning of the system itself.

Further evidence of the disquiet in Germany came from an account of several attempts to counteract the dehumanizing effects of medical technology and overcome the strangeness and loneliness which patients experienced in large hospitals. One hospital had established therapeutic teams for engaging the patients as partners in their own therapy. There was also a weekly meeting of staff and patients together. There are five anthroposophical hospitals today which were inspired by the ideas of Rudolf Steiner where the architecture, administrative functions and the atmosphere within the hospitals are all related harmoniously to a wider concept of health. The disquiet had taken a different direction in the United States. Dr. Ronald W. McNeur, Executive Director of the Society for Health and Human Values gave an account of the events which led to the creation of the Society. It focussed its attention primarily on medical education which produces the doctors of the future and it raised questions of human values as a protest against dehumanization. The churches had supported the Society through the secondment of staff initially and continued to support some of

the faculty now appointed to teach human values in medical schools. Thus the Society was seeking to reform the medical model from within and had succeeded in persuading medical educators to be sensitive to the societal and ethical questions that are involved in the practice of medicine.

In Britain, the Institute of Religion and Medicine was formed in 1964 to provide a forum for dialogue between doctors and clergy and to share experiences across professional boundaries in order to improve the contributions of all who are involved in promoting health. It has dispersed into several field groups many of which have developed their own programme such as offering care to the terminally ill in their own homes as just one example.

While these examples clearly indicate some degree of unease about the prevalent medical model and our attempts to reform it, the participants in the study came to the conclusion that a much more radical approach was necessary because the medical model and the tyranny which it exercises is an example of the idolatry of the problem-solving powers of science. This is kept in place by »a vicious circle of professional self-image, institutional practice and public expectation and investment. All parties collude with one another and while there is an increasing tendency to attack doctors and criticize health services no one really wants to know that the idol has feet of clay. For there is nowhere else to turn. If science, and particularly medicine, cannot save us then where are our ills to be assuaged ? All this makes it clear that the issue is that of Salvation and the Gospel. «

So we have come full circle to the objectives of the two **Tübingen** Consultations which were called to re-discover how churches, congregations and individual Christians by their involvement in sickness, healing and health care could become effective signs of the Gospel. And while we have found this essential need we have also seen that the Church and her congregations are rarely in a position to show such signs. Only a renewed and changed Church which is true to her Lord and willing to risk all in proclaiming and demonstrating His healing power is sufficient for the task. Such a proclamation and demonstration would serve to redeem, reform and renew medicine and medical and health care for their proper servant tasks.

This involves working to be part of a Church which both knows and shows that Christ sets us free in the midst of today's pressures,



uncertainties and quests. What is wrong is not the >medical model< but the human tendency to invest too much in valuable human powers and discoveries so that, first, idols are produced and then there is nowhere to turn when both their tyranny and inadequacy (on their own) begin to be obvious. Thus, the expansion of medical technology first surpassed our dreams only to become a nightmare. It not only dictates our policies and determines our budget allocations but it is applied to the few and so increases the inequities in our societies. It has created a vast industrial complex with vested interests of its own. Like the sorcerer's apprentice we have lost control.

Against this idolatry we can only be saved by a Gospel which points effectively to resources greater than both our power and our failings. To develop a powerful contemporary equivalent to >medical mission< we need, not some modern equivalents of >faith healing< but some contemporary demonstrations of the healing, the freedom and the hope that comes from faith.

## Chapter 10

### THE WAY AHEAD

In his book »The End of Medicine«,<sup>1</sup> Rick Carlson has this to say about the future: »The end of medicine is not the end of health but the beginning. To achieve health, we must enlarge freedom from material want. Of course, the opportunity to seek well-being is not widespread, but the resources are available and could be tapped if they were not harnessed to the causes of war, competition and exploitation. And those uses and misuses of our resources must come to an end as well; if not through revolution then at least through natural attrition and decay.

We must also achieve a change at the conceptual level. We have neither sought health nor revered the healthy individual. We have failed to do so because we have not understood what health is - we have been confused by an assumption that it was an alloy of good luck and medical care. But in the next few decades our understanding will deepen. The pursuit of health and of well-being will then be possible, but only if our environment is made safe for us to live in and our social order is transformed to foster health, rather than to suppress joy. If not, we shall remain a sick and dependent people. In this sense, Virchow was profoundly right: Medicine is simply a form of politics.«

One wonders what Carlson sees as the motivating force to effect such a change. There are few precedents from history which would show that such a transformation could be effected or that "understanding will deepen« to the extent that radical change will be demanded and implemented. While it is true that science and technology will not save us it is unlikely that we will be saved without them. And that is part of our difficulty. It is always easier to persuade people to change when they are convinced that something will not work. It is much more difficult to effect change when they know that something works much of the time. Then, the problem is to persuade them that it would work much better if they were aware of its limitations so that they could match their expectations more closely to its actual achievements and possibilities and guard against its misuses.

1 John Wiley & Sons, New York 1975, pp. 230/1

While, at present, medicine is falsely credited with offering a panacea for most of our ills we must not now swing to the other extreme and reject its obvious achievements and its continuing potential for good. What is necessary is that the medical model be objectively re-appraised in order to take account of those things it does so well; its limitations as well as its potential contributions for the foreseeable future. Such a re-appraisal would need to be undertaken, initially, by the medical profession itself and given wide publicity in order to be accepted by the general public. A start might be made with those social problems which have become medicalized largely because our consumer society can regard them as more respectable in that way and also avoid personal responsibility for change. Secondly, there should be a frank acknowledgement that some of the very costly and sophisticated treatments which medicine now offers are of doubtful effectiveness. This might eliminate those false expectations which medicine has done little to discourage. It is no use arguing that medicine has become what a consumer society wants it to be if little effort is made to present the facts and the consequences to that society.

A further need is to correct the semantic confusions which surround the word health. Even if it is not possible to find an entirely satisfactory definition of what we mean by health, we should no longer fool ourselves with the obvious misuses of the word for they will continue to obscure our understanding of it and, even, our pursuit of it. The World Health Organization might provide us with a good example if it were to offer a more modest definition of its aims and objectives since the present definition encompasses every human activity and makes the attainment of health, in the sense of complete well-being, an impossibility. Its present emphasis on what it calls psycho-social needs may, eventually, make this self-evident.

The use of the word health as in ministries of health, health services etc. is a misnomer which supports the confusion that equates medicine with health. They are medical services and not health services. Medicine does not heal nor does it claim to do so although it has done little to point out the confusion. Medical practitioners would prefer to use the word »treatment« to describe their activities. The healing potential is inherent in nature (whatever that may be). It is part of God's creative design that there is an inherent recuperative factor so that one can say »the wound heals

itself.« It is medicine's task to explore and try to understand this natural process of healing and what is required to promote it and support it and, if possible, remove or change whatever hinders it. If this were more persuasively understood it would enhance the trust between doctor and patient which has considerable therapeutic value in itself.

There is one characteristic of our present situation in the medical services of industrialized societies which will require a radical change in our attitude to health. It is the way in which demand for those services is outstripping the resources to provide them. Technology has advanced so rapidly and at such great cost that we have reached the point where issues of who or what shall be excluded from the benefits of modern medical treatment are becoming more pressing. These are brutal questions to ask and medicine lacks the criteria to answer them. If heart transplants, hip replacements and renal dialysis treatments are not available for all who might benefit from them then who decides who shall have what? If death can be postponed even for a little while what circumstances would warrant it? How does one adjudicate between the claims of the individual and the community if the individual demands and is willing to pay for scarce resources in medical technology? If rationing becomes inevitable what are to be the criteria of selection?

These dilemmas posed by medicine raise again some ancient questions about human life and human values. What is a good life and how much health is required for it? How shall we regard death so that we can accept it with dignity? Questions of this kind in the highly emotive areas of sickness and death are topics which most people would wish to avoid. However, avoiding them may be more painful in the long run for they will ultimately have to be faced. As recently as the last century and the beginning of the present one these sort of questions seldom were raised for people were more fatalistic about their sickness because there was little which the doctor could offer except sympathy and minor palliation. It is only within the last 60 years that the powerful weapons of modern medicine have become available and they have come so rapidly that they have outpaced our recognition of the ethical problems they pose. These are further complicated by the fact that the most recent advances in treatment, which are the results of biomedical research and technology, have been achieved at very great cost and are only

applicable to a few individual patients without any significant gain in the general level of health of the population as a whole.

When demand exceeds supply it becomes necessary to consider alternative approaches. This would require an acceptable definition of what is necessary as distinct from what may be desirable. One would need to separate needs from desires and then seek an egalitarian method of meeting those basic needs either by voluntary restraint or some form of rationing. A further possibility would be to increase the national resources given to "health services« but this could only be done at the cost of other services and, therefore, is unlikely to happen. While we are gradually becoming convinced that we must limit our use of material resources because the earth itself is finite there is no comparable wisdom as yet applied to medicine. However, it must come through addressing ourselves to questions such as what it is we seek in the name of health and how much do we need? We must re-examine our assumption that all ills are potentially subject to cure or amelioration for it is most unlikely to be true. So, ultimately, we must face the reality of sickness and death and our concept of health must include them. So far, our affluence has discouraged us from asking questions of this kind but our increasing poverty whether of means or of spirit will require answers.

In this Quest for Health and Wholeness we have seen some evidence of change in medical theory and practice which we can regard as healthy. This is evident both in developed and lesser developed countries. It springs from a growing recognition that these services belong primarily to those who are to be served and who should fully participate in them. Up to now, medicine has distanced itself from those it would serve. It has justified this on the grounds of aseptic treatment in a clean environment; in making the hospital the normal locus of care rather than the home; in using a technology which is meaningless and often frightening to the patient and, finally, by the exercise of a dominant professionalism which segregates one person from another. (To some extent the Church has unintentionally developed its own counterpart to this separation which one sees particularly in a lay dependency on a professional clergy and the assumption that people must congregate in a particular place in order to worship and be led to salvation. On the other hand, Christ himself healed people where they were both

topographically and psychologically. He did not require them to change their perspective as a condition for healing.)

The success of the Primary Health Care approach must be attributed to the fact that it provides health care where and when it is needed and in an acceptable manner and that its objectives require an understanding and participation by the community as a whole. Such participation diminishes the dominance of the professional group without destroying any of the effectiveness of the health worker. Indeed, it enhances that effectiveness by encouraging a mutual trust rather than a supine dependency. It is not only in developing countries that these principles are now being understood and practiced. There is an increasing number of patient participation groups in Britain, for example, with an organization to link them together. Some of them provide a forum for a critical re-appraisal of normative medical practices in a community. For instance, in an urban setting there may have been a uniform practice of hospital confinement for all child-birth. The new groups may challenge this practice because their view of health is wider than that of the obstetrician alone. A physician working with such a participatory group has this to say: »The participative style of medicine we need will involve a great many people and include large or small projects which recognize health as a character to be sought after, grown into, explored; a quality of life for individuals and communities which cannot be defined so much as cultivated and realized by responsible beings. Medicine has its contributions; it constitutes a province not an empire of health; Health's goals lie beyond medicine's proper scope.«<sup>2</sup>

While it is too early to assess the full contribution of these groups to the practice of medicine in an industrialized society, a Professor of General Practice has given his opinion that they are the most exciting thing that has happened in general practice in the last 20 years because they can facilitate health changes which are acceptable to the community.

Further evidence of change can be seen in the growth of the hospice movement which provides a supportive environment for those facing death and offers palliative treatment when death is preceded by wracking pain. While the separation of the hospice from the acute general hospital was originally criticized as a

**2** *Crucible, Anglican Board of Social Responsibility, London, January-March 1980, pp. 19-24, Dr. Anthony Bird*

reflection of the hospital's unwholesome attitude to long-term and dying patients and because it fostered the growth of yet another specialty - thanatology - there is now some evidence that hospitals are establishing special units which incorporate the hospice concept. This is important because that special emphasis on caring which is so evident in the hospice may again permeate all departments of the hospital and provide a balance to uncaring technology.

The high cost of building and operating a hospice has prompted the development of terminal care support groups operating on a voluntary basis. They care for the dying person in his or her own home, in familiar surroundings and amongst loved ones. They have the advantage of providing support to the relatives many of whom find it difficult to cope with the fact of death because of fear and frustration. A physician who is a member of such a group reports that: »The tranquility and happy acceptance resulting (from the mediation of a caring stranger) has been a feature of our experience in terminal care . . . Easing the emotional impasse and promoting enlightenments and acceptance."<sup>3</sup> Only half the members of his group are professionally trained. The others are given instructions and training and prove as valuable as the professionals. These and other examples represent a gradual shift away from what has been a universal acceptance of institutional care as normative whether in the cities of industrialized nations or in the villages of developing ones. Health workers have been too immobilized by their own technology. They now need to be on the move in order to deal with people's distress where it arises. There will always be need for some institutions but their relevance will be judged by the degree of support they give to the basic health worker and to the caring communities which supplement him. Medicine has concentrated too much on disease to the extent that disease and the sickness which results from it become the objects of ultimate concern. Now, there must be as much or more attention given to ways to enhance health. So, things must be turned upsidedown if we are to discover what is our true health.

This Quest began with the statement that it would involve a search for whatever is unique in the Christian understanding of health and healing. Turning things, ideas, assumptions and values

upside-down is a unique feature of Christian belief and experience. The trouble for most of us is that we stop short too soon in this process because we find it difficult to believe that Christ really meant what He said. He proclaimed an order of reality beyond that which we know and made it clear that we would fail to understand it unless we did turn our own assumptions and set judgements upside-down. So the King comes as a baby; born in a stable and not a palace and we celebrate His humility which is so contrary to our own values that we find difficulty in accepting it. And when the child becomes a man, he speaks to us in parables of a Kingdom whose citizens are children and those whose child-like wonder makes them eligible. It is a Kingdom full of surprises where the great are brought low and the lowly ones are great. Yet even those of us who claim to follow Him believe that so much of His message is impractical and would not fit into the day-to-day world in which we live.

How then do we relate our practicalities about health to the practice of our Christian faith? Do we have to turn back the clock and revert to more primitive forms of health maintenance and promotion? Do we have to wait around for miracles or rely on spiritual healing alone as more appropriate for Christians? Surely not for we are part of a tradition which sees all acts of healing as »signs« of the Kingdom of God. It is only as we grow in understanding of what that Kingdom is like and what it requires of us that we gain the perspective from which to judge the issues of justice and injustice which brought us to a critical analysis of present systems and then to advocate the participation of all people in the pursuit of health. This would call for us to turn upside-down the usual health care pyramid which has the medical profession and its most sophisticated technology at the top and the »patients« at the bottom. However, it does not follow that everyone would be healthy given the proper instruction or even with full participation available to them. Some would choose lifestyles which would make the maintenance of or restoration to health almost impossible. But is health an end in itself? Do we not cheat people by urging them to pursue health when salvation is available to them?

The Gospel has a great deal to say about health and the meaning of life, death and suffering. It also speaks of man's relationship to his environment and the meaning of community. While Christians are rightly called to participation in health services all that they do



should be practical expressions of the Christian understanding of what life is like in the Kingdom where God is all in all. This would require that we make explicit how the Kingdom of God and its demands on us are demonstrated by what we do about health and its limitations both for individuals and communities. This Quest has only begun to do this by pointing to and struggling against those aspects of health care systems which diminish or distort human beings and so deny the reality of the Kingdom. Clearly, this is not sufficient and, yet, we are still uncertain of what will replace the systems we already have. To introduce modifications in the form of primary health care and community participation are only halting steps in the right direction for they are indicative of human collaboration in the search for health and provide glimpses of what is possible beyond health - in a vision of the Kingdom of God.

The way ahead will require much more willingness to turn things, ideas and priorities upside-down. The next step will be to discover what it means, in practice, that the main resources for health are »latent« in those who have so far been the recipients and objects of health care. They should be enabled to become the subjects of the search for health. For this, programmes in health education should be given high priority including an honest appraisal of the limitations to health. The human resources inherent in each community should be directed towards teaching and encouraging people to help one another not only in times of stress but in practical expressions of everyday neighbourliness. The churches should become the models for these activities both to challenge and bring judgement; to serve with compassion and to present a vision of the Kingdom which is the final community of health and salvation.

Inevitably, this process of turning things upside-down - this Kingdom view from the perspective of a child or this receiving of the Kingdom as you would receive a child (for both meanings are there) would place greater value on caring than on curing. It would view medicine, as Dr. Michael Wilson expresses it, as a para-nursing profession. The medical task would be that of serving the nurse who cares for people when they are sick rather than that of attacking disease by technological skills in which the nurse serves as the physician's assistant. Moreover, caring does not necessarily require professional skills. It calls for empathy between persons based on love. It embraces trust, confidence, acceptance and even humour - the qualities one would expect to find amongst the people of God

for these are the gifts of the Holy Spirit which frees us from the insatiable desire for consumer goods and the domination of calendars and clocks.

The Church has long been aware of its constant need for renewal. Being in the world of history it has too often succumbed to the temptations of the world. Obedience to the Gospel has always required conversion and renewal and so the Church must challenge medicine's presumptions that access to health is through the physician who alone grants permission to enter the system. It must also challenge the idolatry of an abstraction called »life« whose preservation and prolongation are the objects of medicine regardless of cost, pain or meaninglessness. But its task is not only to challenge. It must find within itself that fellowship of healing which makes true caring possible and invigorates those who must now learn to take health into their own hands. While a disciplined way of life may increase our longevity it is surrender to the leading of the Holy Spirit which makes us whole and, in the dynamics of interpersonal relationships as spiritfilled disciples, we will discover what it means to be the Healing Church.

## APPENDIX I

Extracts from the Second Tubingen Consultation »Health - Medical and Theological Perspectives."

*On Death* (Sister Mary Luke, a physician and Roman Catholic religious).

»What can such a consideration of some of the dimensions of the mystery of

death contribute to our present concern with medical practice? Should death continue to be an embarrassment in our communities and in our hospitals? Is there a place for a radical change in attitudes? Should we make certain that a man is educated if necessary to bear the truth that he is now approaching his death? It is surely not merely a matter of professional honesty, but a Christian privilege to assist a man in the final phase of his life to live and die with the full richness of freedom of which he is capable. This

involves the best possible technical medicine to keep his pain under control

(with help if necessary from specialists in this area) without removing his psychological freedom, recognizing, however, that there may well come a stage it is legitimate to dull his consciousness to some extent in order to alleviate his distress. Our medical advances are an expression of the victory Christ won in the redemption of the world. Our obligation is very clear to relieve suffering as well as to help a man use worthily the liberation obtained

thereby. There is no place for false pietism expressed in loose medical practice or fear to relieve all suffering where possible. Nor should there be fear on the ground of the above concept of life and death, to struggle to maintain life with all reasonable means until there is no hope of continuance

of personal living. Another consideration is that redistribution of medical resources may be necessary to express a more total vision of the care of man

throughout the whole course of his life process and thus to include a more positive attitude to geriatric practice.

Can it be that our hospital terminology should be rethought as well as our

hospital organization? A dying man is not merely a hospital failure, nor a case of terminal illness, but a man proceeding to his death (as the Son of Man

went forth to die) approaching by far the most important moment of his life

in which will be summed up all that he is. It is true that death is a sign of the still continuing presence of evil in our world and in this sense is a therapeutic defeat, but as we have seen, even suffering and death can become in the light of the Cross and Resurrection a means of victory.

A dying man needs not only kindness, but community. No man dies as an individual, but as one within a human network of relations - in solidarity ultimately with all men. Hospitals exist in which the concept of the community of the dying is expressed: such is surely a rich Christian idea (with ecclesiological implications) and a challenge to medical practice. A positive attitude to death needs to be present (though rarely articulated) in every staff member involved in such a hospital. The educative value of such a community attitude may be immense and should assist the dying and also those who are dear to them and emotionally involved in their dying to have

hope instead of despair, positive peace in place of an attitude of grudging resignation, or even rejection. In this way, out of the death of one, a new richness of life may rise. For those who are bereaved, the old pattern of life is dislocated by the removal of one of those who formed part of it - but from this disintegration, once the ego has accepted it (and the funeral liturgy should aid this process), a new synthesis should arise during the necessary period of mourning. So not only death, but also mourning can be creative.

What, too, of the approaching death of a doctor himself? The renewed positive attitude to death should not only assist him in his relation to those he serves, but may comfort him in his own anguish. Can he see his death as the seal on his servanthood? He will be at last, like that other Suffering Servant, immersed in the sea of suffering which he has labored to alleviate. Surely Christ who has borne our sorrows will strengthen him in this final act of Christ conformity.

But most of all from the concept of death as positive and creative arises the perspective of creative living, gathering out of the stuff of the situation the material through which we may respond freely in Christ under the influence of His Spirit to the call of the Father.

The divine pedagogy involves contrast on all levels: through experience of the death of a loved one, or through a depth of our own suffering, we may rise through His grace to a deeper view of life and health, seeing both as His gift and call to fuller response to His love within the human community. For we do not live and die for self alone, but like Christ, we are most certainly to be men for others, dying that others may live more richly through our death or living that out of our lives others may draw something with which to rise more fully in Christ to the Father.« (pp. 33-34)

*Health and the Congregation* (Dr. R. A. Lambourne, physician and others)

»Our understanding of the health of the congregation suggests that what is needed is for the congregation to become an experimental group which will try to find out what God is doing in any given situation. It must look for the growing points in its corporate life and encourage further growth. The basis of every experiment is the gathered group, in which each member accepts his own weaknesses as well as strengths, for the growing point is not only the strength of the group but equally its points of weakness and immaturity.« (p. 41)

»Our corporate, transactional view of the health of the congregation shows it as the place where groups of people by their acceptance of each other, having all things common, including their negativities, and showing the attempt to produce positive good out of both relative goods and relative bads, become effective signs of the Gospel proclamation that God has already accepted us through Christ and that we can thankfully get on with the business of living for our neighbor, confident that in the process we shall all be changed. It is important to note that the corporate, transactional view of health and salvation in the congregation shifts the locus of this transformation so that it is not in the individual but in the relationship. So,

just to give one example, the idea of repentance as one bad person confessing to an unaffected good person needs sharp revision. The >con< of confession is to be given reality. The relevance of this for family life can hardly be overestimated. Its relevance to the Christian theology of professional consultation and the Christian witness in professional groups has already been noted, and it needs little imagination to see that spread into the structures of trade, of manufacturing, of politics, medicine, and church, and into the counsels of the world, it would be an effective sign of God's reconciling work in Christ which would produce such tangible fruits of peace from war, joy, love and health that men and women could not but praise God's Holy Name« (page 43)

»The healing congregation, in being objective about the health needs of others and about its own ministry for meeting these needs, will learn that in this world being healthy means accepting the fact that any one individual group or nation may not be entitled to an unlimited use of the resources of healing when such unlimited use will mean less available resources of healing for others. By exercising this conscious restraint, the Christian concept of sacrifice will find its way once again into the Christian and secular understanding of health.« (page 48)

*The Sacraments in the Church* (Prof. D.E. Jenkins, theologian)

»But this given reality of the sacrament will not be realized by us, we shall not show the fruits of sacramental living if we withdraw to the sacrament of

the Altar and Lord's Table as if it were a private medical or even magical thing given to privileged Christians to enable them to be sustained against the world and away from its pressures and threats. For example, to have ecclesiastically-authorized ministers slipping into hospitals to dole out the sacraments to the privileged few who are marked out for this privileged and

>spiritual< medication is not to respond to and speak of the universal Gospel

of God, but is to perpetuate churchly selfishness and defensiveness. In such

peddling of »the medicine of immortality« the Church too often makes it look as if it has no water of life even for its members, still less for all men. We all have to learn - every congregation of Christians and every ordained minister of the Church - that Eucharistic and sacramental living in the world is not achieved by the performing of the rite of the Eucharistic sacrament as such and in isolation. In too many congregations, the celebration of the sacrament is a mere rite. This rite has to have its reality kindled in the lives of the members of the congregation, laity and minister alike, by a Eucharistic and sacrificial readiness for living in community. There will be no reality experienced in and through the sacrament in the midst of the congregation gathered if there is no sacramental living in the

midst of the world by the congregation dispersed. The Eucharist offers strength for thankful living to those who bring to it the desire and attempt to practice a thankful receiving of the demands of their neighbours and their world. The Holy Communion offers the strength of sustaining fellowship to those who are open to the demands of being a sustaining neighbor,

member of a family, part of a professional, industrial or educational team. The Lord's Supper offers the strength of direction and purpose to those who are concerned to give purposeful hope to those who live in apathy, indifference or despair. If there is no reality of encounter with the live of Christ in the world, then there will be no reality of encounter with the life of Christ in the sacrament. It is the demands of sacramental living, of drawing health from sickness, living from dying, believing from doubting, response to the love of God from the indifference and cruelty of men, which will send members of the Christian congregation thankfully and hopefully to the Eucharist. There they may receive the power to offer what they have so far discovered of sacramentality, of the reality of God in the realities of the world. And as they receive this power to offer, so they will receive the power to be corrected and the power to be renewed for further and deeper creative living - but living not at the Eucharist but in the world. The ineffectiveness, either by way of power of creative living or of faith-kindling proclamation of the Gospel, of the formal presence of the sacraments in so many situations of sickness and of healing, shows us that we are being called to receive a renewal and a reform of our understanding and practice of the sacraments by a faithful facing up to the opportunities and possibilities of sacramental living in the world and for the world.« (pp. 50-51)

*Implications for Medicine* (Dr. T.F. Davey, physician)  
»The common dualistic understanding of man is expressed in the existence of two parallel institutions each of which is centered about the person of a professional figure. The clergyman and the doctor, each master of his domain, wears his peculiar garb, works in his building with his assistants and his ritual of word and symbol, and is surrounded by the tradition-laden and somewhat esoteric atmosphere of his institution. Around these professionals gather the people, searching for health of either body or soul as the case may be. In the hospital, the pastor is tolerated as a privileged outsider and permitted to carry out what are regarded as his irrelevant but innocuous duties; in the church, the doctor may teach Sunday School but has, as doctor, no particular Christian significance. (Cf. R.A. Lambourne in »Ärztlicher Dienst im Umbruch der Zeit, pp. 65-66).

This dichotomy, overdrawn though it may be here, constitutes a violent distortion of the Biblical understanding of man. The pattern must be broken; and in its stead must be established a relationship that expresses more truthfully both the unity of man as person and the nature of the Christian **congregation** and the **healing Community**.« (p. 62)

*The Medicine of Poverty* (Dr. Aart H. van Soest, physician)  
»Western churches have not often been aware of the fact that not only in liturgy, hymnology and church architecture an illegitimate export of concepts has taken place. The hospital as the main, or even the only, provision for individual and community health is as good an example as any



of this trend. Yet, from the facts it becomes very clear that the isolated hospital is *not* a good solution of health problems at all, mainly because all the infra-structures supporting it in the culture of its origin are still grossly lacking in developing nations. To this infra-structure belong roads, sewage systems, an educated public, district nurses, general practitioners and many other things. Agricultural and, indeed, educational aspects still complicate the problem. It has been argued that with the limited amounts of money available, another type of medical care would be far more effective. It is an oversimplification to see the solution in a switch from curative to preventive medicine. The latter cannot exist without the former, without doing injustice to the Christian understanding of human health. With great enthusiasm, methods have been worked out in many Church-related institutions, as well as secular ones, successfully coping with this problem. This >Medicine of Poverty< offers a wide scope of action for the churches in affluent and developing countries. At virtually every level of it, active involvement of the congregation can become a very practical and down-to-earth reality. It is a great challenge for the Church to take part in this development. Experimental programmes should be set up, either new or related to existing hospitals, and *no* new medical work should be started that does not take full advantage of the possibilities given to us in this field. Some provision should be made for training medical personnel in this »new« approach to medical problems. At the same time, churches in the developing countries should consider how the congregation can be urged to give up its unrealistic demand for medical care of a type not answering its need and denying the congregation the possibility to take an active part in the Church's healing ministry. There is ample opportunity for the application of the experimental method here, and methods tried in both developing and affluent countries can be used. For example, could church-related hospitals start a training program for the many relatives and visitors accompanying their patients? (The possibilities of education of the healthy visitors to hospitals are certainly not restricted to developing countries!) Members of the local congregations could play an important role in it. If land is available around the hospital premises, the concept of the >healing of the land< could be made visible. In this respect the Church may have the advantage of an easy possibility of combining small-scale agricultural, educational and medical forces. Such combinations could be of great value as examples for larger scale programs by governments.« (page 71)

## APPENDIX II

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Dr. Joachim Schwarz, Bad Boll, Germany

Dr. Michael Wilson, United Kingdom

## SUGGESTED READING LIST

by Dr. J. Mathers

### *Basic Texts*

*In Search of Wholeness*, CONTACT Special Series No. 2 (CMC 1979)

A well-chosen selection of papers of critical theological reflection upon health care issues.

*Religion, Medicine and Politics*, R.A. Lambourne (CONTACT, Institute of Religion and Medicine, U.K.)

A memorial issue of this journal containing three representative papers: "Wholeness, Community and Worship" (1959); »The Deliverance Map of Disease and Sin« (1967); and »Personal Reformation and Political Formation in Pastoral Care« (1971), together with a biography and bibliography.

*Health is for People*, Michael Wilson, Darton, Longman & Todd, London 1975

A wide-ranging study of the meaning of health wherein most of the theology is implicit rather than explicit. Perhaps the best simple introduction to new perspectives. Useful references.

*The Winter of Materialism*, Michael Wilson, COMMUNITY, Westhill College, Selly Oak, Birmingham, U.K. (No. 23 Spring 1979)  
Changing patterns of disease call for new patterns of response: the »good news of the gospel is not sinlessness but forgiveness«.

### *Important Texts*

*Primary Health Care*, CONTACT Special Series No. 1 (CMC 1979)

A selection of papers on principles and practice which illustrate attempts to break through the constraints of hospital-dominated medicine. Charles Elliott's paper especially important.

*Medical and Theological Perspectives on Health*

This report of the 2nd Tübingen consultation is promised to be reprinted as a CONTACT (CMC) Special Series. Valuable papers on theological perspectives and attempts to wrestle with the task of the congregation in relation to health.

*Community, Church and Healing*, R.A. Lambourne, Darton, Longman & Todd, 1967

A radical study in the theology of the ministry of healing, aimed at bringing together individual and corporate perspectives, and secular and sacramental healing actions.

*Health Today and Salvation Today*, R.A. Lambourne, 1971

An important paper not yet published in English. It forms the first chapter of the French edition of his book, entitled

*Le Christ et la Sante* (Le Centurion - Labor et Fides 1972)

*Hospital Salt, Theological Savour and True Humanism*, R.A. Lambourne  
Published in CONTACT (Institute of Religion and Medicine, U.K.) No.  
16 under the title »The Hospital as a Source of Standards and Values«.

*The Hospital - A Place of Truth*, Michael Wilson, University of  
Birmingham

This research study of the role of the hospital chaplain contains a number of  
good essays on the relation between church and hospital.

*Health, Healing and Society*, L.G. Wells, Ravan Press 1974

A splendid case-study of the inter-relatedness of politics and health care, as  
exemplified in South Africa.

### *Interesting Texts*

*Violence and Non-Violence in the Cure of Disease and the Healing of  
Patients*, Michael Wilson, Christian Century 1970 (Chicago)

An attempt to bridge discontinuities between different perspectives on  
healing.

*Medicine in Metamorphosis*, Martti Siirala, Tavistock Publishers 1969

A fascinating attempt to overcome some of the splits between theological,  
philosophical and medical modes of thinking by a psychiatrist specialising  
in speech disorders.

*A New Perspective on the Health of Canadians*, Marc Lalonde,  
Government of Canada, 1974

An official working paper which admirably clarifies the relations between  
human biology, environment, lifestyle and health care organisation.

*Religion and Medicine*, M.A.H. Melinsky (ed.) SCM Press, U.K. 1970

*Religion and Medicine 2*, M.A.H. Melinsky (ed.), SCM Press, U.K. 1973

*Religion and Medicine 3*, D.W. Millard, SCM Press, U.K. 1976

These year books from the Institute of Religion and Medicine include  
papers by Lambourne, Wilson, Jenkins and Mathers.

*Man, Medicine and Environment*, Rene Dubos, Penguin Books 1968

A well written account of the evolutionary and historical contexts in which  
modern man and his medicine are set.

*Aspects of Illness*, Robert Dingwall, Martin Robertson 1976

A study of the relation between illness behaviour and social context. A  
good critique of the »absolutist« stance of western medicine.

*Medical Care in Developing Countries*, Maurice King, Oxford University  
Press, 1970

*Health and the Developing World*, J.H. Bryant, Cornell University Press  
1969

*Pediatric Priorities in the Developing World*, D.C. Morley, Butterworths  
1973

These three texts are important as correctives of some basic assumptions of  
western medical practice.