BIBLICAL PERSPECTIVES ON HEALTH AND HEALTH CARE RELATIONSHIPS

Jubilee Centre

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Preface

The following report comes at a time of considerable change in the National Health Service, particularly in the field of primary care. We have also become used to hearing about issues such as hospital closures, lengthy waiting lists, bed blockages and staff and services being stretched to the limit. Yet at the centre of these issues lies a dilemma: how do we deliver and provide equitable and effective care within a framework in which the health needs of the population outweigh available resources?

This report is written primarily for Christians working in the health service and its intention is to provide them with biblical insight concerning the current difficulties that they are experiencing as health care professionals. It also seeks to convey to the Church the importance, biblically, of the problems surrounding health and health care today.

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We are grateful to Dr Chris Wright of All Nations Christian College for his kind permission to use a number of his unpublished lectures, and to Professor Gordon Wenham, Professor Geoff Meads, Dr. Michael Sheldon, Professor Duncan Vere, Dr. John Buckler, and Mary Gobbi for their advice, comments and encouragement.

It is our aim at the Jubilee Centre, that this report will not only provide a source of encouragement for Christians working in the health service, but that it will also highlight the importance and relevance of applying scripture to today's issues which touch and affect the hearts and lives of us all.

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Summary

1. Health and Health Care Relationships: A Challenge for Society

Project Objectives:

- ***To enable Christians to fuffll health care responsibilities*** - Health is a responsibility for all but too often Christians receive little teaching on how to respond to health issues.
- ***To equip Christian health care professionals***
  - The recent White and Green Papers raise key questions about the nature of health and, the relationships between organisations and professions that are needed for efficient, quality health care.
  - This project aims to help equip Christian health professionals to contribute fully to current debate to ensure that change is founded on the right values.
- ***To demonstrate the relevance of the Bible*** as a living, powerful and challenging guide to modern issues.

Health: An issue for everybody

- This is not just an issue for people working in health care for ill health touches everybody's lives, directly and indirectly. The effects of ill health can be far-reaching including our fulfilment identity and selfesteem.
- They contribute to a pervasive fear of ill-health increased by growing recognition of the limits of medicine and changes to welfare provision leaving many people more economically vulnerable.

A **Challenge for Health Care Professionals**

Current reforms present a number of challenges and opportunities including, for those in primary care:

- developing relationships within and between practices to form Primary Care Groups
- developing external relationships m the pursuit of improved public health
- foregoing some personal, organisational and professional body interests to make new structures and partnerships work
- accepting some loss of freedom and independence in primary care in return for more responsibility for care provision and commissioning.

At the heart of these issues are clashes in philosophies and values. The rest of the report seeks to identify the heart of these debates and see how the Bible can guide their resolution.

2. A Biblical Understanding of Health

A) The Contemporary Debate: Reductionism Versus Holism

How we define 'health' has practical implications for the implementation of health care.

The Biomedical Perspective

- is influenced by Cartesian dualism (it separates mind/spirit from the body) and Reductionism (intricate phenomena are derived from a single fundamental principle)
- sees health as the absence of disease - an internal state depressing functional ability and deviating from the norm
- provides a clear understanding of the causes of disease and their physiological consequences, leading to more effective treatment and prevention. It also seeks to understand the ramifications and effects of disease, including personal and psychological

factors
- its limits are becoming apparent e.g. diseases becoming resistant to drugs, the continuing high incidence of heart disease
- is interventionist and can foster the disempowerment of patients and their distancing from the healing process
- does not deal with the whole person thus affecting the nature of relationships with patients and the extent to which wider aspects of well-being are achieved.

Holistic Perspectives

- ***Individual Holism***
  - Disease is seen as dissonance between either the person and their environment or internal fragmentation between mind, body, spirit etc.
  - Health is seen as having spiritual, psychological and physical dimensions balanced
- ***Environmental, Social and Economic Holism***
  - Improvements in water supplies, sewage disposal, nutrition and family planning are understood to contribute to better health.
  - This view is more widely accepted as it is seen to complement biomedicine by balancing out its reductionist tendencies.

Evaluation

- Holistic and biomedical approaches can be superimposed on professional and organisational divides.
- Integration of approach and provision should be sought while maintaining the potential for distinct focused roles.
- A biblical view of health points to deeper roots of health issues which are still neglected by both biomedical and contemporary holistic views.

B) Holistic Health or Holistic Persons?

A key debate is whether a biblical view of health is holistic or whether it is primarily a physical and functional concept set the context of a holistic understanding of the person.

Health in the Bible: A Physical and Functional Concept

- Although at first it appears that the Bible has little to say about health, concern for human well-being lies at the heart of the God revealed in the Scriptures.
- 'In the Old Testament 'shalom' is the nearest Hebrew word to 'health' - it means 'wholeness, wellbeing, vigour and vitality in all dimensions of human life', and is caused by being in right relationship with God and other people.
- This is often used to provide biblical support for holistic views of health.
- Health is understood in terms of strength and longevity i.e. primarily a physical concept, but is pursued within a broader concept of human well-being. Thus the spiritual dimension, for example does have an effect on the physical at both an individual and societal level

The Nature of Relationships

A broad holistic view is in danger of misconstruing a biblical account which regards, humankind's relationships, especially with God, as the cause of good/ ill health rather than being equivalent with it.

- Israel's relationship with God is expressed through the covenant relationship - by obeying the law the people were able to respond to God's love and express their love for him
- A right relationship with God was understood to be conducive to good health and long life.
- Conversely, there is often a link between sin and disease - but there is no easy equation between obedience and good health.
- In the New Testament there is still a causal link between disobedience and ill health e.g. Ananias and Sapphira in Acts, but not true that a lack of good health signifies sin (e.g. Paul's affliction).
- Sometimes ill health exists to show God's goodness e.g. blind man's healing in John 9. Good health is esteemed in the NT because it enables the fulfilment of a spiritual role.
- Health for health's sake is of limited value - it is better to enter eternal life maimed, than to enter hell physically whole c.f. Mark 9:4348.

Holistic Persons

- Understanding what it means to be human is essential to understanding health care.
- A biblical view of the body is not founded on scientific physiology but does display a strong view of the unity of the body.
- The Bible makes the link between the mental dimension (the heart) and the physical body (e.g. in Proverbs 14:30) - no distinction was made between them, unlike Cartesian dualism. In Hebrew thought the emotions were spread throughout the body - there was a real sense of the unity of the person e.g. in Psalm 3 8:3
- Our emotional, spiritual, physical and relational dimensions are interrelated so we should recognise that, for example, our spiritual state can affect our physical health and vice versa.
- The biblical view of the holistic nature of persons resonates with medical understanding of the links between, for example, emotions (especially stress) and the immune system.

Corporate Personality and the Interrelatedness of All Life

- The Bible's physical view of health is not individualistic.
- The understanding of corporate personality and the interrelatedness of all life meant that the the spiritual condition of society was believed to affect the health of the individual.
- Our relationship with God affects us and our actions, which in turn affects others.
- Collective disobedience to God results in damage to the environment or unjust social relationships, with significant consequences for the health of individuals and society as a whole.

3. Health Care Relationships

Relationships are one of the linchpins of good health and health care provision - staff-patient relationships, good communication, co-operation, teamwork etc. all depend on them

A) Health Care Provision In The Bible

Models of Biblical Health Care Provision

There is little evidence for institutionalised health care provision in the Bible. Direct biblical models amount to the collection of practices primarily in the book of Leviticus. Specific instances of health care provision, however, provide valuable insights in terms of priorities and principles.

Laws and Rituals

- Although they initially appear to be health-related, Levitical laws focus more on being pleasing to God and are not so concerned with providing public health guidelines.
- The Hebrew understanding of health was that the Lord upheld it and the only way to protect one's health was by being obedient to him

Obligation and Responsibility

- Levitical law obliged individuals to uphold their responsibilities for their community's health, for example, by not touching dead bodies - which could spread disease.
- This emphasis on obligation and responsibility shows the importance of relationships in health care and the need for values on which to base social relationships on.

'Home Care'

- Health care in the Bible is seen as the responsibility of the family and the wider community.

The Community, Social Support and Health Care

- The community's care is understood, by the Bible and many other traditional societies today, to perform 'social therapy' for those who are sick and prevent illness. Current research provides evidence that backs up this understanding.
- Social support will see people through many crises including ill-health, so relationships need to be nurtured - but it is not an alternative to medicine and institutional care.

B) Relational Health Care in the NHS

Difficulties within the Health Service today

Previous reforms have successfully addressed some important issues but have also left a legacy of low morale, competing organisational interests and performance indicators which can hinder care and collaboration. Against this background the report looks at three kinds of health care relationship to identify some of the fundamental issues which require a biblical response.

Three Case Studies of Health Care Relationships - A Crisis of Values?

The Doctor - Patient Relationship

- Currently there are moves towards a primary-care led NHS - focusing on the need for health promotion and preventative medicine.
- There is some concern that there is too much emphasis on the primary location of care, and not enough on care itself. There is also concern that too much of general practice is characterised by too narrow a biomedical view of health.
- Concern is expressed about impact the impact of reforms on individual cure/care due to time, resources and greater emphasis on community needs.
- Achieving integration of care requires better integration with other professions and organisations. This will change the nature of the doctor-patient relationship with the doctor often no longer being the first port of call.

The Clinician - Manager Relationships

- The introduction of the internal market contributed to the development of a 'them & us' culture between some clinicians and managers.
- The management values surrounding efficiency and performance management were felt at times to conflict with clinician's values surrounding patient care.
- Shifts in power and responsibility, different professional cultures and different time

horizons and some work practices at times contributed to this.
- Negative perceptions about the motivation of others' have a detrimental affect on the quality of care -even if clinicians and managers really have very similar motivations
- Decisions about patient's care needs are not always made in partnership and with a common 'ownership' of priorities.
- Decisions can come to be made on the basis of conflict avoidance rather than rationality..

Inter-Organisational Relationships
- The internal market has led to competition and conflict, not co-operation - this has had a detrimental effect on care: especially of the vulnerable e.g. the elderly.
- There are tensions between the NHS and Social Services e.g. over the provision of long term and continuing care of the elderly.
- Looking at evidence from a Health Advisory Service report there is a need for organisational change to avoid 'perverse incentives' which lead, for example, to speeding elderly patients through acute wards too fast.
- Organisations need to understand that the responsibility for the care of the elderly includes: participation and partnership which leads to trust and collaboration with the patient - this should enable equal access to multi-disciplinary assessment for treatment.

Biblical Values

Biblical teaching reveals underlying moral principles and values which inform of us the nature of loving relationships and the pattern of life that God intends and desires for us. These can provide help and guidance for health care and health care relationships today.

Faithfulness, Loyalty, Commitment and Trust
- These qualities are an expression of the covenant relationship with God.
- God's faithfulness to the covenant show the importance of establishing common purposes within a relationship and boundaries within which these purposes can be lived out.
- These values raise a number of challenges including the question of loyalty to whom, building trust through organisational change, sustaining long-term commitment and vision, and ensuring that therapeutic relationships continue to be founded on trust.

Love, Compassion and Care
- A consistent, practical aspect of God's character - made manifest in Jesus.
- A genuine love for other people is a sign of obedient love of God.
- These values are both a motivation for health care and an important aspect of it. Among the many challenges they raise are the issues of whether caring is undervalued, how it is combined with the more technological aspects of curing, whether we recognise the potential for care in unexpected places, and whether we create truly caring organisations.

Justice
- Justice is experienced through the covenant - God's people were expected to act justly towards others, especially the marginalised.
- Forgiveness and reconciliation are seen as part of` justice - this strengthens relationships.
- This is not always seen in current approaches to handling litigation and complaints.

Equality, Dignity and Respect
- All people are valued because God created us, not because of our social or professional status, or economic worth.
- Absolute equity in provision cannot coexist with diversity, innovation and local accountability.

Power

- God is the ultimate model of how to use power - to serve and benefit others.
- Many individuals and organisations m the NHS feel disempowered and fear its further erosion.
- There are many kinds of power - recognising that all power should be seen as power to serve should enable collaboration which can greatly enhance the capacity to serve.

Responsibility, Obligation and Accountability

- These are the moral implications of the covenant for the whole community and every individual - personal responsibility is seen as a responsibility for others.
- Accountability to God and others is seen as 'the essence of being human' in the Bible.
- There is a challenge for everyone here to take greater responsibility for their own health and the consequences of their actions for the health of others. The doctor-patient relationship should be characterised by an appropriate sharing of risk and responsibility.

4. Conclusion

- A narrow biomedical view can depersonalise health care and fail to address many aspects of patient's needs.
- In response to this more holistic definitions of health have been advocated.
- A biblical view of health seems to recognise a narrower physical and functional aspect of health but firmly set within a holistic understanding of the person. All aspects of wellbeing, physical, emotional, spiritual and social are not merged but recognised as interrelated.
- In this fight relationships can be recognised as a major influence on health (e.g. through the presence or absence of social support) and a key factor in the efficient provision of quality health care.
- The re-engineering of health care relationships is a major feature of current NHS reforms, particularly in building new inter-organisational and inter-professional relationships.
- This is no easy task - there are many challenges and obstacles to overcome. These new relationships must also be founded on the right values to be successful.
- Biblical values of faithfulness, love, justice, equity, service and accountability (among others) are both a powerful challenge and a helpful guide.

Glossary of Terms

Bio-medicine branch of medicine which focuses on the correcting biological imbalances within the body.

Bio-reductionism approach to overcoming ill health which reduces diseases to molecular dysfunction.

BMA British Medical Association, organisation which all doctors belong to and which aims to represent their views.

Cartesian-dualism school of thought that is based on the philosophy of Decartes which assumes two frames of reference (referring to the effects of the mind and spirit on the body)

CJD human disease of the nervous system associated with BSE or 'Mad Cow' disease.

GP Fundholding where individual GP practices manage their own budgets, a scheme introduced in the 1990's by the Conservative Government and which about 40% of General Practices converted to, as opposed to receiving Health Authority funding.

Green Paper Government proposed policy paper for discussion

HAS Health Advisory Service, a former organisation set up to advise the NHS partly through thematic reviews on large organisational issues.

Holism approach to overcoming ill health which assumes that is it caused by dissonance between an individual and their environment or their personal dimensions

Longevity long length of life

Mechanistic an approach which assumes that the body functions like a 'machine'

Multiple Sclerosis disease of the nervous system with multiple symptoms

NHS National Health Service

Physiological concerned with the body

Primary Care Groups (PCGs) Nation-wide new partnerships within primary care involving a multi-professional group, which will take on some former health authority responsibilities, but which will be locally organised.

Psychological concerned with the mind and behaviour

Purchaser/Provider split the term used to describe the relationship between the providers of health care (trusts) and purchasers (or commissioners) of care (health authorities)

White Paper Government proposed policy paper for implementation

1. Health and Health Care Relationships: A Challenge for Society

i) Project Objectives

Health is an issue which profoundly affects everyone from conception to death. Much Christian concern about health is about the ethical issues surrounding the beginning and ending of life. But health is an issue throughout our lives, affecting patients, carers and health professionals in many ways. This project has sought to look at a wide range of biblical material to provide a resource to enable Christians to respond faithfully and effectively to these important issues.

It has particular relevance for Christian health care professionals and the challenges and opportunities they face, but addresses issues of concern to everybody. We are all affected by health: personally; as friends; colleagues; relatives or carers of those who are ill; and as members of a society which invests a significant proportion of national income in health care provision.

Enabling Christians to Fulfil Health Care Responsibilities

Increasingly health is being seen as a responsibility for all and this was made explicit in a national contract for better health in the Green Paper "Our Healthier Nation". This includes an expectation that as partners in a national enterprise (rather than as passive consumers) we should:

- look after our own health
- take care for the health of others (e.g. responsible parenting and transport use)
- be members of families and communities able to provide care in the community
- play a part in local decisions about health strategies and resource prioritisation.

There is a challenge to us here as individual Christians, and also as a church. Historically the church has played a major role in the care of the sick. A continuing expression of this is through hospital chaplaincy as well as the disproportionately large numbers of Christians in caring professions. However as hospital stays become shorter and the focus shifts from hospitals to primary and community care, new ways of linking church and health care will need to be developed.

As Christians we have often received little teaching about our role in health care. Prayers for healing and visits to the doctor too easily become unrelated activities, informed by different worldviews. By looking at biblical teaching on health and the relationships involved in its provision, this paper seeks to make a start in bridging that gap.

Equipping Christian Health Care Professionals

The NHS is entering a new period of reform with the recent White Paper (The New NHS: Modem, Dependable) and the Green Paper (Our Healthier Nation). The evolutionary approach masks challenging changes which raise the two fundamental questions which are the focus of this project: what is health? and what sort of relationships are needed to provide efficiently quality health care?

The Green Paper's focus on public health signals a move towards more holistic views of health with greater emphasis on social and environmental factors. This shift in health definitions has an impact on the whole focus and structure of health care provision. A particular challenge for Christians involved m the debate about, and implementation of, health care provision will be how to ensure that an adequate understanding of spiritual aspects of health and causes of ill-health are included.

Care is fundamentally about relationships between individuals and between organisations. The White Paper will set in train a major re-engineering of health care relationships. Many Christians have been concerned about the dissonance between stated and actual values in the NHS. The current round of reforms will provide an opportunity for new relationships to be founded on the right values.

The extent of the challenge here should not be underestimated. Changing organisational relationships with their inertia and competing and vested interests is never easy. To do this in the context of resource constraints, and in some areas widespread low morale, is harder. For many individuals it will be personally challenging as their jobs change or disappear, power is shifted and sometimes difficult relationships have to be developed.

Responding to this challenge is important for several reasons. First, as Christians we should care for the health of all as an expression of our love of neighbour, and this means caring about the health service. While there is a place for the independent provision of distinctively Christian health care, it is not feasible for Christians to take on responsibility for providing health care for all and so we should play a part in the national health service.

Secondly, this means commending a Christian vision of health care to those who do not share our faith, and working in partnership to pursue as much of that vision as possible. This one issue then provides a powerful case study for the wider question of how Christians can be faithful and influential in public debate.

Thirdly, the reforms will have a significant impact on the extent to which Christians feel able to fulfil their vocation within the NHS. Getting it right will ensure important opportunities for ministry for years to come. Getting it wrong could result in the marginalisation of Christian involvement in the NHS.

Christians have not always been able to respond as effectively as they might. In pan this is because we have not agreed among ourselves. So, for example, some welcomed the introduction of an internal market with the disciplines of stewardship and the freedom and opportunities to innovate that fundholding offered. Others were opposed, fearing the loss of fundamental guiding principles such as equity. Another factor has been the lack of resources on structural and policy issues when compared to the wealth of material and teaching on medical ethics. This project seeks to fill that gap.

Showing Relevance to Christians and to Wider Society

This project is not just about health and health care. It is also about the Bible, and there are two messages here. One is to Christians, to encourage them that on a modem issue, on which at first sight the Bible might appear to have little to say, there is in fact a wealth of wisdom and guidance to be found. The Bible is relevant, and its message is powerful and challenging. We

hope that in our attempts to provide rigour in analysis, we have not masked the vigour of the message nor made it burdensome. The challenge of the Bible must not become another stick with which to beat overburdened people. Rather, we hope that people will find the transforming power that empowers them to respond to the opportunities before them.

The other message, indirectly, is to our society. The Bible is not just the outmoded tradition of a minority value group in a post modem society. It is a living, relevant and authoritative tradition which has an invaluable contribution to make to public debate.

ii) Health: an Issue for Everybody

People's lives can be dramatically changed by the experience of ill-health, which goes far beyond any immediate physical symptoms or discomfort. Although we do not explore this .aspect in any detail, we should not forget the limitations of pain relief, nor that many people's lives are disfigured by persistent pain due to arthritis and other conditions. The experience is not always negative: for some people illness has been a focus for learning

rtant, if painful lessons about themselves, their lifestyle, their priorities and their relationships - with others and with God. The wider personal effects of health include our fulfilment of roles and participation in society, our identity, self-esteem and our security.

Fulfilment

Most people understand health in terms of having the ability to carry out and fulfil social and physical roles. For example, in the "Health and Lifestyles Survey"[1] which involved 9,000 individuals, responses to the questions concerning health - such as "what was it like to feel healthy?" - included the following: health was perceived as "not being ill" or as "reserve". Here, health as a "reserve" implied that some persons were perceived as being healthy because they recovered quickly from illness. Health was also understood in terms of "behaviour", which referred to individuals who looked after themselves by dieting and taking exercise and were therefore perceived as being "healthy".

Furthermore, health was understood as being "physically fit" and with regard to female respondents, it involved the feeling of being energetic and having the ability to do housework. Other respondents understood health as psychological and social well-being (Radley:1994:39) in which health was perceived in terms of the mental state of persons and the enjoyment of being in the company of other people. Finally, health was defined in terms of function, that is to say, the ability to carry out one's duties (Radley: 1994:3 8-39).

Thus in view of the above lay perspectives concerning health, we can see that health is of prime importance in our lives for it is generally comprehended in terms of, or in relation to, others and society - it is a means by which we can interact and achieve tasks. Indeed, it is the means by which we are fit for work and can participate in social and everyday activities. This is supported by studies carried out by Herzlich[2] and Williams[3] (Radley: 1994:39- 41).

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[1] See Blaxter (1990) in Alan Radley's *Making Sense of Illness* Sage, 1994 p.38fr

[2] See Herzlich (1973) in Alan Radley's *Making Sense* of Illness 1994, Sage, p.39ff

[3] See Williams (1983,1990) in Alan Radley's *Making Sense of Illness* p.41 ff.

Identity and Self-Esteem

Where illness prevents fulfilling involvement it can have severe emotional and social consequences. These can combine to influence a person's self esteem, there being a significant step from regarding oneself as basically healthy but with a specific health complaint, to someone whose life and identity has come to be shaped by their ill-health.

In a society where the emphasis is upon health rather than illness, problems with selfimage related to the idealisation and idolisation of health, and its obsessive pursuit, are as much of a problem. Health may be emphasised to such an extent that it has become a value, for as Radley points out, health is understood to have a moral dimension and is now something for which individuals strive to attain:

> *"Health as an aim, is inseparable from what people perceive the 'good life' to be. It has an essentially moral and ideological character to it, because it is tied up with what people believe is 'good' or 'correct', or 'responsible'"* (Radley: 1994:190).

However, in our society - in which people now make judgements over the personal achievements and failures of others - individuals unable to attain health are in danger of becoming marginalised and judged on the basis of their looks or fitness. One gains little from having the sick role, for as Douglas points out, one is likely to be judged as neglecting oneself or not worrying about one's appearance.[4]

It could be argued that the marginalisation of others is exacerbated by the context in which health promotion occurs - in a culture of consumerism Here the leisure industry promotes products which contribute to fitness on the understanding that to be fit is to be healthy, whilst advertisements urge us to buy certain products which promise to make us "feel healthier and look younger". Glossy magazines also fill the shelves of newsagents with pictures of the 'Ideal body" for which we must aim, whilst there are countless books on slimming techniques and healthy diets plus alternative medicines, herbal remedies and meditation.

This obsession with health links with the message that we have responsibility and power to control our health and well-being. Thus with the rise of health consciousness, individuals are endlessly being told to monitor themselves and their lifestyles. Indeed, health consciousness has reached such a point that natural bodily occurrences such as weight gain or hair loss, are often understood to be abnormal and therefore individuals are encouraged to check themselves for these "imperfections" (Radley: 1994:199-200). Between the extremes of inward looking 'health junkies" and outward looking "health fascists" and the opposite extreme of indolent irresponsibility without regard for the consequences of our actions for others, is a notion of responsibility which places the right value on health.

Our obsession with health reveals to us how society understands its importance and this necessarily calls for a Christian response. It is only through biblical teaching that we can comprehend the true essence, purpose and value of life and that for which we should aim Only thus can we begin to understand health in its right context, and in doing so provide guidance, hope and confidence to those members of society who are healthwise less fortunate than others.

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[4] Douglas, M. 1978: p31 Cultural Basis (Occasional Paper No.35) London: Royal Anthropological Institute of Great Britain and Ireland. See Radley, ibid, p200

Fear

It could be argued that to some extent Western society's health consciousness adds to, and yet is also a manifestation of, the aura of fear which clearly surrounds becoming unhealthy. First, it adds to the fear of people that they will be judged on the merits of their looks and youth; their vitality and "normality". Whilst secondly, this health consciousness is an outward expression of the concern individuals now have about health, illness and death. Indeed, fear has arisen because individuals recognise that although medicine has now combated most of the infectious diseases, chronic diseases such as heart disease, multiple sclerosis and some cancers cannot as yet be cured. Thus today individuals understand illness to be chronic diseases and it is the uncertainty of them with regard to cure that has led to the fear of developing them (Radley:1994:136). Nevertheless as Radley points out, the uncertainty concerning chronic illness,

> *"paradoxically, can also lead to an apparent lack of concern about diet and the prospect of getting heart disease. This is because there is no certainty that one's habits will affect one's chances of developing the condition. Nevertheless, the prevalence of chronic diseases has meant that there has been an increased effort to find the risk-factors that lead to the onset and, where possible, to persuade people to modify their lives to minimise risk" (1994:137).*

In addition, the fear surrounding health and illness may also have been triggered by the knowledge of new strains of diseases and viruses emerging which as yet, appear to be beyond the control of modern medicine. Indeed, in recent years there has been a rise of "mystery viruses" and new diseases such as Aids, CJD and different and more harmful strains of influenza. This factor has also given rise to uncertainty, with members of society no longer having confidence in the world of scientific medicine. Arguably, this has led to individuals feeling the need to turn to alternative methods of treatment. For example, 1997 has seen an increase in the use of acupuncture, Alexander technique, chiropractice, herbal medicine and homeopathy.

Further, the fear surrounding health and disease could also be caused by other factors. First, changes in the welfare state have led to certain members of society becoming vulnerable, finding it difficult to obtain sickness and disability benefits. Moreover, with part-time work and selfemployment becoming increasingly common, some people fear becoming ill as they are not able to claim sickness benefits. The rise of short term and temporary contracts has also put pressure on individuals who may feel that by becoming sick, they could lose their hope of promotion and/or long-term employment.

Another factor which could contribute to the fear surrounding illness and health is the state of the NHS itself Not a day goes by without a mention on the news or in the papers of the NHS and its current difficulties - the major concern being lack of funding. Arguably, as with fear of crime the perception created and the fear generated is more negative than reality justffies.

Resource constraints do, however, have implications for us all. For example, evidence shows that waiting lists have increased[5], whilst rationing can have a detrimental effect upon the

[5] An article in *The Health Service Journal, 27.2.97. p.8* shows that almost 1. 1 million people in England and Wales were on waiting lists by the end of December *1996 - this* being a quarterly rise of *3.2%.*

well-being of patients by reducing lengths of hospital stays and staffing levels[6]. Our fear of ill-health and our aim to maintain "good" health for the present, thus preventing illness in later years, may also be stimulated by the knowledge of the debate concerning continuing care for the elderly and the lack of funds given towards their care[7]. Fear of illness may also be heightened by the dispute concerning bed blockages, social services and lack of places in residential and or community care homes. Thus, to address the fear surrounding health, Christians need to be aware of biblical teaching concerning health

Christians have the task of furthering God's kingdom on earth which involves implementing justice and looking after the well-being of others. Accordingly, as part of their Christian duty, Christians should try to ensure that public debate and policy concerning health issues have a measure of biblical input which indicates how to promote human well-being. Indeed, with a biblical understanding of health, it is arguable that health and disease issues could be put into a more meaningful perspective.

iii) A Challenge for Health Care Professionals

We aim to review here some of the challenges currently facing Christians working in the health service to provide a focus and context for the rest of the paper. Christian views on past and current reforms vary widely. Our concern here is not to make judgements about policy or practice but to highlight the issues where biblical reflection can inform better responses. Those who personally and professionally face these issues on a daily basis will have a more graduated understanding of them Our hope is that, standing back a little from the daily pressures, we will provide a resource which will enable those with a longterm commitment to the health service to work faithfully and effectively for its continuing improvement.

There is a long history of Christian involvement in health care provision, both independently and as part of state provision. In the course of this history health provision has been seen as an act of charity and compassion, as an economic imperative, as a right and more recently, as a commodity. Not only has the basis of valuing and providing health changed, but so too have definitions of health and the structures and practices for providing health care.

Attitudes to change in the health service vary from the pioneers keen to pilot the latest method/drug to those who keep their heads down and gradually let change wash over them. Responses to particular changes are almost always varied. Some key elements of recent changes have become widely accepted, but a range of concerns remain such as unequal access, management costs, perverse incentives created by performance management indicators, poor coordination of care and too short a term focus. Regarding the practice of health care there is a continuing struggle to integrate adequately the three cultures which can be stereotyped as scientific cure, compassionate care and managerial efficiency.

The next round of reforms, represented by the White Paper (The New NHS) and the Green Paper (Our Healthier Nation) present a number of challenges and opportunities which can be summarised as:

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[6] See "Humane Decisions" *in Nursing Times,* September *17, Vol. 93, No.38, 1997 p.26-27, by* Iona Heath, discussing the effects of rationing

[7] See for example "Age-old debate" *in The Health Service Journal, 27.2.97, p. 15, by* Mark Crail.

- Developing relationships between General Practices to form Primary Care Groups. These will need to work together in contributing to Health Improvement Plans and in commissioning care. Christian GP practices will have to work with other practices, and communicate and share their vision for health care.
- Changing patterns of relationships between GPs and health visitors and community nurses as their role in public health and developing partnerships with other agencies becomes more important.
- Developing relationships with local authority and voluntary agencies as part of the "duty of partnership" in the pursuit of improved public health and to bridge the cultural differences between them.
- Having the courage to devolve power and risk failure to secure wider involvement in health strategy development.
- Foregoing some personal, organisational and professional body interests to make new structures and partnerships work.
- Accepting some loss of freedom and independence in primary care in return for more responsibility for care provision and commissioning.
- Agreeing local health strategies which take adequate account of spiritual, aspects of health care.
- Keeping patients at the heart of the process.
- And doing all this without significant additional resources.

There are plenty of technical challenges here, but underlying them are fundamental questions about what sort of health we are trying to achieve, who is responsible for achieving it, and what sort of relationships are needed to best provide it. There are many tensions surrounding these questions, and underlying them are clashes in philosophies and values. In the following sections we seek to identify the heart of these debates and see how the Bible can guide their resolution.

2. A Biblical Understanding of Health

A: The Contemporary Debate: Reductionism Versus Holism

Health definitions have practical implications by setting the agenda for health care and so providing the means by which health care professionals are able to understand their roles and the responsibilities involved. This is true for clinicians, managers and policy makers. It is obvious that health care professionals may understand health within a number of different perspectives and this has led analysts such as David Seedhouse[8] to claim that much of the diversity within the National Health Service (NHS) today revolves around the definition of health. These different perspectives (which may be rightly held) give rise to different agendas, priorities, organisational structures, management styles and ways of caring. This diversity can create tensions which are difficult to resolve. The practical need to resolve issues such as the allocation of resources can also discourage a move to more patient-centred care which can seem to increase the diversity rather than restrict it (Seedhouse: 1995: 10-11).

Underlying the range of definitions are two polarised views: one which generally understands determining factors of disease to be biological malfunctions (the Biomedical Perspective); the other view is broader, taking into account social and environmental factors as causes of disease. It is in this context of the debate between these two perspectives, that Section Two seeks to provide a biblical view of health in order to provide the basis upon which to implement biblical principles for health care (Section Three). However, in order to comprehend the biblical understanding of health and its relevance in the light of the current confusion surrounding the nature of health and health care, it is necessary to begin by examining briefly these two different schools of thought concerning health.

i) The Biomedical Perspective

The Development of Biomedicine

No one can doubt the benefits of biomedicine over the years for its development has contributed greatly to health and well-being. Indeed, prior to its development many died unnecessarily from diseases which today, with biomedical methods, are easily treated and cured. The clearer understanding of the causes of diseases and their physiological consequences has enabled the development of more effective treatment within surgery, radiology and pharmacology as well as preventative programmes through immunisation.

The rapid development of new treatments combined with high levels of confidence in the potential of science and technology contributed to the growing dominance of biomedical views. This confidence has, however, been jolted by continuing levels of ill-health (e.g. cardiac disease or cancer) and the reemergence of diseases such as tuberculosis. Greater awareness of its limitations has also grown out of patient dissatisfaction with the dehumanising experience of biomedical care. Greater emphasis on natural childbirth is one example of this.

[8] Fortress *NHS,* John Wiley, 1995

The biomedical perspective developed as a means by which disease could be studied. Engel perceives that biomedicine has its roots in reductionism and Cartesian thinking (1981:589). Laura and Heaney also believe that biomedecine is influenced by Newtonian thinking in which the world is understood as a machine having independent parts which can be analysed separately (1990:30). Cartesian dualism separates the mind or spirit from the body, with the body being perceived in purely physical, chemical and biological terms, whilst the spirit is understood to be separate from the body and healing processes (Sharkey: 1992:47).

Reductionisrn is a philosophical view understanding that intricate phenomena are derived from a single fundamental principle. In this context health is regarded in terms of biological processes and these in turn can be explained by more fundamental laws of chemistry and physics (Engel:1981:589). This scientific method of reductionism in medicine has come to be known as "bioreductionism" (Laura, Heaney: 1990:6). Basically, bioreductionism understands that unless there have been injuries caused by external circumstances, the cause of a disease can be reduced to a "specific micro-organism" (Laura, Heaney: 1990:6).[9]

However it is because of its reductionist influence (which focuses specifically upon one aspect of the process of disease -the cellular and molecular aspect and reduces entities to their lowest level of description) that the biomedical approach is in danger of being flawed. Indeed a scientific reductionist basis for medicine could be limited for, as Laura and Heaney point out "(it)... derives from a limited understanding of the nature of biological phenomena in general."(1990:7). Reductionism has led to biomedicine being perceived as a purely scientific practice that has the tendency to underestimate other (non medical) factors which may contribute to ill health such as public health and environmental factors. Moreover it is the reductionist medicalisation of patients which has led to the perception that biomedicine provided only one form of care in which the full extent of patients concerns are not totally secured.

Reductionism however, is only one aspect of the biomedical perspective; biomedicine also seeks to understand the ramifications and effects of the disease process in addition to finding the causes. In this way biomedicine is aware that personal and psychological factors are of concern.

The Nature of Health and Disease

Reductionisrn has often led to health and disease concepts (within biomedicne) being understood in scientific terms. Thus from the biomedical perspective health is theoretical concept which is understood basically to be absence of disease. Christopher Boorse has argued that the chief components of health are biological and statistical normality (the ability to perform physiological functions which are typical of humans) (1977:542). Accordingly health is understood to be "functional normality" (1981:554). Elsewhere he said that because health is normal functioning an "organism is healthy at any moment in proportion as it is not disease" (1976:62). Diseases therefore in this model are perceived as being deviations from the norm of health - they are internal states which depress functional ability (1977:542). Thus the basis of the biomedical view of disease is molecular biology which assumes that disease in Engels words "(is) to be fully accounted for by deviations from the norm of measurable biological (somatic) variables" (1981:591).

[9] This phrase is used by two authors, Laura, and Heaney. It must be noted that " micro organisrn" is the term normally used to refer to bacteria or viruses.

Evaluation

As already suggested, owing to its reductionist trend and its almost exclusive use of scientific principles and models which are physiochemical in nature, biomedicine neglects the broader aspects of disease and health. Biomedicine may treat the organic manifestations of the disease, but fails to recognise its underlying origins which could be caused by social ' environmental or personal factors (Laura, Heaney:1990:55-56). For example, in the case of cirrhosis of the liver triggered by heavy drinking, it could be that the practitioner would treat the symptoms of the disease without looking into why the person was drinking heavily in the first place.

A bioreductionist view of disease requires mainly scientific treatment by persons who are skilled and trained in this area. However, this approach to healing may alienate the patient from the healing process. Furthermore, the role of the patient within the healing process may be diminished owing to the influence of Cartesian dualism which can potentially negate the power of the mind which is known to contribute to the healing process (the body's natural autonomous system within it) (Laura, Heaney: 1990:65). Thus one of the difficulties in biomedicine is that by using specialist and scientific treatment, whilst undermining the value of the power of the mind, there is the risk that biomedicine could rely on drugs and external chemicals for healing, and not allowing a proper place for the person's determination to be well.

The reductionist tendency, together with the Newtonian understanding of the body, has led to the popular perception of biomedicine as being interventionist by nature in which treatment is not something which the practitioner and patient share, but is something which is done to the patient. So biomedicine may be in danger of leaning towards paternalism (although on the other hand paternalism may be reduced with "patient rights" or "customer rights"). Thus in chronic cases of illness there is the danger that with a scientific, bioreductionist understanding of health which depends heavily upon technological and scientific treatment, the patient may be depersonalised. This is mainly because there is the danger first, of failing to recognise that the patient's personal circumstances may contribute to the origins of the illness and secondly, the tendency of a scientific approach to negate the natural processes of healing inherent within the person. Further, a bioreductionist, scientific approach to health and disease has led to the possibility of depersonalisation occurring within the actual encounter between the practitioner and the patient. Indeed, at times personal contact is lost as human interchange is replaced by technological techniques (Laura, Heaney: 1990:67).

Hence, physicians may be in danger of viewing themselves as engineers, perceiving the body as a machine which requires specialist knowledge and skills, and their having the ability to handle technological and scientific developments to treat the body. In turn, this has the danger of allowing society to understand that medicine, science and technology have the wherewithal to solve all known ills (Guttmacher: 1979:16). Nevertheless, lay perspectives may encourage this view of the body and the ability of sciencelmedicine, for many people nowadays consult their GP on the understanding that the GP can "fix" them. This understanding, however, is flawed, for medical methods are used primarily to restore that which is already blemished and medicine does not seek to transform the person into something else.

Although the biomedical model is construed as understanding health and disease in purely scientific and biological terms (thus negating other factors which may contribute to disease and health) this narrow view of health and disease is largely the result of the reductionist philosophy which underpins biomedicine. Most health professionals however, recognise the social, environmental, psychological, and behavioural dimensions of illness although these factors may not be fully endorsed in practice. The absence of a broader understanding of health

may be the result of the dominance of a scientific view or due to the lack of time that professionals have available to spend with patients. Indeed as Guttmacher points out, although physicians are aware of other dimensions involved in health, "their practice and habits have been constrained to a more narrow approach by the economic, social and ideological framework in which they work (1979:16).

ii) Holistic Perspectives

Until recent years, the scientific approach towards health and disease has been pre-eminent. However, this approach is now being challenged by a broader approach towards health (holistic health). Advocates of this approach wish to encourage health consciousness and in doing so enable society to understand the inadequacies of biomedicine. Indeed they wish to show that the concept of health is broader than that which is found within the biomedical perspective.

Individual holism

There are two strands or elements within holistic views of health. One strand focuses upon the individual and is mainly associated with alternative medicine. Here, disease is understood as being a sign that there is either dissonance between the individual and the environment, or that the individual's personal dimensions are fragmented. Thus a prerequisite of health is that the spiritual, psychological and physiological dimensions of the person should be integrated. The aim of this strand is to highlight the disunity, and accordingly healing will include restoring unity. This necessarily demands first, that both the professional and the patient work closely together in the healing process; secondly, recognition of the significance of the spiritual experience and thirdly that patients develop the necessary ability to cope independently with the problem. Thus the main concern and role of the professional is to show how patients can deal with their illness, how they can achieve a better state of health and also how they can maintain it. Therefore, the patient plays a role in the healing process itself and in the aftermath, by engaging in activities and adopting behaviours that are conducive to health (Guttmacher:1979:17). There is also an emphasis on remedies which are perceived to work with the body's natural healing processes rather than against them.

This approach has received less acceptance within the health service, partly because many believe that too often it does not withstand scientific assessment of clinical effectiveness. In this debate a fundamental clash of underlying philosophies is revealed.

Environmental, Social and Economic F actors

The other strand within a holistic view of health is one which takes into account environmental, social and economic factors. For example, McKowen[10] has made a persuasive case that it was factors such as improved water supplies and hygienic sewage disposal, the increased knowledge concerning food -and nutrition and family planning, which were largely responsible for the advances in health within the last 200 years and therefore these advances were not entirely the achievements of biomedicine. This approach is aligned with the definition of health proposed by the World Health Organisation ("Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity").

[10] McKowen, T. *The Role of Medicine.* Nuffield Provincial Hospitals Trust, 1976.

There is much greater acceptance of this strand of holism, not least because it can be seen to complement biomedicine by balancing any reductionist understanding of the causes of ill health whilst still valuing biomedical treatment as a major part of the response to ill health This can be seen in the greater emphasis on public health in current policy, evidenced, for example, in the Green Paper (Our Healthier Nation). While public health has at times become medicalised, current policy is widening the scope with commitments to tackle, for example, the impact of smoking and pollution on health.

Evaluation

The emphasis now is to broaden the practice of biomedicine, which advocates of holism perceive as being narrowly scientific and excluding other factors which may contribute towards health and disease. However, as the previous subsections have indicated, this view is largely a misinterpretation of the biomedical approach and is possibly the consequence of the bioreductionist philosophy which underpins biomedicine. Nevertheless, although the NHS is beginning to take account of the environmental, social and economic approach towards health and disease (this being more amenable to scientific research), it is more wary of adopting the first strand of holistic thinking which focuses upon the "whole person" and alternative medicine.

In both public health and primary care there is debate, and at times tension, between biomedical and more holistic approaches. This can be superimposed upon rivalries between different professional groups within the health service. The dominance of primary care by GPs, for example, is seen by some as an obstacle to fulfilling the potential of primary care to embrace a more holistic view of health.

Although it is only right that holistic and biomedical approaches towards health are to be integrated, there is the danger that if the balance is not maintained, medicine could be forced into areas of life which may be inappropriate for it. On the one hand biomedicine could become used in areas of life which previously had been outside its control. Consequently, these areas could become dependent upon medicine. Moreover, there is also the danger that the nature of life itself with all its uncertainties and problems may become medicalised and treated by pharmaceutical or psychological means (i.e. counselling). For example, there is the danger that drugs may be prescribed for the housewife who suffers from depression because she feels undervalued as a person in a society which values careerism, power and status Intervention of this nature however, only adds weight to the bioreductionist view that all problems which affect health are to be regarded as resembling disease disorders and malfunctions (Guttmacher: 1979:16-18).

On the other hand here is the danger that if health care professionals are to take on social, environmental and personal factors which contribute towards illness, their role and responsibilities as medical professionals will become less clearly defined. Indeed, medical professionals may find that their workload is increased as they take on other problems and needs of patients which are not necessarily medical in nature. Thus although it is only right to acknowledge that there are other factors which contribute towards health and disease, it is impractical to suggest that medical professionals such as GPs are to be responsible for all of these problems. Indeed the role and responsibilities of practitioners would be far too great for them to manage properly and would put further pressure on them.

The influence of the strand of thinking which endorses an individual or "Whole person"

approach, may also exacerbate biomedicine's inclination to deal specifically with problems at an individual level. This is because this strand aims to address behaviours and habits which may cause ill health and in doing so, encourages individuals to reflect upon their feelings or behaviour which could be causing the illness. It could also have the danger of failing to address the wider implications of health and disease. Potentially it fails to recognise that individuals who adopt harmful behaviours and lifestyles may do so because of social, political and economic forces (Guttmacher: 1979:19).

By concentrating upon the individual and the spiritual dimensions of cure[11] encouraging immediate forms of respite, such as meditation, exercise and healthy eating patterns, this individualistic strand of holistic thinking fails to address the needs of vulnerable members of society who are most at risk from economic and social forces. Indeed, this ideology is unlikely to touch those who are at high risk. This is because those who live in despair and without a sense of hope may find their primary source of pleasure and consolation in adopting unhealthy behaviours (such as excessive drinking). Many of the techniques and practices are unrealistic for the poorer and marginalised members of society. For example, healthy and fresh foods such as organic foods, wholemeal bread and high fibre based products are often more expensive than products which are high in fats and sugars. Moreover, some of the techniques (health clubs, yoga classes, etc.) require substantial financial resources and are unattainable for those whose immediate concerns may be issues such as job insecurity, poor income and occupational health hazards which in the latter, could result in longterm sickness and therefore lower income. Thus the message of the first strand in holistic thinking is only accessible to the wealthier members of society (Guttmacher: 1979:16-19).

Within our present system, there is much diversity concerning the nature of health care and therefore the responsibilities of health care professionals. On the one hand we have professionals who advocate a purely scientific understanding of health and disease. On the other, we have holistic perspectives which, being comprised of two different views, may focus upon the integration of persons with themselves and the environment (whole person centred) or upon the implications that environmental, economic and social factors may have health and disease. Arguably as we shall discuss below both medical and holistic upon approaches to health fail to address the roots of the problems and issues surrounding health today - the issues which cause problems in the environment and society and put pressure upon individuals and their relationships, perhaps even driving them towards adopting unhealthy behaviours.

By turning to the Bible, we can gain great insight concerning health. The Bible informs us of the proper nature of health and therefore provides guidelines concerning responsibilities healthwise - for professionals, members of society and for society as a whole. Moreover, biblical teaching concerning health goes a step further for it is in its understanding of the person, and of society as a whole that we find the roots of the issues and problems surrounding health and health care today.

Part B therefore examines the biblical view of health in the light of recent Christian work in this area and points out its implications for health and health care today[12]. To do this, the first

[11] See Guttmacher, 1979, *The Hastings Centre Report,* 'Whole in Body, Mind and Spirit`. Advocates of holism rightly recognise the link between the spiritual and physical dimensions of persons. This often occurs within the context of Tai Chi or Yoga. From a Christian perspective this does not make the link between the spiritual and physical wrong, for it will be apparent that the link between the spiritual and physical is strongly endorsed throughout this paper. Nevertheless, theologically this paper is cautious of some spiritual alternatives recommended by advocates of holism.

[12] A fuller account of the implications will be discussed in Section Three.

subsection briefly examines contemporary theological views concerning the Bible's understanding of health, whilst the following four subsections set out the thesis that the Bible recognises a narrow physical view of health within the context of a broader vision of human well-being. (The sixth subsection is a summary and conclusion of section Two). In doing this it seeks to achieve greater clarity in distinguishing a holistic view of causes of ill-health, an integrated anthropology, and holistic definitions of health.

B: Holistic Health or Holistic. Persons?

i) Contemporary Views

Given the importance of health in our post-modem world, it seems strange that at first sight the Bible appears to say little about it. This apparent lack of interest in health, however, is not the case; the concern for human wellbeing lies at the very heart of the Jewish scriptures. The specifically Christian scriptures, the New Testament texts, are arguably more concerned with healing than with health since they lay out the pattern of what should be, rather than setting about the restoring of that lost pattem[13]. Indeed they contain no dynamic equivalent to the word "health", but content themselves with terms for healing ("sozo", "iaomai"). Nonetheless, humankind's well-being remains the central concern.

However, most contemporary theologians agree "shalom" is the nearest Hebrew dynamic equivalent to the word "health"[14]. For example, Atkinson argues that shalom means "wholeness, well-being, vigour and vitality in all dimensions of human life" (1993:25). In this vein, health is understood to be part of the concept of shalom for as Atkinson puts it,

> *Health is clearly part of shalom, as can be illustrated by the numerous times in the Old Testament when shalom is bracketed together with a Hebrew word translated "health" or "healing". Thus the vision of peace in Isaiah 2:1-5 (which could almost stand as a definition of shalom) is set in contrast to the sickness of the nation (1:5-6), its idolatry (2:6-22) and social injustice (3:13-15) which bring the judgement that the Lord will not be a healer (3:7b)* (1993:25).

Atkinson goes on to say that it is Jesus who brings shalom (peace and wholeness) and it is when He brings shalom that there is prosperity, a healthy relationship with God, reconciliation between people and all-round contentedness. With this understanding of shalom, perceiving health as a part of it, Atkinson, in accord with other theologians, concludes that "In biblical terms, health is a holistic concept" (1993:26). Indeed, Wilkinson also understands that health is synonymous with right relationships and concedes that the Old Testament concept of health is comprised of wholeness and holiness (1 980:VII,7). He summarises the biblical concept of health thus:

> *It is only when man's being is whole and his relationships right that he can be truly be described as healthy. The basic relationship of all (sic) is man's relationship to God and when this is disturbed all human relationships are*

[13] Cf Wilkinson, *Health and Healing.* The Handel Press, 1980, P. 1.
[14] See Wilkinson, *Health and Healing,* and Fergusson (Ed) *Health: The Strength to be Human* IVP/CMF 1993

> *disturbed whether they are of man to himself, to his fellows, or to his environment* (1980: 1).

However, Atkinson understands that the biblical view of health also takes into account the state of a fallen world riddled with the consequences of sin (disease, suffering, etc) and accordingly, health is limited and never fully attainable in this world (1993:26,29). It is because the world and all creation is sinful and therefore alienated from God, that humans are in need of a renewed humanity - in fact all of creation is in need of renewal and restoration.

However, renewal can only take place in Christ for as Atkinson quotes, "Wholeness of life is synonymous with 'the measure of the stature of the fullness of Christ (Ephesians 4:13. RSV)` (1993:24). Indeed, it is Christ who depicts the essence of true humanity. In this vein, health must be understood within the context of God's Kingdom which He has begun on earth and therefore wholeness of life (i.e. health) is a dynamic process which cannot be attained on this earth, but only in the new heaven and earth (1993:24-25). It is with this understanding of a growing, dynamic wholeness within a fallen world, that Atkinson is able to define health as being that which is indicated in the biblical term shalom. In essence then, Atkinson understands the biblical view of health as,

> *a holistic one in which all aspects of life are involved, a dynamic one which acknowledges that we are part of a salvation-history process in God's dealings with the world, yet a limited one which acknowledges that perfect shalom, perfect health, is not possible this side of heaven* (1993:3 1).

In the rest of this section we will argue that while a more holistic vision of human well-being is biblically correct and an important challenge to the continuing prevalence of overly reductionist views of health in some aspects on contemporary medical practice, there is a danger of losing sight of the very strong physical and material aspects to a biblical view of health. There is also a danger of failing to distinguish adequately between causes of illhealth, what constitutes health and a holistic vision of well-being derived from an integrated anthropology.

Specifically, the following sub-sections will argue that:

a) The term shalom has strong physical and material roots, and that equating shalom and health to justify a holistic definition can be misleading.

b) Equating healthy relationships with health, and the understanding that holiness is health, are misunderstandings of how in ancient Jewish thought, relationships - especially with God were seen to be the cause of good health rather than as being synonymous with it[15]. Indeed, this equation misunderstands the fundamental causal relationship between a person's spiritual state and physical state.

c) In understanding that primarily health is a physical concept, and that the spiritual dimension has an effect upon the physical dimension, this paper will show that the Bible understands persons to be holistic.

d) The cause and effect relationship between a person's spiritual condition and physical state is

[15] Cf. a traditional view that while the Jewish scriptures do not divide the individual into different parts they recognise the individual's different aspects: eg. AR.Johnson, *The Vitality of the Individual in the Thought of Ancient Israel* (Cardiff. University of Wales, 1949), p7.

also relevant and significant at a social level. The spiritual condition of society (i.e. corporately) may have a determining effect upon human well-being and health generally.

ii) Health in the Bible: a Physical and Functional Concept

Health as a Physical Concept

We have seen that the underlying reason for the commonly held belief that the Bible has a holistic view of health, revolves around the concept of shalom which appears to be the nearest word to health. Scholars such as Wilkinson use this in turn to confirm that the Old Testament concept of health is holistic and indeed "not related to the state of the body" (1980:5). In essence however, it is arguable that all they are doing is no more than equating a more holistic word (shalom) with health and coming to the conclusion that the biblical concept of health is holistic. This understanding can also overlook the strong physical and material aspects of shalom.

With regard to shalom and physical health, we see that von Rad gives the root meaning of shalom as simply "well-being" and quotes a number of scriptures such as Judges 19:20 and 1 Samuel 16:5 to show that it has a strong emphasis on the material side[16]. In addition, von Rad cites texts which also equate physical strength with shalom. (e.g Psalm 29:11) In the poetic books we read of the shalom of the wicked (eg. Job 21:7-13, Psalm 73:3-5). Shalom here is certainly not their spiritual well-being! Although these particular texts have a strong reference for shalom, it may indicate the peace of mind that results from (apparent) guilt-free enjoyment of prosperity as much as the comfort and security that such prosperity brings.

There is evidence of a functional view of health in the Bible. Avalos, for example, has found that in the Ancient Near East "illness" was having visible symptoms which rendered individuals as being physically and/or mentally unable to fulfil the normal social and/or physical role ascribed to them by society. Thus the real issue concerning Hannahs closed womb (1 Samuel 1:5) is that she is unable to fulfil the role expected of her in society (Avalos:1995:246-250). A physical view of health is recognised as having far wider consequences -affecting Hannah's emotional state and her family and community relationships.

In Hebrew thought, health was understood in terms of longevity and strength (Buttrick:1962:541). Moreover, Achtemeir has found that the words "health" and "life" in biblical thought were interchangeable and synonymous and indicated survival and well-being (1971:560). Thus the biblical view of health could be construed as primarily physical in nature although this is pursued in the broader context of human well-being. This understanding of health is typical of a traditional society for even today in traditional African religions, health is associated with material concepts such as life, fertility, plenty, prosperity, rain and the possession of cattle (Mbiti: 1975:60)[17]. Here then, we see a similarity with Deuteronomy 28 in which the health of the people was associated with the physical aspects of life although set within the context of a broader vision for human well-being.

The biblical texts value good health because it is the essence of life itself For the writers of the

[16] G, von Rad in G. Kittel (ed), *Theological Dictionary of the New Testament* ffiffand Rapids, MI: Eerdmans, j 964) 11, 402, s,v,e rhnh (eirene).
[17] See Jubilee Centre Working Paper *An African Concept of Health* (1997).

Jewish scriptures especially (for whom concepts of "life after death" were rather vague), "life here and now" was of paramount importance. For example, the Jewish scriptures show how life started, whilst Ecclesiastes 9:4 emphasises the value of- life and survival. Throughout, the premium is on good health, survival and the continuation of the species. In brief then, the Old Testament's understanding of good health comprises the physical and mental ability to fulfil the normal social and physical roles as determined by society. This physical and functional comprehension is further supported by the metaphors used to portray health and illness. For example, the Hebrew word for "bones" ("esteem", "gerem") signifies the body, life strength and substance. As the solid framework of the body, the bones are the scat of health and strength, whilst "breaking", "rottenness" and "dryness" of bones are frequent metaphors to indicate sickness (Grant: 1963:111). In addition, Douglas has found that. bones were often identified with, or parallel to, "flesh" ("basar") (1982:146) and as Anderson points out, in the Old Testament the term flesh was used to highlight human weakness (1972:303). Thus health is associated with the purely physical facets of humankind and indeed a number of texts (e.g.Psalms 3 1: 10 and 3 8:3) appear to link health/ill health with physical strength.

The physical agenda for health put forward in the Old Testament is continued in the New. However, the New Testament texts contain no dynamic equivalent to the word health but content themselves with terms for healing. As such, these texts limit instances of healing to three areas which are definitely tangible:- physical healing, the casting out of demons and the raising of the dead (Wilkinson: 1980:VII). In the light of this, it could be argued that the New Testament understanding of health comprises physical and mental well-being - the absence of illness, physical disability and the expulsion of demons or evil spirits which, could have an effect upon the physical and mental health of persons. (Luke 8:26(ff) Mark 9:14(ff)). In essence then, it can be seen that the Bible as a whole understands health in primarily physical terms, although this view is pursued in the context of a broader vision for human well-being the fundamental concern stressed throughout the Bible.

A physical agenda for health provides us with a narrower perspective. A more confined understanding of health - in the Bible - would provide a guide for the role and responsibilities of practitioners, by restricting their responsibilities within the boundaries of the physical problems of the anatomy. This in turn adds weight to the view mentioned earlier that other agencies and professionals are to be included and involved in order to provide care which deals with the non-biological factors that contribute to illhealth. This would then enable practitioners to practice more effectively, and it would also inform patients that the practitioner alone should not be expected to treat all their health needs and problems.

iii) The Nature of Relationships

A definition of health which equates good relationships with health, is in danger of misconstruing the fundamental causal relationship emphasised throughout the Bible between humankind's spiritual state and physical state. The interplay between the two does not make health a more spiritual concept but rather, for the ancient Jew, made health more spiritually dependent. Biblically, humankind's relationships - especially with God - are seen as the *cause* of good/ill health rather than being equivalent with it[18]. Biblical texts suggest that health is determined by God who bases His decision making on the individual's relationship with Him. Indeed, in both the Jewish scriptures and New Testament, there is some indication that the

[18] See AR Johnson, *The Vitality of the Individual in the Thought of Ancient Israel* (Cardiff University of Wales, 1949),

ultimate determining factor in humankind's well-being was having and maintaining a relationship with God.

Relationships and the Old Testament

In the Old Testament, humankind's relationship with God was expressed through the covenantal relationship not only with Israel (God's chosen people) but all of humankind through the very act of creation. With regard to Israel, God called a people and made them into a nation and gave them particular laws and commands which were unique to them. Thus God first established a relationship with a people and made them His own and gave them righteousness. He made them "right" before Him and therefore expected them to maintain this righteousness - this right relationship with Him. Maintaining this relationship entailed obedience to God and His commandments which involved imitating Him and being holy (Wright: 1983:143). Indeed this was the purpose of the Levitical rituals for, as Wenham recognises, these rituals were stipulated in order to provide God's chosen people with the means by which they could maintain their relationship with God by being holy. Being holy like God (who was perceived as the wholeness of life and therefore the perfect source of life) involved ensuring separation from death and anything associated with it. This was because death was the antithesis to the life of God and so less than perfect, unclean and therefore unholy (1981:18-20). Thus the Levitical rituals were endorsed as a means by which people could avoid unholiness and therefore disobedience.

The law became the framework of the people's lives and existence and at the heart of the law was love. Indeed, it was through the law that God was able to show His love for the people, whilst it was through the law that the people could show their love for Him. Love then, was the basis of the demands of the law and was also the motive for obeying it (Deuteronomy 4 740, Leviticus. 19:33) because paramount to the law was the command to love God wholeheartedly and to love one another (Field: 1995:13).

It was only by obeying God's commands that the people could show that they loved God for the two were equivalent. (Deutoronomy 10: 12) Thus loving God and loving one's neighbour became inseparable, with love being the means by which individuals could fulfil the entire law (Wright: 1983:158-160). Indeed by the people were maintaining righteousness by "doing right", such as ensuring justice (which is another form of holiness[19]) not lying, treating each other equally and looking after the environment properly. Therefore as Wright has recognised, the laws were given as a means by which the people could respond to God's love and maintain the covenantal relationship which He had first established with them. The law, especially the Decalogue, embraced all aspects of this covenantal relationship - God's act of redemption towards His people and the human response of obedience to Him - which was exemplified in loving others (1983:158-160).

Obedience in the Old Testament

A number of Old Testament texts suggest that obedience to God's commands - the means by

[19] Obedience to the command to be holy was a means by which the people could execute justice. This was because being holy not only involved cleanliness for as Wright has pointed out, Lev. 19 indicates the form of holiness which reflects God's holiness; it is practical and involves justice, equality and generosity towards the poor *(Living as The People Of God,* 1983:26).

which the people maintained a right relationship with Him and therefore with others – was conducive to health, if not a determining factor in good health. Indeed there are many texts which indicate that obedience to God's law means freedom from disease, whilst disobedience means the opposite[20].

There are many indications that maintaining righteousness - (a right relationship with God) was understood to be conducive to good physical health. For example, we find that a right relationship with God produces shalom (Isaiah 32:17) whilst righteousness and shalom flourish together (Psalms 72:7,85:10, Isaiah 48:18, Malachi 2:6) We also find that the pursuit of righteousness is the pursuit of life (Proverbs 11:4,19,28 and 30) Further there is the indication that those who are obedient to the law survive and live to a good age. For example, obedience and the maintaining of righteousness is illustrated in the lives of Noah, whose family alone survived the flood (Genesis 6:9ff); Joseph, who lived to see his greatgreat-grandchildren (Genesis 39:2, 21, 23; 50:22-23) and Abraham who lived to an old age and became a father of many (Genesis 12:4, 15:6,15, 25:8). Other biblical characters who maintained righteousness and were seen to live to a good age were Isaac (Genesis 35:29) and Jacob (Genesis 49:33). Moreover, longevity is promised to all those who obey God's law (see Deuteronomy 6:2, 30:20, 32:46-47[21]). These texts add weight to the contention that the Bible understands health as a physical concept, defined in terms of life, longevity and survival.

In the same way, in the Old Testament there is a link between disobedience (sin) and disease. For example, the ten discontented spies died of a plague before the Lord (Numbers 14:36-37) the Lord sent venomous snakes to bite and kill many Israelites when the people spoke against Him and Moses (Numbers 21:4-9); Miriam contracted an unclean skin disease because she spoke against Moses (Numbers' 12:1-15); a plague ("negeph") killed 14,700 Israelites following the rebellion of Korah (Numbers 16:41-50); again a plague killed 24,000 Israelites following the people's worship of the Baal of Peor (Numbers 25:1-9); the baby born to Bathsheba was ill and died as a result of King David's sin (2 Samuel 12:13-23); Jehoram contracted a fatal intestinal disease because of his unfaithfulness to God (2 Chronicles 2 1:11 19) and Gehazi contracted an unclean skin disease because of his greed and deceit - which the Lord decreed was then to be forever inherited by Gehazi's descendants (2 Kings 5:26-27).

The most obvious passage which associates disobedience with disease is to be found in Deuteronomy where God tells His people that if they disobey His commands then they would be cursed with physical problems (disease, famine, blight, drought etc) (28:15fl). Craigie has argued that in this particular passage the root cause of the curses was forgetfulness of God's law. Inevitably, by forgetting God's commandments, the people would be able to do evil deeds and thus bring about disaster (1976:342). For example, failing to keep the commandment to look after the land and treat it properly as God had intended would inevitably lead to famine. Thus as Craigie recognises, although God sends the curses, it is humans who have invited them because of their disobedience (1976:342).

However, the view that disease is sent by God must be put into its proper context otherwise the danger is that God is perceived as one who punishes immediately those who disobey Him. This is not the case and will be discussed in more detail at a later point[22]. The debate concerning

[20] Ex 15:26, 20:12, 23:25-26, Lev. 26:14-16, 23-26, Num.5:20-23, 27-28, Deut. 7:12-15, 28:27-29, 58-62, Pro. 3:7-8, cf Ps. 32:3-5, 38:1-8.

[21] There are other texts which indicate that a long life is promised to all those who obey God's laws: 1 Kings 3:14, Ps. 34:12-14, 91:16, Pr. 3:1-2 9:10-11, 10:27, cf. Eph. 6:1-3.

[22] It is not always the case that suffering is the result of individual sin, nor is it necessarily the case that sin will result in disease. See subsection 'The Relational Dimension and Corporate Personality'

creation and the entry of sin into -the world is complex and an issue upon which Christians are not of one mind. Nevertheless, as the concern of our discussion is primarily the effect that disobedience and sin have on creation and humankind healthwise, this paper will take the view below . When God created the world there was an in-built pattern of conformity and orderliness - consistency in every aspect of life (i.e. wholeness). However, owing to the disobedience of humankind's progenitors (Original Sin) disorder entered all aspects of the world, including health and wholeness. Thus disobedience to God's law (which reveals, and is the model of, the orderly pattern of living intended for the world being good relationships between the people and the environment), may result in disorder because of this original sin (Fountain: 1989:67fl). Indeed, Genesis 3 indicates that the disrupted relationship between God and humankind, because of Adam and Eve's disobedience to God, disrupts the natural order and pattern of life (von Rad:1996:274). In this vein, as Wright understands, Deuteronomy 28 is written as a warning, making the people aware that if they persisted in rebelling against God, disastrous events were unavoidable; the calamities were only avoidable by keeping God's law (1996:282).

Health and Spirituality in the Old Testament

In view of the link between health and disobedience, disease or ill health is not so much a question of punishment from God, but more the case of unavoidable consequences which humans may bring upon themselves through disobedience - which signifies a disrupted relationship with God. In this vein, it may be more appropriate to suggest that health is not equated with holiness as Wilkinson contends, but rather that physical wholeness is a result of holiness.

However, although obedience generally (at a social level) results in good health (i.e. longevity and physical strength), Job was obedient but suffered profoundly. Holiness and obedience are paramount over health and therefore the motivation behind obedience and holiness should not be to obtain health and prosperity; obedience should be purely out of loyalty and fidelity to God. Indeed Satan actually asked God, "Does Job fear God for nothing ?"(Job 1:9) That is to say can humans love and serve God for nothing for no reward (such as health and prosperity)? The story of Job implies therefore that it is obedience and holiness per se one's maintaining a right relationship with God - which is valued and that which God desires.

Thus in Deuteronomy 28 noted earlier, Fountain rightly recognises that God is calling his people to obedience and not to health and prosperity, although these may be the consequences of obedience. Nevertheless if health is the consequence of obedience then it is an extra benefit which serves the purpose of enabling individuals to function more effectively in God's kingdom here on earth (1989:136). Therefore if health and prosperity are received as extra blessings, such blessings will provide individuals with the strength to fulfil the role that god demands of us in society - loving others and looking after their needs.

Relationships and the New Testament

In the New Testament, the link between maintaining right relationships - (with God and therefore others) - and good health and human well-being is still clear, although the old covenant is now renewed with the coming of Christ. In the new covenant, the person in Christ was no longer under the terms of the old covenant but is still nevertheless, expected to fulfil the righteous requirements of the law. Thus the principles contained within the law were still

endorsed for indeed, Jesus quoted from the Old Testament when He commanded the people to love God with all their hearts and love their neighbours as themselves (Deuteronomy 6:5, Leviticus 19:18) (Wright: 1983:158-16 1). Then again in, Jesus informs a lawyer that these are the greatest commandments and goes on to say that "All the Law and the Prophets hang on (them)" (Matthew 22:3740). Thus the rest of the laws and the words of the Prophets are worked out from the command to love God and others.

Obedience and the New Testament

The New Testament also associates obedience to God's commands with the nurturing of a good relationship with Him. This is clearly indicated in the text "We know that we have come to know him if we obey his commands" (1 John 2:3) whilst other texts exemplify this by making it more personal (e.g. 1 John 3:24). It is also seen that Jesus associated obedience with love and did not see any contradiction here (John 14:15, 21, 23-24) (Field: 1995:13).

Further, as maintaining a right relationship with God and fulfilling the righteous requirements of the law are still endorsed in the New Testament, a causal link between disobedience and ill health is still upheld[23]. Believers were thought to be sick and some to have died prematurely because they did not participate in the Lord's supper in a proper manner (1 Corinthians. 11:2930) and Jesus Himself at times (cf. Mark 2:512[24]) appears to make a link between sin and ill health. For example, Jesus warned the man beside the pool of Bethesda whom He had healed to "Stop sinning or something worse may happen to you" (John 5:14). James also maintains a link between sin and ill health, in keeping with Second Temple Jewish belief generally (James 5: 15-16).

However as it was with the Old Testament, a lack of good health does not always signifies sin and disobedience, nor does obedience to God's law always guarantee good health. Indeed, often the righteous become ill, whilst the unrighteous maintain good health. On the other hand, ill health can occur in order to exemplify God's goodness. For example, in the New Testament Jesus contends that the man's blindness is not the result of sin, rather it occurred so that the work of God could be displayed in his life (John 9:13). Paul also had to come to terms with the fact that he suffered through no fault of his own (2 Corinthians 12:7-10, Galatians 4:13-14[25] cf. 1 Corinthians 2:3, 2 Corinthians 4:16).

Health and Spirituality in the New Testament

Health is understood as the means by which a more spiritual role can be fulfilled on earth. For example, some biblical texts esteem good health mainly because it enables the individual to fulfil a spiritual role - Jesus constantly searches for time apart at the start of His public ministry

[23] There are occasions when individuals die because of disobedience, although we are not informed if the cause of death is disease.

[24] The Galileans whose blood Pilate mixed with their sacrifices or the eighteen who died when the tower in Siloam fell on them were merely not more- sinful than their contemporaries (Lk. 13: 1 -5).

25 There is no scholarly unanimity as to the precise nature of Paurs' thorn in the flesh' in 2 Cor 12:7-10. In the Jewish scriptures this expression is used of Israel's enemies (Nu. 33:55, Jos. 23:13, Jdg. 2:3, Eze. 28:24), while in 2 Cor. 11: 13- 15 Paul himself describes his human adversaries as Satans servants (cf. 2 Cor. 12:7 where he describes his 'thorn! as 'a messenger from Satan'). Hence it could be a reference to human adversaries rather to a physical illness. Gal. 4:13-14 is also ambiguous. Paul's 'illness' (NIV) is more literally, a 'wealmess/siclmess of the flesh' (v. 13) and a 'testing/temptation in my flesh' (v. 14). This could just as much refer to a spiritual malady as to a physical one (poor sight is the traditional suggestion: cf. Gal. 4:15, 6:11). Nevertheless, whatever their precise nature the key point is that these are undeserved weaknesses, which elsewhere certainly comprise physical weaknesses (see 2 Cor. 4:16).

with this in mind (see esp Mark 1:2931, 35-38). However, the value of health in itself is limited in the New Testament and this is the inevitable corollary of having a perspective of eternity. For example, Jesus uses typical rabbinic hyperbole to point out that it is better to enter "eternal life" physically maimed than to enter "gehenna" physically whole (Mark 9:43-48). Paul similarly advises Timothy that "physical training is of some value, but Godliness has value for all things." (1 Timothy 4:8) (NIV). Paul is also content that physical death is to his own personal advantage (2 Corinthians 5:8). This insistence that physical health is not of infinite value may help to explain why certain texts appear to be at ease with the notion that God at times selects some and not others to be healed (eg. Luke 4:24-27 cf. John 5:1-9a).

Further, in the New Testament if God's call is in conflict with good health, God's call must take precedence (cf Hebrews.12:2). This is also borne out in the death of Stephen (Acts 7) and the life of Paul (2 Corinthians 11:23b-27, Galatians 6:17; cf. Philip 2:30). Within the Pauline perspective, however, not only is good health of merely relative value, it is at best an approximation. For Pauls view is that ever since the fall, good health has been temporary. Physical life is no longer intended to be lived forever, rather death is inevitable, short of the denouement of the age (Romans 8:23, 1 Corinthians 15:42-44, cf. Genesis 3:19). The redeeming work of Christ does, nevertheless, reverse the consequences of the fall, but Paul saw a fundamental distinction between our spiritual and our physical redemption. Believers have the former now; yet while they can (by the power of the Spirit) also have a foretaste of the latter on this earth, they have it ultimately and by right only in the life hereafter (Romans 8:10,18-24; 1 Corinthians 15:42-57). Indeed, some scholars would argue that our present physical troubles are perceived to be almost a direct prerequisite to our glory in eternity[26] Essentially then, in the New Testament it is one's spiritual condition, one's service to God that is of importance and value and in this vein, the New Testament continues with the Old Testament's emphasis upon obedience to God and responding to His call and commands.

Summary of the Nature of Relationships

Holiness and obedience to God are the means by which we can have a relationship with Him obeying the command to love Him necessarily involves loving others. Moreover, in accord with contemporary theologians such as Atkinson[27], this paper has found that the Bible indicates throughout that it is holiness and obedience (as opposed to health) which is paramount. It is therefore, our relationship with God and accordingly with others - our spiritual condition - which is of concern in the Bible. Indeed many texts indicate that it is the nature of one's spiritual condition which may determine health. However, it is not necessarily the case that a right relationship with God (i.e obedience to His call and commands out of love for Him) will result in health nor should health be the motive for obedience - for this would not be love. On the contrary, love is a response to someone simply for who that person is; genuine love is when it is given recognising that there is nothing in return - no reward - for love is unconditional and given freely. However, if health were to be a result of obedience, it is clear that it may provide the means by which individuals can obey God (i.e. love Him) and serve Him.

Understanding that one of the determining factors of health depends upon the spiritual condition of a person (i.e the nature of a person's relationship with God) has relevance for today. For example in a materialistic society such as our own, it is easy for us fall into the

[26] Kim, 'Salvation, stresses the point that suffering is an integral and essential part of the Kingdom Of God this side of the eschaton: Jesus and the various writers in the New Testament agree that Christians *are bound* to suffer" (195, italics his) (See also 2 Cor. 4:16-5:10. However it must be noted that suffering is not necessarily always from ill-health (Rom.5:1-5))

[27] *Health: The Strength to be Human,* P. 30, Fergusson. (ed.)

temptation of making materialism our idol and to love and cherish it rather than God. Disobeying God's commands and therefore failing to love Him wholeheartedly and instead, loving the promises of modem society will not only disrupt our relationship with Him but could also lead to ill health. Indeed, some ill health could be induced because of the way in which we are endlessly pursuing earthly products which fail to satisfy our needs. Consumerism and materialism can lead to problems such as debt and financial insecurity and individuals who experience problems of this nature might resort to unhealthy behaviours and habits (such as drugs and/or alcoholism) in order to find solace. As a result financial insecurity, debt and alcoholism can often give way to fear, anxiety and poverty and therefore cause ill health. Thus, much of the ill health today could be because we neglect our responsibilities, for in focusing our lives and love on other factors, rather than on God, we are in danger of easily adopting habits and lifestyles which may harm our health. Therefore, we all as members of society have a measure of responsibility for our health.

iv) Holistic Persons

It is clear that the Bible understands the nature of persons to be multidimensional. Indeed it is the condition of the spiritual dimension of humans which may determine or affect the physical state of the person. Hebraic thinking emphasises the holistic nature of persons and this is borne out by the Pauline insistence on physical resurrection (see for example Romans 8:11, 1 Corinthians 15:12-58, 1 Thessalonians 4:13-18), which suggests that the physical body of persons was an integral part of a person's identity. In view of the multidimensional nature of persons, it is necessary to set out the key concepts involved in a biblical anthropology in order for us to fully comprehend the biblical understanding of health and its implications for today. Indeed, scholars such as Atkinson and Fergusson have also recognised the need for a theological anthropology, understanding that if health/health care is to do with human needs and interests, it is essential that genuine human needs be identified and this will involve understanding what it means to be human (1993:19).

Atkinson discusses how it is Jesus who provides the blue print of what it means to be human; it is from Jesus' life that all human life takes its reference and thereby falls short of God (1 993 19-20). Moreover, humans may identify themselves with the experiences of Jesus for His life also reveals the importance of the emotions and the relational dimension of life. Indeed, Atkinson rightly understands that human life is relational; Jesus' life was a life lived for relationships and it is He who shows that to have a relationship with another person is an expression of what it means to be made in the image of God - who Himself is a trinity of persons in relationship. To be human therefore involves relationships, for life is lived in the context of relationships - with God, self, others and the environment and all life is interrelated and interdependent (1993:20-22). Further, by referring to Hebraic thought which perceived the unity of the human person, Atkinson rightly understands humans to be "embodied souls and ensouled bodies without distinction" (1993:22). Atkinson's commendable theological anthropology (very briefly noted here) can be built upon, thereby adding weight to the contention that humans are holistic, whilst still retaining a physical concept of health itself.

Humans as Emotional, Spiritual, Physical. and Relational Beings

By highlighting the different aspects of Jesus' life, Atkinson endorses the point that the Bible understands that humans are multidimensional creatures - humans are holistic beings. Indeed,

Wright[28] points out that persons have spiritual, emotional, mental, relational and physical aspects which are interrelated. First, humans were created to have a relationship with God and therefore have an awareness of Him (our spiritual dimension). Secondly, God made us physical beings and therefore the body itself is not evil. Thirdly, humans are creatures who have a mind; we are rational beings and therefore our behaviour is questionable and accountable not only to God but also to others. This rational aspect is, in other words, our mental dimension and also includes the emotional aspect of humans. Finally, Wright points out that humans have a relational dimension for this is implicated in the creation story when God stated that it is not good for man to be alone (see Genesis 2:18.)

It is only through a theological anthropology that one is able to understand the relationship between these emotional, spiritual, physical and relational dimensions of persons. In turn, recognition of their interrelatedness provides support for the view that it is the condition of the spiritual dimension which can determine, or have an effect upon, the physical dimension. However, the remaining part of this subsection ("Holistic Persons") will be primarily concerned with the mental dimension (the rational and emotional dimension - the mind) together with the physical and spiritual dimensions. The relational dimension, and its connection with the spiritual and physical dimensions, will then be discussed in the following subsection ("Relational Dimension and Corporate Personality").

A Theological Anthropology - The Heart

Most scholars[29] would argue that although there are a number of terms to describe the person (Hebrew:"leb", "nephesh", "basar" and "ruah") the most anthropological term used to describe the person was the heart ("Leb", "Lebab"). Indeed, the main use of the heart in the Bible was to refer to, or signify, the centre of human personal activities[30]. In Hebrew thought, the heart was believed to be the source from which the principles of one's activities had their origin (Hastings: 1963:369). Moreover, as the chief organ, it was understood to be the source of all physical, intellectual, emotional and volitional energies. As such, it was believed to be the dwelling place of the thoughts, plans (see Proverbs 16:9), fears and hopes that which determined the character of individuals. Therefore references to the heart mainly signified the psychic (i.e. the mind - the rational and emotional dimension of humans) and because of this the term "heart" only incidentally refers to the physical organ. Thus primarily, the heart was understood to denote the ... psyche' at its deepest level" (Dentan:1980:549) and in this way it was equivalent to the spirit and innermost part of the person (see Psalm 64:6)[31] .

Numerous texts indicate that the heart signified the mental aspect of humans and that it was the source of the emotions (see for example 1 Kings 8:38 and Isaiah 30:29). Indeed, there are a number of texts indicating that all human emotions were attributed to the heart (Proverbs 27:11, Nehemiah 2:2[32]). The heart was understood to be the source of the intellect and the

[28] Dr. C. J.H. Wright unpublished lectures *(The Doctrine of Humanity* (8.11.93 and 15.11.93)) (All Nations Christian College)
[29] Wright, Anderson and Hastings have all indicated this
[30] The Old and New Testaments have similar perceptions of the heart (for further details see also Dentan, P.549-550 in *The Interpreters Dictionary of the Bible* Ed. G. Buttrick Vol. 2 P.549-550, 1980
[31] See Dentan, 1980, P.549.

[32] The heart could also be courageous (2 Sam 17: 10). See Jubilee Working Paper Biblical References Concerning The Emotions (1997).

functions ascribed to it were those which modem thought would associate with the brain (Wolff. 1974:46). For example, in Hebrew thought the heart was understood to be the seat of understanding and also purpose and determination (Exodus 14:5 (AV) 1 Samuel 7:3, 1 Kings 8:48) and consciousness (1 Samuel 2: 1); it was the place where thoughts arose (1 Chronicles 29:18) and where the quality of wisdom could be found (Exodus 31:6 (AV)[33]) (Dentan:1980:550). As such, the heart was the place where the decisions were made (Wolff. 1974:44).

The heart was also associated with moral character, for it was understood that it was from the heart that the warning of conscience were said to arise (Job 27:6 (AV)) and in this respect, as the idea of conscience is connected to the moral character, the heart itself was believed to be associated with the moral life (Hastings: 1963:369). Indeed Dentan has pointed out that as the heart was the centre of the intellect it is only natural to understand that it was also the centre of the will and therefore moral life. In this vein therefore, Hebrew thought understood that the heart could plan wicked deeds and also become perverted (Proverbs 11:20). Generally speaking, the human heart was perceived as being corrupt (Jeremiah 17:9) and full of evil (Genesis 8:21, Ecclesiastes 9:3) (Dentan:1980:550).

In the New Testament, the Hebrew understanding of the heart is perpetuated. Indeed some of Jesus' words are influenced by the ancient scripts of the Jewish Church which associated the heart with the moral dimension of life (Luke 6:45 cf. Matthew 12:34ff, 15:18fl). For Paul the heart is the seat of the determination and will, and he indicates that the conscience is a function of the heart (Romans 2:15). In accord with the Old Testament, Pauline thought held that the moral and spiritual life (having its basis in the innermost part of persons) arose from the most vital organ of their personal entity (Hastings: 1963:369).

In view of the heart's wide range of functions (physica1[34], emotional and intellectual), Dentan understands that the term "heart" is equivalent to the term "personality" and as such, it was directly accessible and open to God and therefore exposed to His guidance (1980:550). The heart, as the personality, referred to the totality of human emotions and as such, its activities would correspond to what we would understand as the feelings, thoughts and desires of a person including grief, joy, and the mood, temperament and attitude of mind - even the irrational aspects of humans (Wolff.1974:44). Recognising that the heart was perceived as the personality and the place in which decisions and impulses had their being, has led Wolff to concede that in the Bible, the "essential activities of the heart are mental and spiritual in kind' (1974:44).

Non-Dualism

It is by understanding the functions of the heart that we can comprehend the biblical understanding of the intricate relationship between the different dimensions of the person and how each dimension - in particular the spiritual dimension - can affect health. Because the

[33] For further intellectual functions of the heart, refer to the Jubilee Working Paper, *Biblical references Concerning the Emotions* (1997).

[34] Although the heart is mentioned over 800 times in the Old Testament, very little is said of its anatomy and physiology. Wolff has said that it was primarily in sickness that the Israelites began to recognise the heart as being the central and crucially vital organ of the body (1974:42).

heart was the source of the mental dimension and therefore closely associated with the moral conscience, it was also interrelated to the spiritual dimension. This suggests that the emotional and mental activities and dimensions of the person are interrelated to, and therefore could affect, the spiritual dimension. In turn, the Bible also indicates that the state or condition of these dimensions (the spiritual and mental) being closely connected, could then affect the physical dimension and its well-being.

There are a number of texts which suggest that the condition of a person's heart (the mental dimension) could influence the state of the physical body. For example "A heart at peace gives life to the body, but envy rots the bones", whilst the NRSV renders heart as mind and so reads "A tranquil mind gives life to the flesh." (Proverbs 14:30) This suggests that a tranquil mind, that is to say a heart which is focused on God (i.e. loving God wholeheartedly) and therefore obedient to Him (obeying the command to love others, i.e. not envying them), would be beneficial to the body. The Wisdom writers understood that if uncontrolled, emotions and feelings such as grief and worry, could affect the body and ultimately have control over a person's whole being (Oesterley:1929:115). Indeed, Proverbs indicate that moral disorder such as uncontrolled passion will result in ill health (Aitken 1986:154), as will other disturbed emotions such as moroseness. For example, we are told of the benefits of a happy disposition, whilst also being warned of negative feelings healthwise ("A cheerful heart is good medicine, but a crushed spirit dries up the bones" (Proverbs 17:22)). Therefore, the Bible instructs us that for our own benefit, we are not to entertain unbalanced emotions and feelings and once again the implication is that with regard to our health, it is obedience to God's ways and His intentions that are to be cultivated (Wolff. 1974:44).

Although the Hebrews identified different dimensions to being human, contrary to Cartesian dualism, no sharp distinction was made between the physical and the psychic (the mind). This was mainly because the personality (i.e the heart being understood as the mind or mental dimension) was believed to be spread throughout the whole body (Dentan: 1980:549-550). Indeed, scholars such as Wright[35] and Wolff[36] have found that the terms used to denote the person ("nephesh", "ruah", "lebab" and "basar") and therefore the heart, were used interchangeably and could also refer to the physical dimension of humans.

For example, Wolff has found that nephesh (or nepes) could refer to the whole being (Genesis 2:7). Nevertheless, it also denoted the neck and the throat and it is in this connection that nepes became associated with the emotions. Indeed, we read of the insatiable desire of the throat in Ecclesiastes 6:9. On the other hand, the sense of human vulnerability and neediness is stressed by using nepes to describe the neck, which the Bible points out could be endangered by the sword (Jeremiah 4:10). Recognising the use of nepes to refer to the neck and the throat - being organs of vital needs - could indicate that nepes carried the emotional connotations of desire and yearning (such as food and water etc. see Proverbs 16:26) and thus represents unlimited desire and yearning. "Nepes" does at times also describe emotions such as lust in a treacherous sense (see for example Proverbs 23:2) (1974:11-17).

Because of its associations with the seat of desires however, "nepes" could also be extended as the seat and action of other spiritual experiences and emotions. Indeed, "nepes" could signify the soul and in this sense could again refer to needs or desires for as Wolff has shown, this was the case with Job who understood the soul to be the central organ of the suffering human. Wolff supports his understanding of nepes by highlighting a number of texts which understand "nepes" (or soul) to be associated with the emotions. For example, we read that the soul can be

[35] Unpublished lecture, The Doctrine of Humanity (1993). All Nations Christian College.
[36] See Anthropology of the Old Testament, SCM Press, 1974

in despair and disquieted (Psalms 42:5fl) and also feel distressed (Proverbs 31:6), whilst other texts show us how the soul itself can be troubled because of illness (2 Kings 4:27) (1974:17-18).

Unity of the Whole Human Body

In understanding that the personality was spread throughout the body and that there was no distinction made between the physical and psychic (i.e.. mental / mind), in Hebrew thought it was not only the external organs of the body - such as the neck and throat -which were associated with the mental functions of the heart, but also the inner organs. Indeed particular texts suggest that the inner parts of the body also bear the ethical and spiritual aspects of humans (Proverbs 23:16) It is clear for example, that the bowels ("quereb") were also associated with the emotions and had psychic characteristics, whilst the kidneys were believed to be the seat of the conscience. (Wolff. 1974:63-65).

As the personality was dispersed throughout the body, the emotions and feelings of a person could be located anywhere and therefore particular psychic functions cannot be assigned to particular organs (Detan:1980:550). Indeed, in Hebrew thought it was understood that even the flesh (basar) - the whole being itself - could have psychic functions and was (as already indicated) an outward manifestation of the soul (Buttrick:1980:276). Wright points out that basar is not only related to, but functions in correspondence with, the spiritual state and that therefore the spiritual dimension has an effect upon the physical dimension of a person. He understands that when we are obedient to God there are blessings to our flesh and bones; conversely when we refuse to obey God and His will this may result in distress[37]. This is borne out in a number of texts, in particular Psalm 38:3, "Because of your wrath there is no health in my body; my bones have no soundness because of my sin".

Therefore it is clear that although multidimensional, there was a greater sense of the unity totality or "wholeness" of the person. This is indicated in Psalm 84:2 which, by referring to heart flesh, soul and will, shows all the ways in which to describe the whole (or one) self ("My soul yearns even faints for the courts of the Lord: my heart and my flesh cry out for the living God'")[38].

Implications

In the light of the influence of science, reductionist philosophy, Corrosion dualism and a mechanistic approach towards the body and health, biblical insight concerning the holistic nature of persons is significant for today. Current research is pointing in the direction suggested by our biblical analysis. Science is seeking to prove that there is a connection between the brain and the immune system, not only showing that the emotions and stress can affect the immune system[39] but also, therefore, how the psychic or mind, is linked to the

[37] Taken from Dr. C. Wright's unpublished lecture, The Doctrine of Humanity (1993).
[38] The Doctrine of Humanity (1993).
39 For further information see Jubilee Working Paper, Stress, Disease, Relationships and Social Support (1997).

physical. In this vein Cartesian dualism, separating the physical from the psychic is beginning to be challenged - although it is acknowledged that further research needs to be undertaken in this area. Nevertheless, evidence suggests that stress and the emotions (being mental or psychic) can diminish the functions of the immune system (physical) and thus cause certain individuals to become more susceptible to disease. Kennedy et al, for example, have found that one's susceptibility to disease increases because of immunological changes which are linked with psychological distress (1988:84).[40]

Evidence of this nature is consistent with biblical thought which understands that bodily organs are interrelated to, and therefore can be affected by, the psychic or emotional condition of the person. Thus such evidence adds weight to the biblical view that owing to the interrelatedness of the human body, persons may benefit healthwise if they are fully integrated with God, having a right relationship with Him through having an open and obedient heart[41]. In addition, the biblical understanding of the holistic nature of persons indicates that a strictly scientific and reductionist approach towards the body is in danger of depersonalising patients and undermining other factors and causes (such as emotional and spiritual) which can contribute to ill-health.

v) The Relational Dimension and Corporate Personality

So far we have found that the Bible understands health in primarily physical terms with one of the determining factors of health being a person's spiritual condition. On the whole, the Bible suggests that one's health largely depends on the nature of one's relationship with God, which necessarily influences relationships with others. In order to maintain a right relationship with God and thus maintain one's health then, a person needs to be focused on God and this requires loving Him before anything else. Indeed, it involves keeping His commandments which involve loving others and looking after their needs and well-being.

Conversely, failing to love God - (largely manifested through being disobedient to His commandments) will often result in neglecting the well-being of others. The Book of Isaiah provides numerous examples of how the well-being and needs of the weaker members of society were neglected, because the more powerful failed to love God and keep His commandments which by nature ensure justice and equity. The implication is that as we are instructed to keep the commandments (which protect the well-being of others) and love one another (a sign that we love God), we have a responsibility for the well-being of each other. In this vein we recognise that our relationship with God -our spiritual condition- may affect not only our own personal health but also the nature of our relationships with others and accordingly their health.

The Interrelatedness of all Life

In the previous subsection ("Holistic Persons') we saw that the Hebrew term "basar' was used to denote the person or body and was also interchangeable with the term "leb" (heart). "Basar"

[40] Stress, Disease, Relationships and Social Support (1997).
[41] A Person being fully integrated with God as conducive to health is a view that is put forward by D. Fountain in Health, the Bible and the Church, Published by Wheaton College, Billy Graham Centre, 1989.

however in Hebrew thought not only denoted the individual person or body as such, but was also the means by which the fourth dimension of humans was conveyed - the relational dimension. Indeed, the Bible[42] indicates that "basar" not only referred to individual but also to communities - communities shared their "flesh". In this vein, scholars such as Hastings and Wolff recognise that flesh could refer to humankind as a whole[43]. Wolff for example, has found that "flesh" was used in association with the idea of binding people together - that in one sense it was, the legal term for relationship. He understands that basar represented and emphasised the relationship between all living things (1974:29). Flesh was used to refer to natural relationships, as shown for example in Genesis 2:23 ("The man said, 'This is now bone of my bones and flesh of my flesh. `(NIV)). Flesh could also refer to different units of relationship such as the family (Genesis. 29:14), the township (Judges 9:2) and the people (2 Samuel SA). These relational connotations have led Porteous to conclude that "Flesh almost stands for corporate personality" (1980:276).

Corporate personality was the term used to convey the Old Testament thought that the soul of the family was centred in one - the father - and that the soul of the people was centred in the King, whilst the nation of Israel was often perceived as one person (Isaiah 1:5). Here there is the sense that all of life was one whole and accordingly the actions and behaviour of individuals would manifest themselves in a corporate sense. Thus for example, King David's sin in 2 Samuel 24:17 led to the whole nation suffering with a plague (Solanki:1980:18). With regard to "basar" and corporate personality then, the implication is that humankind/society is one "person"; all relationships found within society will have an effect upon each other because all of society is interrelated. It is in this context that Porteous understands that basar became the basis of obligation to serve God and others (1980:276).

However, not only were humans interrelated, but all human life was related and connected to the environment. Indeed, as the subsection above "The Nature of Relationships" pointed out, human disobedience had an effect upon the natural order in creation. For example, there are a number of passages which show how human sin has implications upon the rest of creation (Genesis 3:17-18, 6:1314, Deuteronomy 28, Amos 4:7ff and Romans 8:20). Moreover, the sense of corporateness and interrelatedness also included the nature of humankind's relationship with God. Individuals would enjoy a relationship with God but through the community (i.e. corporately). It was, therefore the responsibility of the community as a whole to maintain the relationship with God, whilst individuals would enjoy the relationship through the tribe (Maddocks:1995:5). Therefore, owing to the interrelatedness of all life it was essential that the community maintained a right relationship with God in order to have well-being as a whole (Maddocks: 1995:4-5).

Obedience to God then, was a responsibility that both the individual and society shared this sense of responsibility expressed itself in Israelite law. Indeed, Elazah and Cohen show how the Torah emphasised social relationships, commitment, obligation and preferential action. Thus in, Jewish thought two concepts were endorsed, "humans are partners with the sovereign universe in the development and governance of the world" (and) "..every citizen is linked to his neighbour by covenant obligation"[44]. Thus for example, if members of society were "unclean"

[42] McCasland points out that the term 'flesh' in both the Old and New Testament is used in the same way (The Interpreters Dictionary of the Bible, Ed. G. Buttrick Vol. 2, 1980, P.276-277).
[43] Hastings, 1963. P.299; Wolff, 1974, P. 29.
[44] Elazah and Cohen, Polity, 4, 7.

or "unholy", they were unable to participate in and uphold the cultic activity, out of responsibility not only to themselves but also to the community.

If all life is interrelated, it is clear that within the biblical view of health, the spiritual condition of those who represent society (such as the King) or the spiritual condition of society as a whole, could determine or have an effect upon, the health of an individual. In this sense, therefore, illness or disease could occur through no fault of one's own. That is to say, a person could develop or contract an illness although the individual's own relationship with God was right. This phenomenon is clearly indicated in a number of passages. 'For example in Psalm 6:2 ("Be merciful to me, Lord, for I am faint: 0 Lord, heal me, for my bones are in agony." (NIV)), Anderson suggests that the supplication is a metaphor of a greater misfortune, which like any disaster, brought weakness and a general lack of vitality and perhaps illness. The Psalmist prays for deliverance because the disaster was understood to be (like any disaster in Hebrew thought) linked with sin and disobedience (1972:86-89). In this case the suffering occurs not so much because of the Psalmist's own negative spiritual condition (i.e. disobedience to God) but due to society's disobedience.

Again, in Psalm 102:5 (given the context in which this lament was written, being the destruction of Jerusalem) the afflictions of the individual may be related to the condition of the Jewish society at that time. That is to say, the illness of the individual is the result of the dis-ease in society which was brought about by sin and disobedience (1972:704-706). This is also the case in Isaiah 1:6 which refers to the desperate state of society because of its sin and disobedience to God's commands, and also in Ezekiel 32:27 and 37:11 (the Valley of the Dry Bones). In all of these passages the nation or society as a whole had a responsibility to obey God and His commands. Moreover, these texts also indicate that Israel's disobedience as a nation not only severed the relationship between herself and God, but also brought about her downfall physically within the created order, as an inevitable result of disobedience to God's laws which reveal an orderly pattern for all aspects of life. Thus it was not only the spiritual condition of the individual that could determine and affect health but also the spiritual condition of society corporately.

Implications

The idea of corporate personality together with the idea of the responsibility of society as a whole for the individual and also the belief of collective suffering (the latter being a result of society's disobedience), is evident in our own contemporary world. For example, human mismanagement of God's creation, thus indicating a broken relationship with Him has resulted in the outbreak of BSE and the human version of it (CJD). Indeed, despite warnings to the contrary, politicians have allowed dried and powdered sick sheep (i.e. with scrapie) to be fed to cattle. As a result, innocent humans now suffer and as the newspapers indicate, even those who deny themselves meat on the grounds of animal rights cannot escape the outcome of society's disobedience to God. Air pollution, chemical waste and radiation, which are known to result in various forms of cancers and disasters such as Chernobyl, are caused at root by society's broken relationship with God (disobedience to Him and His intentions for life and creation) and consequently a lack of love and concern for others.

There are many more examples of society's negative spiritual condition as a whole -and/or the negative spiritual condition of those who represent society- which potentially can have an

effect on the health of society. Society's neglect of God's pattern for life (which is revealed through the commandments) might result in disruption to the natural pattern of life that God has ordained for both the environment and members of society.

vi) Summary and Conclusion of Section Two

In essence, the Bible understands health to be a physical concept although this is pursued in the context of a broader vision for human well-being. Health was understood to be physical strength, longevity and the ability to fulfil social and physical roles within the community. Throughout the Bible the two main factors determining health were the individual's relationship with God and the community's relationship with God. Maintenance of this relationship required obedience to God - loving Him and loving others with this being the fulfilment of the laws. Indeed, the laws revealed the nature of loving relationships and it was therefore through keeping God's commands that the people could actually show their love for others and thus show their love for God in obedience to Him.

Understanding health as being associated with humankind's relationship with God, demonstrates that the spiritual condition or dimension of persons which could determine their state of health. It also shows us that the Bible understands humans to be holistic beings. Indeed, the Bible depicts how the emotions, being closely associated with the spiritual dimension through the conscience, could influence the physical dimension. Thus the human person was understood to be a psychophysical unity, with no sharp distinction being made between the physical and psychic. In biblical thought having a mind which was attuned to the will of God (i.e. loving Him and obeying the commandments) would be beneficial to the physical well-being of a person because it would be in accord with the consistent pattern for life revealed through the Law. Conversely, a mind that harboured feelings and emotions such as envy (being a sign of a disrupted integrated relationship with God) would inevitably run the risk of being a negative influence upon the physical dimension.

Further, as loving God and having a right relationship with Him means loving others, our broken relationship with Him (our lack of love for Him by disobeying the commandments which instruct us to look after others) would be signified in our failure to love other people. Thus bearing in mind also that we are *social and interrelated* creatures, having a broken relationship with God could affect not only our own health, but also our attitude towards, and relationship with, other people. This in turn could affect their health and well-being. Practically speaking, this can be seen today. For example, breaking our relationship with God through adultery, can often result in the physical ill-health of both the innocent and guilty as a result of sexually transmitted diseases.

Moreover, in general poor relationships with one another (often indicating a lack of concern for each other) can have a negative effect upon health. For example, research carried out by Kennedy et al, has found a link between the quality of interpersonal relationships and health (1988:84). Indeed, other sources have found that those who have unsatisfactory interpersonal relationships are more likely to adopt unhealthy habits which in turn may lead to ill health (Duck:1991:164-165)[45]. Turning to marital relationships, those who experience marital disruption and divorce, also experience stress which may result in physical and emotional disorders (Bloom et al: 1978:869). It is evidence of this nature that adds weight to the biblical

[45] See Jubilee Working Paper, Stress, *Disease, Relationships and Social Support (1997*

view that having a right relationship with God may affect us healthwise not only on an individual level, but also on a social level.

Indeed, failure to heed to God's commands may have ramifications for others. The Bible demands that society is to be obedient to God and warns that if it is not faithful to Him and fails to uphold His commands then society as a whole could suffer (see Deuteronomy 28:15ff for example). Thus innocent individuals could suffer as a result of society's spiritual condition (its relationship with God and therefore others) as a whole, or because of the spiritual condition of those who represent society (i.e. King/politicians).

Ill health then, is not necessarily a direct result of individual sin, but can be the result of the sin of others or society and this we can see, is apparent in modem Western society. Here social inequality and injustice has mainly occurred because Western society no longer loves God wholeheartedly; it fails to obey the commands to endorse justice which is another form of holiness and a means by which we can show our love for others and therefore God. Instead Western society cherishes its own self-made values and norms such as individualism, consumerism and economic principles which take priority over and above human values and needs and are therefore opposed to God's laws**.** It is the sin and disobedience of Western society as a whole - the sign of a broken relationship with God and lack of love for Him - that has contributed to the rise in numbers of people who are homeless and also to widen the gap between the rich and the poor.

This lack of love for God and therefore others inevitably manifests itself healthwise. Indeed, the marginalised members of our society may turn to drugs, sex or alcohol in order to find a sense of love and solace. In turn these unhealthy behaviours can result in forms of ill health such as liver cirrhosis, Aids and other sexually transmitted diseases which are clearly on the increase. Moreover, research has also found that the poorer members of society who live in inadequate housing are more likely to suffer from respiratory diseases (Macintyre:1986:405-406).

The biblical view of health, in which humans are holistic against the background of a physical understanding of health, informs respectively both members of society and health professionals of their responsibilities concerning health. Furthermore, the biblical view of health addresses the roots of the issues surrounding health - issues which can cause health problems in the environment and society and problems for individuals. The Bible enables us to see that at the root of many of the problems and issues surrounding health is our failure to love God and observe His commandments which reveal to us an orderly, peaceful way of life, and also promote a just and loving society. Indeed, factors such as environmental, social and/or economic structures (resulting in injustice and poverty) which can contribute to many health problems, are often the result of our failure to love God and focus upon His intentions for life. Therefore the biblical view of health, together with its understanding of relationships, persons and persons in relation to society, indicates that both individually and as a society, our failure to love God and keep His commandments (thus breaking our relationship with Him and others) has implications for our health today.

3. Health Care Relationships

A: Health Care Provision In The Bible

Section Two discussed the importance of relationships - primarily with God and then with others -this being the central concern in the biblical view of health. The aim of Section Three, Part A, is to show why relationships are important for health care today and it therefore commences with a general discussion of this issue. Following this there are two subsections which provide the basis for Part B: the first examines a biblical understanding of health care, whilst the second briefly examines and applies the importance and relevance of the biblical view of health care for contemporary society.

i) Why Relationships Are Important

Section Two has pointed out that our relationship with God and with others can influence not only our own health, but also the health and well-being of others. It emphasised that, as social and interrelated beings, if our behaviour is not in accord with God's commandments - which reveal the nature of loving relationships and are intended to promote well-being - then it is inevitable that the well-being of others will be endangered. This can be seen to be true today in the delivery of health care. Here, relationships are a vital factor in the efficient and effective delivery of quality health care for it is known that diagnosis and treatment are aided by the continuity of relationships between medical staff and patients. Thus with many staff involved in the care of a patient, relationships and relational skills - which underpin the co-ordination and planning of services - plus communication, co-operation, teamwork, trust and goodwill between staff, are essential for good treatment. Conversely, low morale and poor relationships may result in a lack of communication and collaboration between staff (both medical and non-medical - such as managers) and between health care organisations - such as health authorities, social services and hospital trusts. In turn, poor communication and collaboration can lead to a lack of co-ordination and planning, which could have an effect upon health care delivery and patient well-being[46].

ii) Models of Biblical Health Care Provision

Specific instances of health care provision in the biblical texts provide valuable insight in terms of health care structures, priorities and principles. However, there is little textual or archaeological evidence for institutionalised health care in the biblical world. Indeed, direct biblical models of health care provision amount to the collection of practices laid down for ancient Israelite priests primarily in the Old Testament book of Leviticus.

Laws and Rituals

The ritual laws promulgated in the book of Leviticus (the Priestly Code) have a primarily

[46] See T. Robson's paper, Relational Health Care, Relationships Foundation 1996.

health/hygiene motivation[47] and this at first appears to be quite plausible. For example, the commands to eat meat within a short period of time after cooking it (7:15-18, 19:6-7), not to eat carrion eaters or pork at all (11:7, 13-19) and to wash with water (11:40, 13:54[48]) are good practice medically in view of the hot climate. Other commands which discourage eating dead carcasses (17:15-16 cf Exodus 22:31), eating offal (3:4, 9-10, 15, 4:11[49]) and touching dead bodies (11:39), along with commands to quarantine and isolate people who have infectious skin diseases (13:1-46), to incinerate unclean food and material (4:11-12, 7:19[50]) and to bury human excreta away from where people live (Deuteronomy 23:12-13), suggest an understanding of the causes of ill health which would be endorsed in modem societies. Indeed, the commands not to eat fat or blood (7:22-27, 17:10-14) are recommended today in order to avoid heart disease and high blood pressure. There are other laws also, such as the incest laws (18:6-14) which would promote a healthy community. Biblical texts indicate that if the people upheld such laws, they would not suffer - as the Egyptians would - from various diseases (Exodus 15:26 cf Leviticus 26:14-16). Here again therefore, we have an instance of the link between keeping Gods laws and health (cf. Section Two, Part B).

However, although a health/hygiene concern can account for some of the laws, it does not necessarily account for them all. Darling has discerned discrepancies in a number of those understood to be concerned with health and hygiene. For example, although burying human excreta may promote a healthy community, the command to do so fails to mention washing one's hands afterwards (1986:98). Further, Darling has pointed out that even with the texts which seemingly do endorse a health/hygiene concern, there are problems with interpretation. For example, the Hebrew word translated "leprosy" in the Authorised Version bears little relation to the "leprosy" of modem and New Testament times, and may well have been non-infectious, non-fatal and self-limiting. In view of the inconsistencies, Darling concludes that, "the Mosaic code on uncleanness, as given in the Pentateuch, was primarily ceremonial and only at times of practical use in the prevention of disease, though there are certain basic points of hygiene associated with the ritual" (1986:98). This is supported by further evidence in the New Testament where the earliest Christian communities and arguably even Jesus Himself were content in abolishing them (Romans 14: 14 cf Mark 7:19).

The inconsistencies within the Levitical rituals have given rise to many other theories which similarly come to the understanding proposed by Wenham[51] and have been briefly discussed in Section Two: that the Levitical laws are primarily concerned with theology and therefore with the holy being separated from the unclean. This explanation is in accord with the Ancient Near East background generally[52] and is expressed in a number of texts (Leviticus 11:44-45, 19:2[53]). Moreover a theological concern, as opposed to a health/hygiene concern, largely explains why the role of priests and Levites appear to be more concerned with declaring people healed or clean, than with specifically curative treatment. (It must be borne in mind however, that as

[47] A. Rattray, Divine Hygiene: Sanity, Science and Sanitarians of the the Sacred Scriptures and Mosaic Code (2 Vols: London: J. Nisbet 1903): AN- Short, The Bible and Modern Medicine (London:Paternoster, 1953), esp 37-46: McMillen, None of These Diseases (London: Marshall Morgan and Scott, 1963): S. Munter, Medicine in Ancient Israel', in Rosner, Medicine, 3-22, esp. 3-11. Such scholars invariably argue that these laws provide an eternal blueprint for good hygiene and healthy hying

[48] Other texts include Leviticus 13:58,14:8-9, 47,15:5-13,16-18, 21-22,27,16:28, 17:15-16.

[49] Other texts include Leviticus 7:4, 16:27, cf. 8:17, 9:11

[50] Other texts include 13:52, 55,57, 16:27 cf. 8:17, 9:11

[51] Wenham G The Book of Leviticus, Eerdmans Publishing Co. 198 1. and also, "Clean and Unclean, in New Bible Dictionary, Third Edition, Eds. I Marshall, D. Millard, J. Packer, D. Wiseman 1996

[52] See Wilson, *Holiness,* esp. his conclusions (93-96). For further ANE material, see Martha T. Roth, *Law Collections from Mesopotamia and Asia Minor* (SBLAWS 6; Atlanta Georgia: Scholars, 1995); New York Koln: Brill, 1997; 2 *more* volumes forthcoming).

[53] Other texts include Leviticus 20:7-8, 26, Numbers 5:1-4.

necessary medical knowledge to prescribe appropriate treatment had not been established, it is no wonder that the Bible does not seek to suggest forms of treatment.) Other practices, such as the burying of human excreta outside the camp, are also made sensible within an Ancient Near East background when they are understood to be efforts to keep the camp aesthetically pleasing in order that Yahweh might remain there and accordingly bless His people (cf. Leviticus 15:31) (Darling: 1986:97).

Although the Levitical rituals and laws are primarily concerned with theology, even if they did have a health purpose, they would still not provide a model of health care. Indeed, it is arguable that there are few direct models of health care as such in the Bible for although health and longevity were valued, it was understood that there was nothing one could do about health, except abide by God's law. Thus for the ancient Israelite, it was the Lord who upheld health (cf Deuteronomy 7:12-15). The point being made here is that "national models of health care provision" are essentially an anachronism for a pre-modern world. Any "health care" provision as such which extended beyond the home environment in the Ancient Near East, was invariably little more than an expression of the national religious cultus. Therefore not only was health care of little value healthwise, it would compromise Jewish faith.

Obligation and Responsibility

Although the Levitical rituals are primarily concerned with theology, they do have some status as an ancient health/hygiene code in that they uphold the notion that individuals have a responsibility to safeguard the health of society. For example, individuals have a duty not to touch dead bodies, not only for their own sake, but for the sake of others. The ri equally uphold the notion that society has a responsibility to individuals and that therefore individuals have a right to expect certain minimum health standards within society. In this vein, the Levitical model enables us to perceive once again, the importance of relationships within health and health care. Indeed, the Levitical model indicates the need for values which provide the basis upon which social relationships can flourish values such as duty, obligation and responsibility. It was values such as these which contributed to the health and well-being of the community.

The sense of communal obligation and responsibility is also continued in the New Testament with the emphasis being on the Christian community (cf. Romans 12:4-8, 1 Corinthians 12:12-31), which also had a social application (cf. Roman 12:8, 2 Corinthians 8-9, Galatians 6:10). indeed, in the specifically Christian scriptures the Church takes the place of Israel as the point of community reference, but community is increasingly encouraged to be seen in the widest possible terms. For example, Jesus uses the parable of the "Good Samaritan" to illustrate that the command second to loving God with all one's heart (i.e. loving one's neighbour as oneself) includes every person (Luke 10:25-37). Therefore, although it may appear that the primary responsibility is given to those who are in closest proximity (1 Timothy 5:4,8), this sense of responsibility became wider.

"Home Care"

It was the sense of obligation to, and responsibility for, one another against the cultural background of the Ancient Near East, that influenced the nature of any form of health care in Old Testament times. Here health care was the responsibility of the home, family and the community and there are a number of texts which indicate this. For example, when David's child by Bathsheba is terminally *R* the child remains at the palace whilst David maintains a

vigil (2 Samuel 12:15-18). Then again, when the Shunammite's son falls seriously ill, his father has him carried back home to his mother who sits him on her lap until he dies (2 Kings 4:18-20). The one exception to this understanding of home health care is the leper in 2 Chronicles 26:20-21 who is forced to live away from the community.

The story of Job highlights the need not just for physical care within the home but also for psychological care from friends and family who are willing to give support and encouragement through difficult times. Once again the emphasis here is upon our relationships with others as a means by which health and health care are to be promoted. Home health care and support also remained the primary setting for care in the New Testament. For example, in Mark 1:29-30, we find Peter's mother-in-law at home in bed sick with a fever, whilst although the texts in 1 Timothy 5:4, 8, 16, do not refer specifically to health, it is indicated that care and support for elderly dependants is in the first instance the responsibility of their families.

iii) Application: The Community, Social Support and Health Care

The Bible's insight concerning the importance of relationships, the responsibility of the individual and the community (society) for health and well-being, and the need for individuals to receive help and support from the community when presented with health concerns, is a view which is still endorsed in a number of traditional societies today. For example, Shorter has found that some African societies understand that the sickness afflicting the individual is often inseparable from the problems afflicting the society to which the individual belongs and therefore the role of the community or society in the healing process is essential. It is the community which normally cares for the sick, with family and friends gathered around the person concerned. By caring, it is understood that the community is performing a social therapy, with the main concern being the restoration of relational harmony and therefore social healing[54] (1985: 60-61). Closer to home, the biblical view of the community and social support in health care bears significance for our own society. Current research (discussed below) provides evidence which suggests that the role of others within health and health care and the healing process is vital.

Current Research

Argyle has found that when people are facing difficulties, turning to others for support may enable individuals to counteract and cope with the stress and problems in a number of ways. First, turning to others can increase a person's self-esteem and confidence. Secondly, social support could suppress depression and anxiety, for it is arguable that it may have a direct influence upon the emotions. Thirdly, the perceived external stress factors could be seen as less stressful if the individual has knowledge of available support and help. In addition, turning to others could safeguard the person from adopting unhealthy lifestyles which may give rise to ill health (19 8 8:242243).

Research carried out by Cohen and Wills concerning the role of social support in maintaining the health of the individual, reinforces Argyle's view. Their studies suggest that a lack of social support and social relationships may lead to ill health. On the other hand, they found that those who have spouses, friends and family - those who can provide psychological support and/or aid in times of difficulty - are likely to enjoy better healthThus Cohen and Wills would argue that

[54] See Jubilee Centre working paper African Concept of Health, 1997

generally, lack of positive social relationships may lead to negative psychological states. In turn, these states may influence health either by having a direct effect upon physiological processes which can influence a person's susceptibility to disease, or through patterns of behaviour which may increase the risk of disease and mortality (1985:311). Nevertheless, such evidence is not finalised for Cohen and Wills warn that although much can be said for the role of social support the "..mechanisms through which social support is related to mental health outcomes and to serious physical illness outcomes remain to be clarified" (1985:311). Indeed, Cobb also reminds us that as yet, the evidence concerning the relationship between social support and health as a protective factor is insufficient. However, Cobb has found that social support, in his words, "..facilitates coping with crisis and adaptation to change" (1976:302). Thus on the basis of his research Cobb argues that,

> *adequate social support can protect people in crisis from a wide variety of pathological states from low birth weight to death, from arthritis through tuberculosis to depression, alcoholism and other psychiatric illness. Furthermore, social support can reduce the amount of medication required and accelerate recovery and facilitate compliance with prescribed medical regimens* (1976:3 10).

Cobb's evidence here builds upon the understanding that the role of other members of the community can help *prevent* the onset of disease through helping individuals who are facing difficulties to cope with their problems. Moreover, Cobb is going a step further by suggesting that the community and social support can affect the amount of medical treatment required for recovery. His view is supported by evidence showing how some cancer patients today use social networks and support as part of their treatment and are finding that their medical problems tend to be more controlled than when they relied solely on medical treatment.

Reflection

In accord with the biblical understanding of health and health care, contemporary research has found that positive relationships and the role of the community are essential to health care. However, it is not being suggested here that the community/social support is an alternative to medicine and institutionalised care. What is being stressed is that as the Bible clearly shows us that we are interrelated and social creatures, and because individuals and society as a whole have a responsibility healthwise, the nurturing of good and honest relationships are vital.

B: Relational Health Care in The NHS

Part B discusses some of the difficulties within health care relationships which can potentially affect the delivery of health care; it then addresses these problems through biblical values and teaching. Hence, we will commence with a general discussion, highlighting a number of difficulties within the NHS which could have an effect upon relationships. Following this, the next subsection discusses in turn three case studies of health care relationships and some of the difficulties and problems experienced within them This subsection then closes with a brief summary and conclusion concerning the three case studies. The third subsection applies biblical values to these models so as to show how relationships can be restored and therefore how the provision of health care and patient well-being may be improved. it ends with a short reflection and conclusion to Section Three.

i) Difficulties Within The Health Service Today

Low Morale

Evidence suggests that morale amongst health care professionals is low. For example, as many as 4 out of 10 medical students are dropping out of practice within a short time of qualifying and up to 15% of medical students leave their course before completion[55]. Given the huge expense of their training (£250,000 to £500,000 each) this not only represents trauma for many individuals but also a substantial cost to the Exchequer. The BMA has also stated that a quarter of junior doctors have become so disenchanted with the health service that they are no longer working in medicine: it was found that one in four young doctors was not working in medicine in the three years after qualifying[56]. Also, it has been found that younger doctors are less likely than their elders to view medicine as a vocation; among doctors aged over 55, one in six viewed medicine as a vocation compared with one in a hundred among those under 30[57]. Further, two thirds of GPs who responded to a survey said that they wanted to leave the NHS[58] and according to the BMA, the number of GPs taking early retirement has risen by more than 50% during the last decade[59] and this reflects trends in the medical profession at large.

The low morale amongst health professionals may well be primarily a result of relational problems, which in turn could be the result of organisational and structural changes. Pratt, for example, has found that professionals such as GPs, feel undervalued in the system He has found that many have a low morale as a result of increased workload and uncertainty since the reforms (1995:3).

Re-Organisation and Competition

The reforms of the 1990's were partly implemented in order to establish an "internal market" for health services. The concept of the internal market is based upon the notion of effective competition in the private sector business environment and the operation of this particular market entails purchasers having a choice of where to buy care. As such, purchasing health care was initiated because the demand for health care has exceeded supply. Thus in order to find a means of rationing, purchasing was intended to make the rationing decisions more explicit and more -rational". Its central tenet was that District General Hospitals should provide all basic (hospital) services for a defined population. In rural areas as there is usually only one NHS hospital, choice is limited, whilst in conurbations there is greater opportunity for purchasers to choose providers and therefore more amenable conditions for competition. Arguably, the operation of the internal market is biased for, previous to its inauguration, the purchasers of care (district health authorities and GP fundholders) and the providers (mainly trusts) had a different relationship with each other. Indeed before the changes, most trusts were directly managed by their purchasers and so on separation, trusts - having more freedom - needed to make selfpreservation their priority rather than collaboration with the purchasers.

With the implementation of the internal market, then, a competitive environment was initiated

[55] Financial Times, 14/8/95. (See Relationships Foundation Report, Relational Healthcare, Tom Robson, 1996).
[56] Independent 4/7/95. (T. Robson report).
[57] BMA survey of 800 members quoted in Times 15112/95. (T. Robson report
[58] Financial Times 16/5195. (T. Robson report).
[59] Financial Times 29/9195. (T. Robson report).

within the NHS generally which arguably, operated on interests which were not entirely oriented towards patient health care, but rather self-preservation. This in turn however, has the effect of reducing the sense of co-operation between trusts and health organisations - co-operation and collaboration being essential to the delivery of health care. Indeed, the perceptions of conflicting and competing priorities and values - often linked to the allocation of resources - could find expression in difficulties of communication. The absence of shared common values and therefore vision in balancing such as cost control, quality, equity and rationing of services, has given rise to conflict and difficulties within a number of health care relationships. The point being made here then, is that collaboration, co-ordination, communication and therefore good working relationships need to be nurtured if health care is to be administered eflectively.[60]

ii) Three Case Studies of Health Care Relationships - A Crisis of Values?

Case Study One: The Doctor-Patient Relationship.

Briefly, under the 1990's reforms there has been a substantial move towards a primary care-led NHS, with the emphasis now being upon the health needs of the population, health promotion and preventive medicine rather than cure. This had led to the development of a number of initiatives such as the provision of out of hours care, health promotion strategies and practice charters. Indeed, with the implementation of the reforms, there has also been a greater awareness of the financial constraints and limited resources, and therefore the need to introduce managers to prioritise health demands and plan services. It was partly these issues which gave rise to the 1989 white paper "Working for Patients", which aimed to allow money to follow patients and had a large emphasis placed upon performance management, finance and planning how to meet the health needs of the populations[61]. However, Huntington argues that the danger in developing a Primary care-led NHS is that the "care" aspect of a "primary care-led NHS" could be neglected, with greater emphasis being placed on the "primary" (1996: 1).

The re-evaluation and development of Primary care (largely focusing now upon health promotion and the health needs of the population) is partly to address issues such as inequity and social and economic factors. Pratt however, has argued that the emphasis upon health promotion and the health of the population conflicts with the core values of GPs who tend to focus upon the individual and cure (1995:4,5 1); Huntington has gone so far as saying that GPs feel alienated because of the reforms. She argues that GPs believe that their traditional role of diagnosis, treatment and continuing care is becoming devalued by the 1990's policies and the govermnent's development of General Practice which, as she puts it, "..is mainly driven by managerial and public health agendas of which many GPs remain suspicious" (1996:8-9).

Within the present organisation and structure of the health service therefore, some doctors may find it difficult to provide the care of their choice. Indeed, Pratt and others would argue that under the reforms GPs find it increasingly difficult to provide continuity of care for the individual. Thus for example, rather than patients waiting for their regular GP, surgeries find that the practice will operate more efficiently if patients can consult whoever is available (Pratt:1995:59).

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[60] Taken from Tom Robson's paper Relational Healthcare, Relationships Foundation Report, 1996.
[61] For further information refer to Jubilee Centre working paper by Cathy Lewis, 1997 The Doctor/Patient Relationship.

One could also argue that the way in which primary care is organised (operating largely on business principles and values) may be in danger of undermining the importance attached to the amount of time that a GP can spend with the individual patient and the value of care given. Buxton for example, argues that although doctors have been given a greater role in increasing the well-being of the patient, they now find this difficult in a system which focuses upon financial targets and initiatives (1997:15). Moreover, with the emphasis upon the population rather than the individual, there is the danger that precedence is given to the health needs and interests of the population, rather than the individual as a person. In turn, this could have an effect upon the GP's relationship with the patient, with the patient feeling uncared for as an individual and therefore depersonalised. For example, Pratt points out that a particular practice may be concerned with reducing the common occurrence of obesity within the community by urging obese individuals to lose weight. Although the practice may achieve its aim it could, by taking a general approach, induce further problems for particular individuals, by causing them to feel guilty. In contrast, practitioners are required (in accord with their own core values) to take a different approach. By putting the needs of the patient first, practitioners would support individual patients in aiming to reduce weight and providing them with the reasons why this was in their interests (1995:5 1

Further, Pratt has also pointed out that although greater emphasis is placed upon population-based health care, overall resources have not been increased and the result is that there are less resources available for individual consultations. Accordingly, practitioners have to ration the amount of time that they spend with their patients (1995:53-54). With less time to spend with the patient the practitioner may find it difficult to listen to, and fully take into account, the illness narratives, personal circumstances and medical history of the patient (1995:22).

Doctors working in secondary care also find it increasingly difficult to provide individual care for patients due to the re-organisation of the NHS and meagre resources. Glazer points out that the strategy of extra contractual referral may undermine the needs of the patient and could have the danger of giving priority to more profitable patients. Indeed, he has found that when cases have to be prioritised, there appears to be less emphasis upon the patients' clinical condition but more emphasis upon economic issues; Glazer found that some purchasers would not allow treatment of complicated cases in their hospitals owing to the costs (1995:40-41). Laing has also found that some decisions concerning patients are based on the financial concerns and position of the fundholder, rather than the clinical needs of patients (1995:10-11). Glazer's and Laing's analyses indicate that due to social ideologies and economic principles, there is the danger that the health needs of patients may be judged and prioritised within these categories, rather than on their needs as individual persons.

It appears then, that there is a conflict of values - between the values of administrators, whose interests are (arguably) more oriented towards the health of the population generally, and the values and wishes upheld by GPs/individuals. Indeed, GPs are trained to care for sick people initially, not to safeguard healthy people. Moreover, the values of the managers and administrators lead to the understanding that clinical effectiveness and performance are to be measured in terms of reduced waiting times, the number of consultations, immunisation performance and drug expenditure. However, as Pratt points out, clinical effectiveness measured in this way conflicts with the values of GPs, for these measurements do not take into account the work of GPs and their relationship and encounters with their patients (1995:3 8).

The Effect of Bioreductionism

The influence of bioreductionism. may also put strain upon the doctor-patient relationship and therefore influence health care. Indeed, by focusing upon the disease process and malfunctions the professional is in danger of failing to recognise the patient as a person and accordingly, the patient may feel depersonalised and undervalued. This can occur in institutionalised care in which patients are in danger of being identified by their illnesses and conditions rather than as persons.[62]

The tendency of bioreductionism to focus on the symptoms and immediate cure (through medication) rather than seeking out factors that may be giving rise to the medical problems, can also add strain to the doctor-patient relationship. For example, take the case of an elderly gentlemen suffering from anaemia who is prescribed iron supplements. Although the supplements are vital for his physical health, they do not tackle the underlying problem which could be caused by a poor diet -a result perhaps of his inability to cook, financial problems or depression (i.e. losing the will to five). Failing to take into account the personal circumstances of the patient - which many patients believe to be the source of their complaint - may lead to tension and paternalism within the doctor-patient relationship, with the professional taking control in the healing process, as opposed to coming alongside and working with the patient. On the other hand, acknowledging and taking into account that other factors are involved in health and disease will strengthen the doctor-patient relationship by perhaps promoting trust, mutual respect and with regard to patients, by giving them the feeling of assurance in the sense that their health concerns of a non-medical nature are being recognised. However, as it must not be assumed that GPs are to take on board all the non-medical factors involved in health concerns, the *actual* treatment of such factors demands the need for GPs to be able to co-operate and collaborate with those agencies and professionals who can provide the necessary care.

Trust, respect and co-operation between the doctor and patient are essential for it is well known that the nature of the relationship between patients and their doctors is crucial to the healing process. Indeed, communication itself between the patient and the doctor has a result on the treatment and care - the outcome of the encounter[63]. It is vital therefore that doctors recognise that patients as persons are multidimensional beings whose feelings and personal circumstances may possibly be contributing to the cause of their illness. Thus doctors need to ensure that where necessary, patients are able freely to convey their illness narratives. These narratives are significant to patients - often being the means by which they "prove" that they are ill. More importantly, in the case of chronic illness, illness narratives enable persons to put the illness into context and thus give it meaning (Radley: 1994:145-146, 175-176).

If effective health care is to be promoted, the relationship between doctors and patients demands values such as trust, commitment, respect and dignity. Indeed these values are essential for without them, those patients who feel at their most vulnerable when giving an account of their personal details, may find it difficult to communicate with their GP. On the other hand, patients must be truthful in their accounts of illness and realise the measure of responsibility that they themselves have towards their health. It will become apparent in the subsection "How Can Biblical Values Help?", that the Bible addresses issues such as respect

[62] Messer for example tens of a story in which a hospital doctor informs his colleagues of the death of a patient who Lid agreed to act as subject for the medical students' exam. The hospital. doctor stated that "Our spleen died today!" See The Therapeutic Covenant, Grove Books Limited, Grove Ethical Studies, 103, October 1996.
[63] See Alan Radley Making Sense of Illness Sage Publications, 1994. p.92.

and dignity and thus provides guidance as to how a positive relationship can be maintained between doctor and patient.

Case Study Two: The Clinician - Manager Relationships

Focusing specifically upon the relationship between clinicians and managers provides a helpful model to highlight the problems that may occur in inter-staff relationships within the NHS. The clinician/manager relationship is often perceived to be the most strained and although it is wrong to assume the homogeneity of either "group", recognising that individual relationships vary, it is arguable that the generalisations made here reflect a "broad picture" that can be said to exist in the NHS. However, detailed study would need to be more specific regarding the many differing roles of managers and doctors that exist. Moreover, although the term used here is "clinician" and so focuses primarily on doctors, it must be borne in mind that nurses and the professions allied to medicine are often referred to as clinicians. Indeed, many of the relational problems that exist between doctors and managers are reflected in the state of relationships between other health professionals and managerial staff in the NHS.

The Effect of Diversity

McCartney and Brown[64] have found that health professionals tend to have a poor perception of managerial staff. In their research the authors have stated that there is a "them and us" situation between the two groups in many hospitals, with much of the tension and conflict towards NHS managers being the result of varying perceptions of what actually constitutes a health professional. The authors' report cites that amongst clinical staff, there often exists extreme levels of distrust and resentment of managers. Indeed, McCartney and Brown highlight the contentions of clinical staff who perceive managers to be distant, wishing to separate themselves from clinicians. Clinicians also believe that the priorities of managers are (in essence) to meet the directives of their supporters rather than seeking the welfare of patients. Further, with the recent elevation of professional managers, many clinicians feel that their own position has been degraded, with their status being lowered to health care technicians.

Whether the view of managers put forward here is realistic or not is highly debatable. Nevertheless it is significant - for the state of inter-staff relationships - that such perceptions are prevalent amongst nursing and clinical staff in the NHS. On the other hand when turning to the managers' view, it is apparent that amongst them there is a deep sense of mistrust and resentment towards clinical staff. Managers often complain about the unwillingness of most clinicians to face the realities of cost constraints, prioritisation and planning. However, some professionals occupy the "middle-ground" as both clinicians and managers - an experience which many find uncomfortable. Indeed, Clinical Directors and other clinicians involved in the managerial process are often faced with the dilemma of balancing apparently conflicting priorities.

Missing Essential Ingredients and the Effect of Power Struggles

In focusing specifically upon the *actual* relationship between the clinician and manager, it is

[64] McCartney S., Brown, R.B. 'Professionals in Health Care: Perceptions of Managers' Journal of Management in Medicine, Vol.7. No. 5, 1993, p. 48-55.

arguable that the essential ingredients for a good relationship are missing. For example, in most cases encounter between the two is minimal, for the domains of the administration block and the wards are often perceived to be separate, whilst continuity within the relationship is limited mainly because of the short tenure of many management appointments. Thus the context for relational proximity (closeness of a relationship in which each individual recognises the uniqueness of the other) is negated. Moreover, as already indicated, there is also little respect between the two groups and arguably this is because of a power struggle between the two. Here managers use their control over financial resources as a means to accumulate power, whilst clinicians use the notion of professional clinical autonomy as the means to maintain power.

The apparent power struggle between clinicians and managers is mainly the consequence of the restructure and organisation of the NHS and greater emphasis being placed upon care, health promotion and financial initiatives. Indeed, one of the consequences of the 1989 white paper "Working For Patients" was a policy shift within the NHS. Contracts, resource allocation and performance, having been previously controlled by doctors, became the concern of managers. This resulted in a conflict of interests, with problems arising between clinicians and managers over how to share these responsibilities. The policy shift then, challenged a deep rooted tradition for it had always been understood and accepted that clinicians had the ability to cure individuals and that therefore they had the power and control[65].

Evidence of the power struggle between clinicians and managers indicates that clinicians do indeed still try to maintain a stronghold of influence and to a certain degree, resist some of the changes in policy. Flynn. for example, has found that in a study of six District Health Authorities, although managers were increasingly involved in medical priorities, their actions were resisted by clinicians[66]. Harrison has also argued that although it is management who supposedly control selection, in reality it is still GPs who initially provide the selection for consultancy work. Furthermore, Harrison has also found that it is the consultants who make the decisions concerning not only which patients they are to see, but also the number of patients and how to diagnose and treat these patients; it is also the consultants who make the decisions concerning discharges and admissions[67].

This sense of resistance commonly found amongst clinicians could be the result of their being a strong body of professionals. It is clear that they are in a position to defend themselves as they have an official and well-known organisation to represent them (the BMA). Furthermore, because of their long and shared experience in training and their common background (on the whole they are middle-class), clinicians have a shared interest and common independent thought. In contrast, the organisation which represents managers (ISMA) is younger and carries less influence than the BMA. Moreover, unlike the medical profession, managers tend to come from a variety of backgrounds and therefore do not have the common background and sense of collective thought which the medical profession share. Nevertheless, this sense of resistance upheld by clinicians is only partly the case for as evidence and news reports indicate, it is clear that management influence is strong in a number of areas and incidents. For example, the case in Exeter in which 2,700 patients were due to have operations before April 1996 but had to wait until 1997 because of financial constraints[68], suggests that current funding decisions *which are* implemented by managers have an impact upon the delivery of health care services.

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[65] Much of this section concerning power is taken from the Jubilee Centre working paper Power in the NHS 1997 by Cathy Lewis.
[66] Flynn,R 199 1, 'Coping With Cutbacks and Managing Retrenchment in Hedth' Journal of Social Policy 20, (2). p. 215-236.
[67] Harrison, S. 1988, Managing the NHS (Chapman and Hall).
[68] Guardian, 15. 11.96.

With closer examination of the relationship between managers and clinicians, generally speaking, there is a lack of common purpose between them in that their motivations, aims and goals appear to be different. For example, it is generally believed amongst managers that clinicians are unrealistic in their focusing upon individual patients to the detriment of the broader picture. Conversely, managers are perceived by clinicians to be more concerned about financial targets and less concerned about "patient care". However, these perceptions are not necessarily typical and can not be taken at face value although they are "reality" in that they affect co-operation and ultimately the quality of care provided to patients. However, they do not necessarily accurately describe the motivations of clinicians and managers. Indeed, clinicians and managers do often share similar motivations. There are many managers who are concerned with the well-being of patients and the quality of care provided to the users of services. Moreover, many share a similar sense of vocation to public service, and endeavour to improve the quality of care provided to patients within imposed financial constraints. Likewise, many clinicians understand the need for prioritisation within a cashconstrained service.

The Effect of the Relationship Upon Health Care

The general poor state of the relationship between managers and clinicians has been accepted by some as inevitable, especially given the degree to which the structures and processes under which the NHS operates have changed substantially in the last few years. Nevertheless, although it may be inevitable, the problems within their relationship need to be addressed because the nature of their relationship is affecting health care provision and therefore patients. The absence of effective cooperation between clinicians and managers in the management of human resources is having a detrimental effect upon the quality and extent of care provided to the users of services. Cooperation in the allocation of resources is hindered if there is a lack of dialogue between the clinicians who have responsibility for referral and prescription, and the managers who often have the responsibility for the budgets. In order to ensure that patients' needs are met within a framework which allocates resources according to broader concerns, these decisions need to be made in partnerships. Without common "ownership" of priorities, there is a tendency for obstructionism amongst clinical staff that is costly in terms of morale and financial considerations. Moreover, there is also the temptation on the side of the clinicians to describe patients in terms of what managers want to hear. This however has the effect of giving false statistics which in turn misguide the decisions made by management concerning health care. Arguably, due to the underlying conflict between managers and clinicians, there is the danger that decisions concerning health care could be made on the basis of conflict-avoidance rather than rationality[69].

Case Study Three: Inter-Organisational Relationships

Some of the difficulties currently experienced within the NHS are the result of the structure, organisation and recent reforms. The implementation of the internal market has led to competition and conflict between trusts and health care organisationslagencies between purchasers and providers. This of course is detrimental towards promoting collaboration and co-ordination which are essential if the health needs (both medical and non-medical) are to be treated both effectively and equitably. Indeed, poor relationships between organisations have

[69] Much of tile detail concerning inter-staff relationships is drawn extensively from Relational Health Care a Relationships Foundation Report, 1996 by Tom Robson

resulted in patients suffering the consequences. Millar for example, who has gained evidence from the Health Advisory Service, has found (as he puts it), that "despite the largely "good intentions" of commissioners and providers of care, older people with complex needs are falling through the cracks between the agencies" (1997:13). Millar identifies the cause of this to be the disunity of services, funding problems, insufficient assessment and reassessment and, in his words, "...inadequate communication between commissioners and providers" (1997:13).

The Effect of Fragmentation Between Organisations

It is within the care of the elderly that we see most prominently the effects of the lack of collaboration between health care organisations. Millar reports that the Health Advisory Service (HAS) visited ten districts in England and Wales and in its final report came to the conclusion. "that the purchaser-provider split has proved to be "intrinsically unstable, (allowing) perverse incentives and unwelcome boundaries to communication and to the seamless delivery of care" 1997:13). Indeed, the HAS found that care for the elderly was actually hampered because of the purchaserprovider split. Obstacles included GP fundholding, which has, in the report's words, -----fragmented the purchasing role, dispersed the financial resources of Health Authorities and denuded them of personnel' (1997:13).

The report also found that although GP fundholders had vast amounts of purchasing power, they had little experience of purchasing. Organisational issues implemented under the reforms (such as the merging of Health Authorities and Family Health Service Authorities) have also proved to be obstacles and have led to tensions and a loss of personnel. There have also been pressures involving financial control which has meant that Health Authorities find it difficult to plan care for the future, whilst commissioners/purchasers have had to undertake new roles and competencies. However, non-fundholding GPs tend to view collaboration with Health Authorities suspiciously, and accordingly these new relationships are being created in a context of tension. Moreover, tension and suspicion exist between organisations as new relationships are established with the creation of more local authorities. In turn, this causes problems for the delivery of social services which are crucial to the health needs of the elderly (Millar: 1997:13).

Further, the report was able to show that there were problems between health services and social services, largely arising over the funding of long-term and continuing care. These problems often resulted in strained relationships between the agencies. Moreover, it was found that individual hospital and community trusts providing a wide range of health care services for the elderly were not hying to work towards delivering seamless care, whilst commissioners/purchasers, although claiming that they felt that health services for the elderly were vital, when it came to prioritising this did not, in reality, take effect (Millar: 1997:13).

Other problems which surfaced m the HAS survey were the perverse incentives involved within purchasing contracts which led to over-emphasising the importance of speeding. the throughput of elderly people in acute wards" (Millar: 1997:13). The HAS also disclosed the fact that access for the elderly in undergoing a full multidisciplinary assessment was varied. In view of the importance of the process of this assessment which, as the report puts it, "is a linchpin in the development of services because older people's needs are manifold" (Millar:1997:13[70]), the HAS report recognises the need for collaboration between the agencies. Indeed in recognising its importance -for care of the elderly, it understands that this

[70] Richard Williams one of the authors of the HAS report (Health Service Journal, 27.3.97, p. 13).

multidisciplinary assessment can only take place through a process which "..involves GPs, primary healthcare teams, care of the elderly team specialists, social workers, health visitors, care managers and informal carers - a process that demands rigorous and inspired collaboration between those different elements" (Millar:1997:13[71]). As such however, this process at present is only available to those who are admitted to a specialist ward or geriatric day hospital and in view of this, the report stressed the need for co-ordination. Thus the report recognises that in order for the elderly to receive adequate and proper health care, collaboration between the agencies needs to be improved (Millar 1997 13).

The HAS report then, highlights the need for changes in organisational objectives and working practices. it also highlights the need for open and honest relationships. Organisations need to understand that their responsibility for the health needs of the elderly involves partnership, participation and therefore trust and collaboration between them It is only when these values become the central tenet of these relationships, that equal access to a multidisciplinary assessment can occur - which in turn will contribute to the well-being of many elderly people. It will become apparent that the Bible has much to say about responsibility, trust and the delegation of power and it is therefore an essential source for Christian reflection on how relationships generally between agencies and organisations can be restored and promoted.

Summary and Conclusions

Examining these particular health care relationships has indicated that there are a number of tensions and problems arising from recent organisational changes and worsening and severe financial constraints. Problems have often occurred due to a crisis of values, and/or conflict over power, status, responsibilities and at times, over a lack of shared common purpose. Difficulties of this nature have the danger of damaging and limiting cooperation, communication and collaboration within health care relationships, which in turn can affect the distribution of equitable and effective care. It is now once again to the Bible that we turn for guidance on values which could be conducive to healthcare relationships and therefore to the delivery of health care itself and thus human well-being.

iii) How Can Biblical Values Help?

As discussed in Section Two, the Old Testament laws were both a manifestation of God's love for the people and also, as Field puts it, "(an) explanation of what loving relationships meant in practice" (1995:13). The laws were given to the Israelites as a means by which they could respond to the relationship that God had established with them (Wright: 1983:21-23). They were then, the means by which the people could show their love for God and maintain the relationship with Him (Wright: 1983:143,158). Indeed, the people expressed their love for God through loving others for this was at the heart of the commandments. Accordingly, loving God and loving one's neighbour were inseparable with this being understood as the fulfilment of the law (Wright: 1983:158-160). Nevertheless, Israel knew that her relationship with God did not entirely depend upon her fulfilling the law, for as all humankind are fallen because of original sin, this would be impossible. Israel understood that the relationship depended upon God's faithfulness and loyalty to His covenantal promises and therefore upon His character being love, justice and righteousness (Wright: 1983: 23).

[71] Richard Williams ibid.

Israel's social structure and pattern (under the law) served as a paradigm to the surrounding nations in order to demonstrate the meaning of love and justice in social, economic and political life (Deuteronomy 4:8). Old Testament Law therefore can be understood as a collection of inter-related precepts which outline an orderly pattern for the structure and life of society. With the coming of Christ and therefore the inauguration of the new covenant, Jesus stated that the way in which to apply the Old Testament laws was to examine their significance for relationships with both God and neighbour (Matthew 22:34-40) (Schluter: 1995). The implication here, then, is that the laws contain underlying moral principles and values which inform us of the nature of loving relationships and the pattern of fife that God intends and desires for us. Formed within the context of the covenantal relationship, these laws therefore may provide help and guidance for health care and health care relationships today.

Faithfulness, Loyalty, Commitment and Trust

God's faithfulness was at the heart of the covenantal relationship; His faithfulness to the relationship enabled it to survive and through being faithful God was able to communicate His love for the people. Indeed, God showed the people that His love is everlasting by promising them that He would always be fa~ to the covenantal terms (Jeremiah 31:3). God remained fa~ and totally committed even when the people were unfaithful to Him and lacked commitment (Hosea 3A:1, 11:89) (Field: 1995: 10).

These values of loyalty and commitment are characteristic of the New Testament. Paul, for example, in order to encourage the people refers to God's faithfulness (1 Corinthians 1:9, 10:13, 2 Corinthians 1: 18, 1 Thessalonians 5:24). He also encourages his churches in their new Christian behaviour by showing how God is faithful and that therefore they too must be faithful in their relationships with one another (Malina: 1993:68).

Malina understands the term "faithfulness" as personal loyalty; as such, faithfulness is solidarity and fidelity and may refer to the social attachment that bonds one person to another. (1993:67-68). In both secular thought and Christianity, loyalty involves relational bonding. In the latter we are told that we have bonds with one another (Romans 12:5) and with God (Galatians 4:6). in the New Testament, loyalty is understood to be a Christian virtue and as Christians we are expected to be supportive and ready to give aid loyally to one another, even though this may be costly for us. Nevertheless, whilst being loyal we are assured in knowing that God, who is faithful and loves without ceasing, will stand firmly with each person (Roberts: 1995:558). The value of trust is also associated with God's faithfulness and is embodied in His precepts to the people which declare that He would be their God and they would be His people (Bridger: 1995: 866).

Although the relationship mainly depended on God's faithfulness, God expected the people to respond to the covenantal relationship and His love and faithfulness by obeying the Law which itself promoted love, justice and peace (Wright: 1983:158). Indeed, it was through obedience to the Law that God could establish a new community which reflected His characteristics and so fulfil His purpose (Wright: 1983: 34-35). Thus faithfulness and loyalty were to be reciprocal.

The values of faithfulness loyalty and trust demonstrated within the covenantal relationship, indicate that if a relationship is to survive, then these values are to be at its heart- Moreover, God's faithfulness to the terms and purposes of the covenant show first, the importance of establishing common purposes within a relationship and then secondly, establishing terms, boundaries and expectations wherein these purposes can be lived out and achieved. Thus

thirdly, the covenantal model encourages and reveals the importance of commitment and loyalty to the terms of the relationship so as to promote bonding and trust.

Values such as these are so fundamental that they have many applications. To illustrate the range of issues where these values have a bearing some examples are given below:

- Loyalty to whom? - as greater emphasis is placed on public health there is potential for tension between commitment to individual patients and commitment to the needs of the community. Where problems arise the claims of loyalty to patients, colleagues and NHS organisations may not always coincide.

- Trust and organisational change: there is always the potential for fear and mistrust surrounding organisational change. Sustaining existing relationships, and developing those which have been neglected or are fragile, through the change process requires considerable trust as well as steadfast commitment when trust has been broken.

- Long-term commitment: there is a widespread perception that long-term issues in health care tend to be neglected, despite the long-term nature of many health needs. Short-term vision and career goals are not expressions of covenantal commitment.

- Patient's trust: health care often requires both openness to allow good diagnosis and vulnerability to allow potentially dangerous actions to be performed. Both require a relationship of trust to be cultivated between patients and medical staff.

Love, Compassion and Care

God's love for His people is mainly expressed practically. For example, the people were redeemed by God from slavery in Egypt by His loving intervention on their behalf (Deuteronomy 4:37-38, 7:8, Psalm 106: 6-12). Then in His love and mercy, God enabled the people to return to their land after being exiled because of their sin (Isaiah 43: 44 ff). God also lovingly supports the marginalised members of society such as orphans, widows and immigrants (Deuteronomy 10: 18). Indeed, God's love and care is like a farmer who cares for his vineyard, and a shepherd who cares for his sheep (Isaiah 5: 1-7, John 10: 11 16), whilst His concern is like that of a parent (Psalm 103:13, Isaiah 49: 15, 66:13, Hosea 11: 1). As He dealt lovingly with the people, God commanded them to be loving, just and merciful towards the minority and marginalised (Exodus 22:21-27, Leviticus 19:9-10, 14, 34, Deuteronomy 24:14-15) (Field: 1995:10 -11). God's character then, is full of compassion and the Psalms constantly claim that "God is a compassionate and gracious God" (Psalms 86:15, 111:4, 145:8). Indeed, He suffers with those who suffer (Parkyn: 1995:244). God's compassion is at times placed within the context of His covenant promises and is often linked with mercy (2 Kings 13:23, Isaiah 49: 13[72]) (Pitch: 1993:29).

God's loving action also manifests itself in the New Testament for it is His love that evoked Him to send Jesus His son to die for humankind in order to save it from the penalty of sin and death. Thus Jesus' life and death demonstrates the depth of God's love. Jesus continued with the Old Testament command to love God wholeheartedly and to love one's neighbour as oneself (Deuteronomy 6:4-5, Matthew 22:37-38) (Field: 1995: 10). However, it was not only Jesus: the writers of the New Testament generally understood that God's love prompts believers to love

[72] Other texts include Isaiah 54:8- 0 and Jeremiah 33:26 (Pilch, 29).

others (Ephesians 5:1-2) and that love for God's people is love shown for Jesus (Hebrews 6:10 cf Matthew 25:34-40; 1 John 4:20). In accord with the Old Testament, they understood that evidence of a genuine love for other people was a sign of obedient love to God (1 John 5:2) (Field: 1995: 10-11). Texts elsewhere indicate that as we obey the command to love one another and also partake in each others problems we are showing compassion, which itself is an active response to the needs of others (1 John 3:11-18, Galatians 6:2) (Parkyn: 1995:244).

Associated with love and compassion are the laws which instruct us to care for one another. In the Old Testament, social rules and stipulations highlighted the understanding that Israel had been called by God to be a caring community. This call is emphasised in Deuteronomy and its concern for social justice, the poor, widows, orphans, aliens and also in this context, the economy (i.e. laws concerning the land, harvesting and almsgiving in order to safeguard against poverty). In the New Testament, Jesus continues with this call for care by instructing the members of a Christian community to love each other as He has loved them (John 15:12). The Gospel of John defines this love as being the same love that exists between the Father and Son which is then given to all those who believe. As care comes from this love it becomes an all embracing and prevailing covenant and begins on a simple everyday level - this being essential for the recognition of personal worth. Care therefore, expresses the goodwill and love of God which all require. Thus as all are in need, genuine care is mutually supportive and involves both carers and the persons for whom they care - in times of difficulty and stability. Care is an example of the love described in John 3:16, it loves to the end and is costly and giving (Keeble: 1995:215-216).

These values not only motivate health care but also constitute a key aspect of it. They also contain a challenge for many aspects of our current provision including:

- The value of care: carers are often low-paid or under-supported. The technology of curing too often takes precedence over the more human aspects of caring.

- Creating caring organisations: staff are less able to care if they are not themselves cared for. The environment in which care is provided can sometimes be impersonal. Both can inhibit the development of a culture of care.

- Who cares? A recurrent theme in the Bible is that true love and compassion are often found in unexpected places. Within the NHS there may be much under-utilised and undervalued capacity to care e.g. among ancillary staff.

- Love at all times: a characteristic of God's love which is a particular challenge for us is the steadfast love for the unlovely and the unloving. In a health service struggling to rebuild weak relationships and to develop new ones the capacity to act with love and generosity when under pressure, facing conflict and working with difficult people is both a vital witness and service.

Justice

Linked with love, care and having compassion is the concept of justice - this being embodied in the precepts of the Law and associated with God's faithfulness to the covenant. Indeed His justice was primarily experienced through the terms of the covenantal relationship. God was declared just (Psalms 7:9, 103:17, Jeremiah 9:24) and because He had dealt justly with them,

the people were to do likewise (see Exodus 22:21 22, Deuteronomy 10: 18[73]) (Forrester: 1996:502).

In the New Testament Jesus is presented as the Just One (Acts 3:13ff. and 7:52) and the One who has become our justice (1 Corinthians 1:30). Jesus' life and teaching demonstrates the call for a just society. His association with the poor, marginalised and despised shows that God's justice reaches those whom society tends to neglect, so as to affirm their worth and re-create relationship. There are also a number of parables which concern justice (see Matthew 20:1-16, Luke 15:11-36, John 18:28-19:22) whilst Pauline teaching concerning justification by faith illustrates the justice of God and associates justice with reconciliation - the restoration of relationships (Forrester: 1996:502503).

Demands for justice are becoming an increasingly important aspect of doctor-patient relationships with far-reaching consequences. Litigation costs and defensive medicine suck resources away from addressing health needs without necessarily leaving either doctor or patient feeling that justice has been done. This partly reflects a number of flaws in the doctor-patient relationship such as the sharing of risk and responsibility but it is also a consequence of a view of justice which does not have the restoration of relationships at its heart.

Equality

In the Old Testament the people of Israel were commanded to recognise the equality of all people and treat them as such. Their sense of equality was based on the knowledge that God had created men and women in His own image and therefore there were to be no inequalities or distinctions made between persons (Eichrodt:1956:35-36). In addition the Israelites' understanding of equality arose from the knowledge that they had once experienced slavery and oppression and only enjoyed their freedom because God had delivered them. Thus they were a redeemed people and were all equal before God and owing to God's treatment and dealings with them, they were to treat slaves and aliens likewise. The command for equality and the giving of legal and human rights to slaves and aliens underlies a number of laws and stipulations (see for example Exodus 21:20-21, 26-27, Leviticus 24:22, 25:39). indeed numerous texts affirm the equality of all people before God, regardless of their status (Proverbs 22:2, 29:13). Particular verses in Proverbs identify God with every human being and therefore indicate that whatever is done to a person is done to God Himself (for example Proverbs 14:31, 17:5 and 19:17) (Wright 1995:49-54)[74].

The demand for equality is continued into the New Testament and is embodied in the new covenant relationship in Christ. For example, Paul describes how there is no distinction of persons in Christ (Galatians 3:26-29) whilst the Book of Acts instructs Christians to hold all things in common (Weale: 1996:295).

A biblical understanding of the equality of persons is vital for our society which can tend to judge the worth of persons on the basis of their contribution to the goals of society, their social status and their economic worth. Principles and mechanisms underlying the health service could also be in danger of operating on cultural ideologies of this nature and accordingly,

[73] Other texts include Deuteronomy 14:29, 15, 7, P~ 82:3,4, 103:6 and 140:12 (Forrester: 1996:502).
[74] See also Wright Living as the People of God, IVP 1983.

providing a service of care that is inequitable. It is therefore essential that the individuality and yet equal worth of all persons is recognised and accepted.

On a more personal level, a sense of equality is required between health care professionals and their relationships with each other. For example, with a greater understanding of equality between clinicians and managers, animosity over power and status could be negated and replaced with respect for one another. A sense of equality ensures that we give each person the dignity and respect to which they are rightfully entitled and this has implications not only for relationships between professionals, but also for the way in which some patients are treated.

For a health service with equity as one of its foundational. values there is a particular challenge in how to foster innovation, diversity and accountability at the local level without unequal access to some services developing. In this context it is perhaps worth noting that in the Old Testament there were systems to place some limits on the degrees of inequality (e.g. the Jubilee laws) without seeking absolute equality of outcomes. Provided that there is good accountability and that no individual or group is treated as of less worth than another some elements of inequality must be accepted.

Dignity and Respect

The Bible commands respect because God Himself respects people (Psalm 138:6, Genesis 4:4). We are to hold all people in reverence and because all human individuals are made in the image of God; they are the "thou" in relation to God and are not to be considered as being selves, but as selves who are in relation to God. Therefore although sin has broken our relationship with God, a remnant of His image still remains within us. This remnant is itself confirmed in the knowledge that humans have a purpose - a purpose which is expressed in Jesus' death for all and it is because of this that all humans are to be treated as sacred. Human dignity therefore has its being in the self-giving of God which is described in the creation narratives and covenant relationship; dignity arises from the knowledge of being in relationship with Him and being loved by Him It is with this knowledge that all persons are to be revered by others (Falconer: 19 8 6:279).

Power

Although power itself is not a value, the way in which it is used can be instrumental in promoting positive relationships and may even serve to endorse other relational values such as care, love and compassion. The Bible clearly indicates that all power comes from God with whom nothing is impossible (Jeremiah 32:17) (Lacan:1973:440). The New Testament also emphasises that all power comes from God (Matthew 26:64, John 19:11) and accordingly power (including political power) is not inherently evil (Romans 13:4, John.19:1 1) (Marshall: 1995:680). On the contrary, power is understood to be essential to human affairs and is given by God to human agents. God's power is assigned to certain humans by means of office (Genesis l;26-28, Psalm 8:5). Those with office (such as judges, elders and rulers) are given their authority in order to withstand evil and aid good and therefore as a means by which God's will can be endorsed (Marshall: 1995: 680). Numerous texts in the Old Testament indicate that those who are powerful are to have compassion[75] (Pilch 1993:28-29); for example, it was the duty of the king to protect the cause of the least powerful (Proverbs 31:4ff, 8ft) (Wright:

[75] 1 Kings 8:50, Nehemiah 1: 11, Daniel 1:9, Jer 42:12, Psalms 106:46, 2 Chronicles 30:9 (Pilch:1993:28-29).

1983:145). At times however, God uses weak, humble and ordinary members of society to carry out His intentions and enforce justice and peace (Exodus 4:10-13, Numbers 12:3[76]) (Lacan: 1973:44 1).

In the Old Testament God uses His power faithfully and loyally (in accord with His covenantal promises) to protect His chosen people with whom He has established a relationship. Thus His power is used out of love to show His love to His people. Indeed, Israel's strength lay in intercession and God's protection (Psalms 20:2, 8ff, 44:5-9[77]); it was Yahweh who ensured her victories, being the head of Israel's army (Exodus 12:41). At tunes He would intervene either by strengthening the people or strengthening particular individuals (Deuteronomny 8:17-18, Judges 6:12ff, 1 Samuel 2: 10). Again therefore, it is seen that power comes from God and is used to carry out His will for Israel's power and strength as a nation came from Yahweh being used initially to maintain His will and purposes for Israel (Lacan: 1973:440-44 1).

In the New Testament it is Jesus who provides the perfect example of the use and understanding of power. Although the Messiah, Jesus was born of a humble young woman in a stable (Luke 1:27). He was sent as a servant and therefore humbled Himself in order to serve humankind. Jesus' power was given by the Spirit[78] and expressed itself in miracles which benefited and promoted the wellbeing of others. For example, Jesus cured diseases and raised the dead and expelled demons (Matthew 4:23ff, 12:28). Finally, Jesus used His power to save all of humankind from sin and death by conquering death itself (John. 10: 18). Indeed Jesus Himself tells us that He does not use His power for His own glory, but wants only His Father to be glorified and the Father's will to be fulfiled For example He states that, "By myself 1 can do nothing: I judge only as 1 hear, and my judgement is just, for 1 seek not to please myself but him who sent me" (John 5:30 (NIV)) (Lacanl 973:441442). Recognising the way in which Jesus understands and uses His power, has led Lacan to conclude that "humility is the source of His power" (1973:441).

Lacan's view of the source of (God's) power clarifies the understanding that power is to be used to serve and benefit others and accordingly may involve the giving of oneself in order to do so. This is a view which is similar to the one taken by Oppenheimer who claims that the humility which characterises God is an aspect of agape (love) (1 Corinthians 13:4-7). Agape, as Oppenheimer puts it, "empties itself for other people's sake (Phil. 15-11) - which is the opposite of pride in the sense of self-centredness" (1986:284). The genuine source and essence of power then, is love and self-giving; power is to be executed in order to serve God's will and intentions and thus promote the wellbeing of others. This is epitomised in the life of Jesus who understood power to be servanthood (Mark 10:42-45, John 10: 17-18[79]) (Marshall: 1995:68 1). As Marshall puts it, Jesus' understanding of power shows us that "all forms of power must find their true place in a life of love lived in the power of Jesus Christ (John 13:1, Phil 15-11)" (1995:681). In essence, the correct use of power stems from the power of love.

However, power can easily be corrupted and used for wrong and harmful purposes. Marshall. (bearing in mind Micah 2:1-2) points out that "Power is often used to oppress and exploit those subject to X' (1995:680). Indeed, scripture describes many incidents when power is misused by humankind (Exodus 5:2,6-18, Isaiah 14:12ff[80]) (Lacan: 1973:440). The perversion of power is also an issue in the New Testament. Paul uses the term "principalities and powers" to embrace,

[76] other texts include 1 Samuel 16:7ff, Jeremiah 1:6-10, 18-19 (Lacan: 1973:44 1).
[77] See also Psalms 105;3ff 124:8 (Lacan: 1973:440 -441).
[78] Luke 3:22, John 1:32ff, 3:34ff (Lacan:1973:441-442).
[79] Other texts include Romans 1: 16 and 1 Corinthians 1: 18 (Marshall: 1995:68 1).
[80] See also Isaiah 47:6, 3:14ff, 10:1ff, Amos 1;3-2:7, Micah 3:9ff, Psalms 58;2ff (Lacan 1973:440).

and refer to, a number of forms of power (and their perversion). The term at tunes can refer to human authorities (Romans 13:1-3, Titus 3:1 or angelic/demonic powers (Romans 8:38, 1 Corinthians 2:6[81]). Paul warns that these powers can turn against Christ (even though it is in Him that they find their origin) and although they are essential facets of the world, they can disrupt the mind, politics and religion (Galatians 4:3, Colossians 2:8 20-21) (Marshall:1995:680). Clearly then, all power is in danger of being abused.

The concept of power in Western society today is perceived as a value; it is a mark of personal identity and signifies status and prestige, thus providing individuals with a sense of self-worth and esteem. As power carries prestige and status, those with it can at times use it to assert their presence, control and authority and so further assist their own personal aspirations and interests over and above the needs of others. To a certain extent power may be misconstrued in the health service today. For example, it was noted earlier[82] that the poor relationship between some clinicians and managers was partly the result of a power struggle. The danger here is that their Godgiven abilities and powers (in both groups) could be used in order to assist their own interests (selfworth, control, status, etc.), with the result being that the needs of patients might be given second priority. Arguably, with a biblical understanding of the worth and identity of persons, perhaps the desire for power as a means of gaining self-worth, could diminish.

A common feature of current health care relationships is that neither party feels that they have power and, in the face of change, may fear its further erosion. This is in part because power takes many forms: the control of policy and its implementation, the control of finances, control of the mechanisms of delivery, of access to services, and so on. Where power is seen as control the pieces of the jigsaw do not come together. Where power is seen as the capacity to serve then it is more easily enhanced by collaboration between those who hold different levers.

Responsibility, Obligation and Accountability

In the Bible power and responsibility, obligation and accountability go hand in hand. In the Old Testament the Israelites' sense of responsibility for themselves and others and ultimately towards God arose through such laws (see for example Leviticus 19:34)[83]. Thus the laws gave the Israelites the knowledge of good and evil and so a sense of responsibility (Guillet: 1973:49 1).

Although the responsibility to maintain the covenant was corporate, the moral implications of it (its ethical stipulations) affected each individual (Wright: 1983:198). In this way, personal responsibility towards keeping the laws and one's own moral life (and therefore maintaining the covenant) would also benefit the nation. Thus personal responsibility was also a responsibility for others[84]. In addition to the laws and covenant, the people's sense of social responsibility arose because of their understanding of their common created 'humanity. Reference to this is found in the Wisdom Literature (particularly Proverbs 14: 31, 17:5, Job 31:13-15) and in the creation narratives (Genesis 4:9ff, 18:20ft) (Wright 1983:136-137).

With regard to accountability, Wright has said that a sense of accountability for ourselves and others to God "...is of the essence of being human" (1983:199). Personal accountability to God is indicated in the first question in the Bible in which God asks Adam his whereabouts

[81] See also 1 Corinthians 15:24, Ephesians 1:2021, 3:10, 6:12, Colossians 1: 16, 2:10, 15 (Marshall: 1995:680).
[82] See Case Study TWO
[83] Eichrodt discusses how Deuteronomy evokes a personal sense of responsibility through the laws, p. 12ff
[84] Eichrodt provides insight concerning this issue; ibid.

(Genesis 3:9). Wright understands that this question is addressed to each individual that Adam represented, whilst our accountability towards others is indicated when God asks Cain about the location of his brother (Genesis 4:9) (1983:199).

In the New Testament, it is Jesus who gives individuals the responsibility to love their neighbours, give alms and look after the poor and needy, and neighbourly responsibility constitutes giving help to anyone whose circumstances provide one with an opportunity of doing so (Fyffe:1921:739-740). Indeed we are all under obligation and have responsibilities, since as Cole notes, some New Testament texts indicate that "all in Adam are responsible for the conduct of their creaturehood to their creator and will appear before the great white throne of Revelation (Roman 1:18-32, Revelation 14:6-7, 20:11-15) (1995:736).

In view of the rise in legal claims against the medical profession today (claims which damage relationships), professionals and members of society need to be clear about the significance and the extent to which their responsibilities lie. The medical profession as a whole has a responsibility to respond to the health needs of the population and therefore organisations and professionals are to fulfil this to the best of their ability. In certain cases this may require working together in order to effectively respond to particular needs. For example, the HAS report recognises that care for the elderly, which requires a process of multi-disciplinary assessment, would be more effective if organisations worked *together*. Thus the particular organisations concerned have a corporate *responsibility* to provide such care.

Further, GPs generally have a responsibility towards (and therefore are accountable to) their patients as it is GPs who have the means, power and opportunity of (to some extent) meeting the health needs of patients. On the other hand, patients too have a responsibility towards maintaining their health to the best of their ability. It would be unreasonable to expect GPs to take full responsibility for their patients' health if contrary to advice, patients consciously engaged in harmful activities. In order to safeguard against this and perhaps patients who take legal action against GPs for negligence although they themselves might be partly responsible for their condition, basic limits, boundaries and expectations concerning responsibilities need to be established.

Summary and Conclusion of Section Three

Section Three has sought to establish the relevance of the argument in Section Two (that the nature of relationships can affect the health and well-being of individuals and society) for the health service today. Although the Bible provides no direct model of health care, Section Three has found that in biblical times, the role of the family, relatives and friends in times of difficulty and illness were vital. Evidence today suggests that the family, community and friends (i.e. positive relationships) are still beneficial healthwise, even though we have a sophisticated service of health care. Indeed, research has found that having positive relationships might provide not only practical help, but also psychological aid to the sufferer and serve as a buffer against stress and therefore could prevent behaviours which are harmful healthwise. Moreover, some evidence suggests that good relationships could even assist the healing process. Conversely, it was found that those with poor relationships or fewer contacts were more likely to experience health problems.

Focusing specifically upon health care relationships, Section Three has found that economic, social and ideological forces, scientism, the structure and organisation of the NHS, together with cultural norms and values are having a negative effect upon the level of cooperation,

collaboration and communication amongst health care professionals and organisations. This in turn can lead to poor relationships, not only between health care professionals themselves, but also with their patients. Evidence suggests that negative and poor relationships within the NHS could affect the delivery of effective health care and therefore patient well-being. Thus as the nature of health care relationships can affect the health of others, it is essential that these relationships are strengthened.

By explaining the nature of loving relationships[85] the principles and values within the Old Testament laws provide the ground upon which relationships generally can be strengthened and renewed. Indeed, Jesus pointed out that the Old Testament laws stem from the first and greatest command which is to love God wholeheartedly, and also from the second, which is to love one's neighbour as oneself (Matthew 22:34-40). Thus Jesus teaches us that the way to apply the Old Testament laws within the new covenant is by examining their relevance for relationships (both with God and neighbour) (Schluter: 1995). These laws, framed within the old covenant, therefore have implications for health care and health care relationships today.

The laws indicate that if health care relationships are to be renewed and strengthened, they need to be rooted in values such as faithfulness loyalty, trust, compassion and care. Futhermore, professionals within a health care relationship require a sense of responsibility and accountability, not only to each other and the relationship itself, but also to others who are involved (such as patients). This entails recognising the equality of all, promoting justice and treating persons with dignity and respect and therefore any God-given power is to be used in accord with these values. It is, only when we start to recognise and address the needs and bases of relationships that perhaps the (health) problems currently experienced within society and the health care service generally, may begin to subside.

[85] Field, 'Love', New Dictionary of Christian Ethics and Pastoral Theology Ed. Atkinson et. al IVP, 1995, p. 13.

4. Conclusion

The issues of health and health care provision present a number of challenges to the church, to individual Christians, and to Christians working in health care.

A challenge for the church

The church has a long association with health care provision rooted in Jesus' concern for the sick and publicly and visibly expressed through the founding of hospitals. The current reforms and situation present three particular challenges.

i. To ensure that spiritual aspects of health are not neglected and that pastoral care is provided in primary care. Hospital chaplaincy has been a major link between church and healthcare. As hospital stays become shorter, and more care is provided in the community new links will need to be developed. As multi-agency alliances for health develop there will be opportunities for churches to become involved. It is likely that the greatest opportunities he at the outset.

ii. Supporting members working in health care. Many Christians working in the health service feel under pressure and are not always adequately supported and equipped for their ministry within the health service.

iii. Teaching all church members. As Christians we are not immune from our cultures false values surrounding health such as the idolisation of perfection or the separation of the science of curing from the values of caring. Individually and corporately we have responsibilities for our own health and the health of others yet too often the prayers on Sunday and the visit to the doctor on Monday operate within completely different worldviews.

A challenge for Christian health care workers

Many Christians working in health care have felt an increasing dissonance between their own values and those evident in current practices. These concerns have surrounded issues such as the nature and quality of care for patients in the face of work pressures, resource constraints, performance management regimes and the contracting process.

Current reforms place the understanding of health and the nature of health care relationships high on the agenda. It is important that Christians working in health care are active in forging these new relationships and shaping their nature. There is an opportunity to start to foster new values before they get locked in by policy implementation decisions.

There is a particular need for leadership and vision to encourage and broker new relationships, sometimes in the face of difficult circumstances. Low morale, disengagement, cultural differences and the legacy of bad relationships in the past all present significant obstacles. The biblical values outlined in this paper are important qualifications for a role in helping to overcome them.

The nature of health

The increasing influence of science in health care has enabled important advances in understanding and treating disease but has become linked with a reductionist view of both health and the person. This has distorted the relationship between clinical staff and patients and undermined patient well-being. Recognising these limitations there is now much more emphasis on more holistic views of health though medical training and much health care is still working with a narrowly medical view of health.

A biblical view of health seems to recognise a narrower physical and functional aspect of health but firmly set within a holistic understanding of the person. All aspects of well-being, physical, emotional, spiritual and social are not merged but recognised as inter-related. From this it is possible to identify three key challenges of a biblical view of health to contemporary health care:

i. it is not reductionist, but set within with a holistic understanding of the person.

ii. it is not individualist for there was a strong belief that the actions of the individual could affect the health of others and that the state of society could affect the health of the individual. A concern for health should lead to concern about the relational state of society in terms of the potential for social support and the extent of social injustice.

iii. there is a strong belief in the link between spiritual and physical health. It is not a simple causal relationship but is an important factor which is often ignored in contemporary health care.

Health care relationships

The frontline relationships between clinical staff and patients and the whole network of supporting relationships between health care staff and between organisations are key factors in the quality of care provided.

The current quality of these relationships is varied. There are many negative influences and obstacles, both historical and current. They may be rooted in policies such as the implementation of the internal market; differing professional and organisational cultures such as those between NHS and Social Services or between doctors and nurses; or more interpersonal issues such as splits in General Practices.

Current reforms place considerable emphasis on the development of new relationships within primary health care teams, between practices, and with external agencies such as Social Service Departments. The development of all these relationships in the face of these negative influences and obstacles will be no easy task.

At one level they can be addressed through good policy and practice. There is much that can be done to ensure that organisational structures, work practices and communication processes, for example, foster rather than undermine these key relationships. But there are also more fundamental issues to be addressed surrounding the values which inform the goals of health care provision and the manner of their delivery.

Different understandings of health; different approaches to determining quality; conflicts over power, influence, status and funding; winners and losers in tackling health inequalities; diversified consumerism or centralised paternalism; fear, misunderstanding and mistrust - these are just some of the conflicts of values at the heart of health care provision today. For Christians seeking to negotiate these difficult waters and to provide leadership in the resolution of these conflicts biblical values can provide invaluable guidance.

There is a wealth of biblical material which could be drawn on. In the light of the nature of current problems the key challenges presented by biblical values include:

i. long-term commitment which influences both the nature and depth of health care relationships. Many people regard the covenant as a good model for health care relationships which go beyond the contingent commitment of the customer and supplier.

ii. taking the risk of trust to help create a virtuous cycle of closer working enabling greater understanding leading to increased trust as a basis of further collaboration. The alternative is the danger of downward spiral of mistrust and disengagement fuelled by shifts in power and influence and the legacy of the weak relationships of the past.

iii. revaluing care and compassion so that professional status is not found only at the temples of technology and biomedicine. The consistent emphasis of the Bible on the power and importance of love is a challenge to what is commonly regarded as the essence of health care.

iv. maintaining steadfast love through pressured circumstances, in difficult relationships, and while upholding core values. Love, in the Bible, is robust in the face of adversity and conflict.

v. fostering innovation and local accountability while ensuring that there are limits to any inequity in provision that may arise.

vi. seeking power to serve rather than power to control, so enabling different kinds of power to be brought together for more effective service provision. Jesus is our model of how power should be used.

vii. ensuring that power, responsibility and accountability go together and that health care relationships are characterised by partnership rather then dependency In this lies a challenge for all Christians for we all have responsibilities for our own and others' health.

In each case there are many detailed issues of application which go beyond the scope of this project but which will be a major part of the Jubilee Centre's continuing work on health issues. We hope that this report will prove to be of help and encouragement, not least through reminding those who face these issues on a daily basis that the Bible can be drawn on as source of empowering wisdom.

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Source are cited with an appropriate abbreviation of the name of the author and title. Abbreviations of the titles of biblical books are taken from the UBS (45-46); abbreviations of Philp's, Josephus' and other Greco-Roman writers' works are taken from the Logo Classical Library (London & Cambs, Mass.: Harvard & Heinemann); abbreviations of other ancient Christian and Jewish works, and of the titles of periodicals and serials, follow the conventions prescribed in the Journal of Biblical Literature 107 (1988), 584-96, with the following additions:

CM - Contra Mundurn (Ethics and Society)
CP - Cambridge Papers (towards a biblical mind)
CTPI - Centre for Theology and Public Issues (Edinburgh)
JHCC - The Journal of Health Care Chaplaincy
NE - Nursing Ethics
Th -Thernelios

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