GMC: Medical ethics education conference

Medical ethics – a Christian view

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Author's abstract

All ethics has a religious dimension. This paper considers how specific Christian insights concerning death, suffering, human nature and human creatureliness can help to expose more fully the moral issues at stake in some of the dilemmas faced by doctors. It ends by acknowledging the crushing burden of decision-making which rests on many in the medical profession, and indicates the importance of religious resources in dealing with this.

I start with the bald assertion that all ethics, including medical ethics, has a theological dimension. This is because all serious ethical discussion pushes us back to questions about ultimate beliefs and values – the very stuff of religion. Theology is the attempt to articulate such questions, to relate them to the thinking of those who have faced them in their classic forms, and to make sense of them in the context of today's world. It thus forms an essential background to rational ethical thought.

I say this briefly, and without arguing the point, because people have such varied ideas about what theology is, and therefore about the kind of contribution a theologian might be expected to make to the discussion of medical ethics. There may be suspicions that theologians come armed with some predetermined set of answers which simply have to be applied to the cases in hand. There may be a suspicion, too, that theology is a kind of optional extra, as if one can avoid theological questions simply by ignoring them. But ultimate questions, questions about life and death, about meaning and purpose, about the source of our hopes and values and the things which ultimately matter to us, such questions keep intruding whether we want them to or not. And the usual alternative to a thought-out theology is an unthought-out theology.

What I want to suggest is that proper attention to the theological dimension in ethics can help to open up ethical problems, can reveal unexpected depths in them, can be a source of awkward questions, and can help to give shape and coherence to the sense of values with which we tackle them. Above all, it can undergird

those values by revealing their roots in some ultimate reality.

In what follows I write from an explicitly Christian standpoint. I have deliberately started with some very general remarks to make the point that the theological questions are there, whatever the precise framework one uses for exploring them. Let me stress again that I am concerned about a dimension in ethics, not about the whole content of ethical decisions. In the actual business of wrestling with some of the appalling dilemmas many doctors have to face professionally, it is not surprising if immediate practical concerns, care for the well-being of actual patients, and concern about the technical problems of helping them, occupy the forefront of attention. The pressure to deal with individual cases in a purely pragmatic way must be huge. But that is one reason why there needs to be this other dimension, insights and values from another field of awareness, fed into the practical business of decision-making, to redress the balance.

Suffering and death are the most obvious examples of areas of medical concern in which religious insights make a difference – and make a difference, I suggest, not only to patients but to doctors. The management of the process of dying, the value placed on death as an experience, and the acceptance of death as not necessarily being a sign of medical failure, are all practical matters in which beliefs about whether or not death is the end must surely be highly relevant. But there are also more subtle indicators of belief about death, as in the way a hospital may be so organised as to deny its reality. The basic difference between the management of death in a hospital and in a hospice lies somewhere here, on the fringes of theology.

And so with suffering. This is a subject on which Christians need to be cautious, because there have been times when Christianity has seemed to encourage an unhealthy resignation to suffering, and there is a sad history of Christian opposition to many pain-relieving techniques. But when all that has been admitted, there remain some profound ethical issues about the extent to which *some* suffering has to be accepted as an inevitable part of any mature life, and so used as a basis for spiritual growth.

The point has often been made in the discussion of the disabled, particularly disabled neonates, that a

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society is judged ethically by the amount of care it shows for its weakest members. This is not a complete answer to the question of what one ought, or ought not, to do in a case, say, of severe spina bifida. But it alerts those concerned to a dimension of the problem which can easily be overlooked; a dimension directly related to a Christian theology of suffering.

Similar questions arise when one thinks about the extent to which the pressures of modern society invite an almost obsessive evasion of suffering. How far is it right, for example, to tranquillise away the experience of grief?

Many strands of Christian theology come to a focus in strong claims about the values and the possibilities inherent in individual human lives, and the way in which those lives need fulfilment in something transcendent outside themselves. Doctrines of incarnation and salvation, translated into the language of ethics, have this thrust to them. To believe that human nature is capable of bearing the divine image, and that no matter how far a particular human life may have gone wrong, there is still something there worth saving, and capable of being saved, is to be sensitised to the mystery and the dignity of other people. And this surely is a dimension which needs constant stress in an age when we can do so much with people technically, and when we are tempted to think we understand so much of what is going on inside them. I was involved not so long ago in very difficult discussions about the allocation of resources to a geriatric hospital. Thoughts about the dignity of human beings, whoever they are, did not help much in trying to decide how to save £2m. But if that dimension had been allowed to drop out, the decision could have been easier, and different, and worse.

There is a whole range of problems appearing over the horizon in modern medicine which revolve around the question how far one has to accept an element of 'givenness' in human nature and in basic human institutions. How far, for example, should one tinker with the reproductive process? If it becomes possible to make genetic improvements, where and how can one draw the line? How wise would it be to allow an element of choice to enter into, say, the determination of the sex of one's children? How far can one safely separate the purely physical and genetic elements in reproduction, from the personal, emotional and social elements?

There are deep religious feelings in this area which favour being cautious. I think they are rooted in a sense of creatureliness. Human beings are not God. And if there is one proposition in theology which is fundamental and certain, this is it. And that is why the temptation to play god is seen as the root of evil.

Once again, this is not a theological statement which without further ado settles the question of whether one ought to encourage the development of human genetic engineering. But the danger of playing god is a vitally important dimension in the ethical assessment of such issues.

I have related it to creatureliness, because the doctrine of creation has often functioned as a restraining influence on too much interference with the way things are. But there is another side to the doctrine of creation, the affirmation of human creativeness, which can function in precisely the opposite direction, as an invitation to innovation. I mention this to make the point that theology is not a very easy discipline to handle, and does not necessarily produce unambiguous pointers to the right direction in which to go. But it does at least open up the questions and take them away from purely individual and technical considerations into deep human and potentially universal ones.

I suspect that in this particular contrast between human creatureliness and human creativeness, the balance is usually tipped by realistic thoughts about human sinfulness. This brings us back to the danger of playing god. If it does nothing else, theology can remind us of how even the best of human plans and intentions are tainted with self-interest, fall short of the full complex mystery of the way things are, and are open to infection by evil.

And this brings me to my last point, not now about the reasons for making particular decisions, and the theological insights which might have a bearing on these, but about the style in which decisions are made. Doctors, so I believe, are more concerned about ethics than those in many other professions, because they have harder decisions to make, and ones which bear more directly on the lives of individuals with whom they are personally involved. And this can be a crushing burden. Hence the need to share it. Hence also the need for some inner resources to cope with the dilemmas and to bear the pain of having to choose between evils, and having to forego doing all that they know might have been done had time, skill, resources and circumstances been different.

The real resources of theology lie not in some intellectual scheme, but in the awareness of a power greater than our power, a care for individuals greater than our own care, and a forgiveness greater than our own capacity for failure and error, which makes it possible for us to live with ourselves without complacency and without despair.

I hope that in saying this I have not gone beyond my brief. But the truth is that in the end theology is nothing, unless it points us to God.