THE RELATIONAL PERSON WITHIN A PRACTICAL

THEOLOGY OF HEALTH CARE

Patrick McArdle

Bachelor of Theology (SydCollDiv), Bachelor of Theology (Pontifical, CathInstSyd), Licentiate in Sacred Theology (Pontifical, CathInstSyd), Graduate Diploma of Education (SAust), Master of Education (ACU)

A thesis submitted in total fulfilment of the requirements of the degree
Doctor of Philosophy

School of Theology (ACT)

Faculty of Arts and Sciences

Office of Research
Australian Catholic University
St Patrick's Campus
Locked Bag 4115
Fitzroy VIC 3065

Date Submitted: 29th September, 2006

TABLE OF CONTENTS

STATEMENT OF SOURCES

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma.

No other person's work has been used without due acknowledgement in the main text of the thesis.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

_____   _____

Patrick McArdle   Date

ABSTRACT

Aim:

The aim of this thesis is to elaborate a theological understanding of health care at its most vulnerable point: the meaning and exercise of personhood itself. Personhood, as I develop the concept, is understood in relational terms. Through this exploration of the relational dimensions of the human person, I provide a conceptual framework in which health care is able to derive fresh vigour and inspiration. This approach accomplishes two things: it establishes a role for theological insights in the public discourse of health care; secondly, it demonstrates that theology is able to assist health care to better understand itself and renew itself. As an exercise in Practical Theology, the investigation is interdisciplinary in nature, drawing on insights from philosophy, health care and various dimensions of theology.

Scope:

Historically, the focus of theologically motivated contributions to health and medicine has been on ethical dilemmas that arise in clinical practice. In this thesis, however, the focus is on bringing theology and health care into dialogue in order to advance the conversation between the two disciplines. The thesis, therefore, has three elements that determine its scope. Firstly,

advancing the place of the human person in health care theory and practice: hence, this thesis is an exercise in practical theology. Secondly, situating theology in a field of engagement with wider contemporary culture—especially the culture of health care—in a genuinely interdisciplinary manner. Thirdly, critiquing current theory and practice in health care, and reinvigorating the central meanings and values that inform and motivate health care.

Conclusions:

There are five substantial conclusions deriving from the research and argument of this thesis: Firstly, and the basis for other conclusions, the theology developed in the thesis argues that a relational model of the human person is indispensable to contemporary health care. Secondly, while relational personhood is not a panacea for all the dilemmas posed by modern health care, thinking about personhood in relational terms opens the possibility of a dialogical approach to ethical dilemmas in health care. Thirdly, relational personhood represents a fundamental shift in the discourse of health care and of theology. Fourthly, a focus on relationships inspires a priority for the vulnerable and gives rise to an ethic of responsibility. Fifthly, a practical theology of relational personhood can bring about a rapprochement between religious concerns and health care.

As I note in the conclusion to the thesis: "These are not dramatic claims but they do have the capacity to transform both disciplines and to enable them to more adequately meet their own goals."

ACKNOWLEDGEMENTS

In preparing any thesis there are a range of people who have supported the researcher in the process all of whom deserve to be thanked and acknowledged for their efforts, suggestions, cajoling and kindness. At the risk of forgetting someone, I want to single out some individuals and groups for mention.

I would like to thank my students and colleagues at Australian Catholic University, particularly those in the Schools of Theology (ACT and NSW) who have waited patiently for this project to be finished and who have helped shape it through their insights, questions, and criticisms. The product is richer for their contributions.

Several of my colleagues require special mention for their efforts. Mr Rohan Curnow allowed me to bounce ideas off him while he was a student and currently as a colleague. He was particularly helpful in discussion some of the Trinitarian implications in the research. Dr Anne Tuohy has been a friend throughout and has encouraged me to persevere, especially at those times when my attention began to wander to other more ephemeral tasks. She has also been constant in her readiness to share her humour and optimistic insights about the state of the church, the University, politics, religion and the

world. These have often been a boon at times when I could not see the end in sight!

I must record my very sincere thanks to Associate Professor Raymond Canning. Raymond not only agreed to have me on the staff of the School of Theology (ACT) from 1999 but has been tireless in his support. He has encouraged me to apply for teaching development grants, study leave and an excellence in teaching award all of which have been successful in no small measure due to his refinements to the applications and his meticulous endorsements. Raymond has been a loyal colleague and a good friend throughout the last seven years but this has been most evident in the last two years when he has provided every assistance since I have been Head of School, including agreeing to take over the position for four months while I finalised the thesis. I have no way to adequately thank him for his generosity, courtesy and professionalism. I will not forget what he has done for me.

Professor Tony Kelly has been a guide and mentor throughout the project, ever querying the status of the project, declaring his willingness to read, critique and assist in any way. As a supervisor Tony is simply excellent! His capacity to maintain focus and to cut through any "dross" is invaluable to a research student who has gathered too much information and wants to do more than the thesis will bear. Tony's supervision style is never threatening

or oppressive but he never let me forget that this was a major professional task to be completed. I will always be grateful for his efforts, his kindness and his donations to the cause of my education!

My family have had to cope with a great deal over the course of this research. I have not always been attentive enough or focused enough on their needs. My siblings and extended family have waited tolerantly for it all to be over. My mother-in-law, Colleen, has put herself out to ensure I had the time to finish by helping to keep our home and lives from decending into chaos. My father, Tommy, would have liked to live long enough to see it finished; I don't think he ever understood why I would want to do this, but he would have been interested to see how much he shaped the content. My mother, Betty, has despaired of it ever being finished but she has always supported my educational endeavours. I have never doubted her love and support and these have been so necessary during the course of writing this thesis.

Finally, my own family have supported me, followed my progress, encouraged me and, most importantly ensured that it all stayed in perspective. My children have convinced me that my basic premise is absolutely accurate: persons are formed in and through their relationships. Aislinn and Diarmid have called me into deeper, kinder and more loving relationships and made it possible for me to be more open and loving to

others in the process. Denise is the love of my life and the companion of my heart. She has been a guide and bulwark when I have needed it; a challenger and critic when it has been necessary. Above all, she is loving, faithful and never lost sight of the end. Beyond this words fail. Thank you my love.

CHAPTER ONE: INTRODUCTION

Each element of the title of this investigation, *The Relational Person within a Practical Theology of Health Care*, will be defined and critically developed in due course. In this thesis I argue for a theological understanding of health care at its most vulnerable point: the meaning and exercise of personhood itself. Personhood in this thesis is understood in terms of its relational aspects. By exploring the relational dimension, I intend to provide a conceptual framework in which the theory and practice of health care can draw fresh vigour and inspiration. In this way I argue not only for a role for theology within health care discourse, but also argue that theology can assist health care to better understand itself and renew itself.

In this introductory chapter, I will present my approach under the following nine headings:

1. Preliminary Descriptive Definition of Health Care

2. A Particular Standpoint

3. Practical Theology

4. The Scale of the Challenge

5. The Context of this Study

6. Framing the Question

1. Preliminary Descriptive Definition of Health Care

As the thesis unfolds the phrase "health care" recurs. I am using the term to designate that area of human need and incapacity that is the object of the healing professions and of the systems and institutions into which they are organised in order to achieve their goal. Reference to "care" focuses on the fact that while these professions have long traditions of curing disease, overcoming malady and healing injury, their prime goal is to achieve optimal physical and mental functioning for the human person when and where this is possible, but above all to engage in "care and compassion in the face of mortality."[1] Noting this does nothing to diminish the magnitude of the question of what health care is, and of what constitutes the system and culture. These questions and the many and provisional answers to them are embodied in the professions and the medical science underpinning them, in the institutions and in the public policies that shape it in this or that direction. Historically, as the witness of many nursing institutes makes clear, health care

---

[1] Mark J. Hanson and Daniel Callahan, *The Goals of Medicine: The Forgotten Issue in Health Care Reform*, Hastings Center Studies in Ethics (Washington, D.C.: Georgetown University Press, 1999).

is made real, even incarnated, in the care and compassion that have prompted and still inspire communities and individuals to stand with people at the boundaries of suffering and debility. Of greatest significance for this thesis is the experience of the patients to whom the whole activity is directed—the person who suffers as a result of sickness, disease, malady; who has to face the health-crisis that now affects him or her, at the deepest level of identity and self-worth.

The focus, then, is not so much on the concept of "health", though this is obviously important. As far as that term is concerned I accept two broad, comprehensive descriptions as sufficient for my purposes. Health is "optimal functioning of the human organism to meet biological, psychological, social, and spiritual needs."[2] Alternatively, but still adequate for my purposes, in 1958 the World Health Organization defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity."[3] These descriptive definitions obviously lie behind the understanding of health care that is crucial to this thesis. My task, however, is not directly concerned with refining such descriptions of health, except in relation to the notion of the human person involved.

---

[2] Benedict M. Ashley and Kevin D. O'Rourke, *Health Care Ethics: A Theological Analysis*, 4th ed. (Washington, D. C.: Georgetown University Press, 1997).

[3] Cited in Ashley and O'Rourke, *Health Care Ethics: A Theological Analysis*.

My investigation does nonetheless aim to contribute something further to the mainstream of Catholic Christian writing about health care. For pragmatic and historical reasons the focus of such philosophically expressed and theologically motivated contributions in the area of health and medicine tries to deal with the dilemmas that arise in clinical practice. The ethics of health care and medical ethics have been the main concern. My interest, however, lies more in bringing theology and health care into dialogue in order to advance the conversation between the two disciplines. Though I will deal with ethical considerations as essential to any theology of health care, the resolution of ethical dilemmas is not my main concern. That lies in advancing the place of the human person in health care theory and practice.

Though this exploration is not an exercise in the ethics of health care, I hope that the particular philosophical and theological approach to the patient as person will enrich the context in which ethical decisions are made when individual cases or even systemic policies are addressed. My concern is directed more to the vision and values of health care practice, by appealing to the philosophical and theological principles—or at least assumptions—most relevant to its conduct. In other words, I will be treating of the concept of the person implied in every aspect of this multi-faceted activity called health care.

2. A Particular Standpoint

Once such questions are opened up, it will become clearer that religious faith, spirituality, and the theology and philosophy aiming to articulate the basic experiences of human life, have a role to play in the field of health care. Such a concern is not an amateurish intrusion into what is best left to professionals, for while disciplines are different in their respective areas of expertise, the patient is not primarily a pathological state but a person who is suffering: the quality of his or her life is at stake. From another point of view, if the professionals involved accept into their attitudes and activities a deeper philosophical or theological understanding of the complexity of the human beings they treat, their own professional values and goals are refreshed, and a theology of health care begins to be formed, at the heart of their professional experience.

I accept that health care today operates in a pluralist, multicultural and indeed multi-faith society, and that since this is the case, it would be ill-advised to reduce all such complexity to an interpretation limited by a single religious tradition—in this case, for instance, a Christian and Catholic theological standpoint. Still, in any research and exploration of a field of enquiry one must have a standpoint, and the more it is openly expressed, the better the communication will be. Following on from this point, the validity

of the particular perspective can be tested in its ability to embrace this complexity of the cultural situation and contribute something humane and inspiring within it.   Here, the words of the Spanish-American philosopher, George Santayana, are worth pondering with this topic in mind:

> Any attempt to speak without speaking a particular language is not more hopeless than the attempt to have a religion that shall be no religion in particular.   Thus, any living and healthy religion has a marked idiosyncrasy.   Its power consists in its special and surprising message and in the bias which that revelation gives to life.   The vistas it opens up and the mysteries it propounds are another world to live in; and another world to live in, whether we expect ever to pass wholly over into it or not, is what we mean by having a religion.[4]

Theologically speaking, there is no "religion in general", just as there can be no "language in general".   Each religion and each theology, as well as the standpoints they generate, is specific, particular, living within a distinctive horizon which affects every aspect of life, its meaning and its value.   This is the familiar problem of the particular and the universal.   To opt uncritically for the universal can result in dissolving all particularity.   On the other hand, to hold defensively to the particular can lead to fundamentalism.   Christian faith has from its origins lived in a multi-cultural world.   Theology has the central and unending task of elaborating the universal meaning of its message deriving from its particular commitment to Christ.   This is not only true for theology in general terms but also for the forms of human activity it

---

[4] Cited by Clifford C. Geertz, in M. Banton, ed., *Anthropological Approaches to the Study of Religion* (London: Tavistock, 1963), 31

promotes, including health care. Christianity holds that, through Christ, the universality of God's healing and saving grace for all, and the particular manner in which this healing grace has entered our history, come together: the universal is embodied in the particular, and the particular opens out to the universal. Our current context—the world of today, the country I live in (Australia), the language I speak, let alone the forms and institutions of contemporary health care which are taken for granted—would be beyond the imagination or comprehension of the writers of the New Testament. Yet, in this time and in this space, faith continues to seek, not only to understand more fully its own meaning, values and practices, but also to communicate this in relation to the culture and the social institutions of our day—and in the case of this thesis, in relation to the particular culture, systems and practices of health care.

3. Practical Theology

In the course of this study I highlight the manifold relationships in which each person exists in its various philosophical and theological dimensions. But, before commencing that aspect of the thesis, it is necessary to reflect on theology, especially the specialisation now usually termed, "practical theology".

Traditionally, theology has been defined, following Anselm, as "faith seeking understanding." Within this broad definition there are a number of more specific and more specialised fields of study. In the same way, within the broad discipline of science there are numerous specific fields of enquiry. Theology, as with any discipline, exists only within a given matrix of culture, people and context. In the cultural context, it seeks to articulate the role and significance of religious faith with reference to the meanings and values that inform a particular way of life, as Bernard Lonergan suggests.[5] Within the larger field of contemporary culture, there is a particular culture of health care, living from a whole complex of meanings and values informing and motivating its systems, institutions, theory and practice.

In seeking to make a contribution to this particular culture, theology, along with health care itself, encounters the problem of specialisation. For those people who have rich experience in health care, it may be that they are unable to articulate their experiences, due to an inadequate theological or faith language with which to express their understanding. On the other hand, while theologians may have a precise language in the area of faith and morality, some simply do not have the experience of health care—especially the wonder and the challenges involved in the varied activities that make up the professional practice of health care today. These extremes are clearly

---

[5] B. Lonergan, *Method in Theology* (London: Darton, Longman and Todd, 1971).

identifiable, for example, when health care professionals find themselves cut off from any deeper sense meaning in what they are doing. At the other extreme, theologians can be so naive when it comes to the genuine challenges involved in health care that they tend toward the abstract and the irrelevant. These problems are not insurmountable and can be lessened if both parties admit that fruitful interdisciplinary collaboration can be possible—by putting the interests of patients foremost together with the promotion of their integral health as human persons. Health care without a philosophical, religious or theological vision, is reduced to treating the suffering other as a pathology on which its particular expertise is focused. Theology, on the other hand, if it is insensitive to the lived experience, imperatives and complexities involved in health care is simply out of touch.

There is a more sophisticated way of putting this view. Take Lonergan's *Method in Theology* referred to above. It presents the role of theology as "mediating between a cultural matrix and the meaning and role of religion in that matrix."[6] Culture is understood in this context pragmatically as the meanings and values that inform a particular way of life. Obviously, this "mediation" cannot happen all at once, or be achieved by any single person. It requires a creative and collaborative framework within which to operate—

---

[6] Lonergan, *Method in Theology*.

and in this way stimulates the collaboration and creativity of many specialisations, if the cultural reality is to be addressed.

I am postponing further discussion of theological method only to make an important point on theology's relationship to health care. In Lonergan's complex description of a collaborative "framework", there is an eightfold process necessary for collaboration. These eight theological activities arise in order to respect the dynamic structure of human consciousness. To be a creative agent in any situation, it is necessary to first attend to experience. Experience provokes questions for understanding: what does it all mean? Posing such a question demands a reasonable judgment on the truth of the many possible meanings that the question generates. Once that is resolved, responsible decisions can follow.

All theological activity is historical. It happens in history, not above it or outside it. Theology, along with all other disciplines, has a past, and it also has responsibility for the future in harnessing its resources for the common good, by highlighting the values of healing, wholeness and hope. In the effort to respect its past, theology must occupy itself gathering the data of its experience (Research), and proceed to interpret what it finds (Interpretation). It is necessary then to set all this within the larger stream of events that affect our present (History), and then face up to the problems and enduring

conflicts that emerge (Dialectics). But then, in a creative concern for the future, theologians have to objectify their respective standpoints, and the human, philosophical, religious, Christian and, in this case, Catholic imperatives that affect a particular outlook (Foundations). If this task is to be critically honest, it must be followed by the effort to clarify the priorities and the non-negotiable aspects that flow from the particular standpoint and its imperatives (Doctrines). It is possible that this could leave only a disjointed list of things to be believed or done—hence the necessity of working these basic positions into a coherent and panoramic vision (Systematics). But this whole process is not complete without Communications—the point where theological activity makes renewed contact with the culture, with the resources developed in the other seven specialisations.[7]

This methodological framework of specialisations provides a convenient background for the application of theological positions to health care. Theology at its most practical, in the activity Lonergan named *Communications,* is a specialised way of communicating with a particular profession and with the system within which it operates, in the way it understands itself and the values it seeks to promote.[8] Raising the question of health care at the personal level, and seeking to contribute something to the

---

[7] Lonergan, *Method in Theology.*

[8] Lonergan, *Method in Theology.* pp. 355 - 367.

meaning, values and sense of identity at work, will, in its turn generate new data—demanding further research, interpretation, historical perspectives, diagnosing conflicts, clarifying standpoints, rearranging priorities, filling out the big picture—and beginning the process of communication all over again.

Practical theology, then is a particular phase or field within the overall discipline of theology. Anderson's definition brings together the points made so far: it is a "dynamic process of reflective, critical inquiry into the praxis of the church in the world and God's purposes for humanity, carried out in the light of Christian Scripture and tradition, and in critical dialogue with other sources of knowledge."[9] As it mediates the role and significance of religious faith to this social and cultural sector of health care, practical theology makes a distinctive contribution in three ways: (a) It functions as a critique of reductive or mono-dimensional views of health care. This is especially the case when these lose sight of the value of the human person and the inter-relational dimensions of personal existence. (b) Theology contributes further by supporting and deepening the basic meanings and values that religious faith shares with activities of health care—for example, scientific and professional expertise, compassion, and the transcendent value of personal dignity; (c) in performing these two tasks, the method of practical theology suggests opportunities for a productive interdisciplinary approach focused on

---

[9] R. S. Anderson, *The Shape of Practical Theology* (Downers Grove, Ill.: InterVarsity Press, 2001).

the patient and on health in its integral meaning due to the priority of practice over theory and the focus on engagement with other disciplines.

This approach to theological thinking in health care is still novel, but not unique. David F. Kelly's recent book, *Contemporary Catholic Health Care Ethics*, is an attempt at something similar.[10] Kelly is seeking to place the discussion about practical judgements in health care ethics into a broader theological context. His focus, in my view, remains that of ethical decision-making in health care; my concentration is on that broader theological context. Despite this, Kelly's work and this thesis share two basic positions, namely, that religion and theology have a place in health care and that the key to this involvement is an understanding of the human person.

We agree, therefore, that religion and theology have contributions to make to health care due to the continuous involvement of religion in health care— shaping the discipline, providing health care, forming bioethical discourse. Linked to this point, we both contend that theological language adds richness to the discourse of health care, and religion and theology assist people in forming frameworks of meaning.[11] Moroever, Kelly and I both argue that the

---

[10] David F. Kelly, *Contemporary Catholic Health Care Ethics* (Washington, DC: Georgetown University Press, 2005).

[11] Kelly, *Contemporary Catholic Health...*

key to theological participation in health care and the ethics of health care is an understanding of the human person.

We differ, however, in terms of a basic anthropology and its application in health care. While we both begin our theology of the human person with reference to Scriptures, Kelly confines his discussion to the origin of humanity made in the "image and likeness" of God (Gn 1: 26). From this point he moves to an anthropology based on divine election as the chosen people of God.[12] His reasoning here follows a fairly dated, though valid, approach articulated by John O'Grady in 1975.[13] In contrast my own anthropology is founded in the relationality of the divine persons and the consequential relationality of human persons. While this approach is no newcomer to theology, it has been under-utilized in terms of the practical applications of theology.

A second point of divergence between Kelly's approach and my own is his use of Christian anthropology in order to provide a basis for ethical reasoning in health care, whereas I am primarily interested in how Christian anthropology can assist health care to better achieve its own goals. This, too,

---

[12] Kelly, *Contemporary Catholic Health...*

[13] John F. O'Grady, *Christian Anthropology: A Meaning for Human Life* (New York: Paulist Press, 1975). Kelly indicates that he is following O'Grady's outline of the topic and issues, Kelly, *Contemporary Catholic Health...*

will obviously have ethical implications, but I am looking at considerations

broader than the ethical concerns of Kelly in his book.

Kelly's anthropology is firmly based in the biblical doctrines of creation and

election. That certainly enables him to focus his ethical reasoning on the

individual in health care. Yet, while he does recognise that humanity was

created as a community,[14] he immediately moves to a defence of

individualism:

> "Coherence," "solidarity," and "community" can be oppressive, and
> both church and state have brought tyranny in their name.
> Individualist philosophy reacted against that by emphasizing the
> potential of the individual and by trying to create structures where the
> individual could not only survive, but could thrive.[15]

This perspective also dominates in his approach to health care ethics where

the interests of individuals take precedence over community concerns. Kelly

is certainly more balanced in this regard than other writers, for example Tom

Beauchamp and James Childress,[16] but it reflects a distinctly American

emphasis, as I will mention later.

My own anthropology approaches the need to balance individuality and

community in a different manner. Instead of favouring one over the other I

---

[14] Kelly, *Contemporary Catholic Health...*

[15] Kelly, *Contemporary Catholic Health...*

[16] Tom L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001).

draw on philosophical and theological perspectives which promote an understanding of human persons as individuals-in-community in the health care context. This is where the distinctive contribution of this thesis is to be found.

In short, Kelly's fine book is properly located in the field of theological ethics in health care. In contrast, this present investigation makes a modest contribution to the engagement of theology with health care hence it is a more explicit exercise in practical theology. As Terry Veling suggests, one of the distinctive features of practical theology is that instead of a model of theological reflection that is uni-directional, commencing with theory and moving toward practice or application, it proposes a dialectical engagement so that "theological reflection can regain its intrinsic connection to life." [17]

Through this thesis I hope that the topic and its method of exploration can genuinely enrich the philosophical and theological context of health care, ethical decision-making in health care and beyond. Taking up Veling's idea that practical theology is a dialectical process, I would hope that those reading this work are assisted to envision new horizons to their work in philosophy, theology and health care due to a renewed understanding of the human

---

[17] Terry A. Veling, *Practical Theology: "On Earth as It Is in Heaven"* (Maryknoll, NY: Orbis Books, 2005).

person as a person-in-relation. Of course, I am realistic enough to realise that while I may be hopeful of significant outcomes for others, this thesis represents a quite modest contribution to the field by giving greater focus to a particular way of thinking about persons and how this might enrich thinking and practice in the field of health care. Following these optimistic observations, I now return to the more precise challenge before me in this thesis.

4. The Scale of the Challenge

Any external discipline seeking to engage with health care encounters an enormous field of human endeavour and enquiry; this too is the case for practical theology, and no individual or particular research project can hope to address all the issues involved in the practice of health care, the public health system or the pastoral care of the patients treated within it, to say nothing of vocational motivations of either a religious or professional kind. In an obvious way, health care is more a continuous questioning of what health, healing and care might mean and what this meaning is in a particular time and place. For the practice of health care, either as a system of human activity or the particular work of individuals, intends to respond to the basic human experience of suffering, illness and injury, by offering hope of prevention or cure for what most ails human beings. As a discipline and a practice it is

continually being renewed, even reborn, as a result of dissatisfaction with previous limitations and also those experienced in present practices and attitudes. For this reason, health care must include matters such as public policy advocacy, the creation of pro-health networks and environments, the strengthening of community action, and the development of personal skills. In this thesis I consider one aspect of thinking with which health care should concern itself: the inspiration and critique that can be derived from the best philosophical and theological sources. My reasoning about this is that if the focus of health care moves from a narrow concentration on curing to a broader vision of care, then this will enhance the prospects and potential flourishing of the human person and that theology, and the philosophy which informs it, offer an opportunity to achieve this goal. Health care is always, therefore, something given, yet ever developing, and, whatever is motivating its values, it will never quite rest content with any achievement. The call to serve the sufferer through any of the specific activities inherent in health care is always bigger than the discipline, the profession, or the system. It is never quite reducible to any particular organisation, never quite reconciled to the way things are. The "new", the advance or the breakthrough never quite has the last word. As such, this is the area with which practical theology has considerable alignment in that "it is a theology that is given over to passion

for what could yet be, what is still in-the-making, in process, not yet, still coming."[18]

Clearly, scientific research and an ever increasing range of professions are integral to the care for the whole person, existing in all his or her fullest relational matrix. The closer we approach questions as to what makes human communities function and work, what do human beings really want, in what does health and happiness consist, along with the further questions of who, in any given society, are the really healthy or the truly sick, all take us into intimate considerations of deepest human personhood. Here, radical philosophical and theological questions arise, with the possibility of critiquing current health care and the attitudes, practices and systems it expresses. For lying dormant in the practice of health care are dimensions that might easily be overlooked. For instance, the fact that there are limits to any and all attempts at cure and repair—human suffering and death are inevitable—must be candidly and positively faced if health care is not to be the promotion of an illusion. Secondly, though in a quite different way, recognising the make-up of the human person — the who and the what — is essential for the healing professions, especially in regard to the suffering person. Further, how can the reality of personhood, common to both the patient and to health care

---

[18] Terry A. Veling, "'Practical Theology': A New Sensibility for Theological Education," *Pacifica* 11, no. 2 (1998).

professionals, be the source of an interpersonal relationship in the interactions that constitute health care? This practical theology presents partial answers to such questions as it strives to articulate an appreciation of the human person at a deeper level than pathology, or a health consumer in an economically rationalised society. In this sense, my particular or distinct contribution aims to bring together, from its perspective on the relational person, the health of persons in terms of their psycho-somatic well-being and beyond this to the well-being of persons in their complex, multi-faceted personhood.

Practical theology seeks to work within a "holistic" sense of both the person and society. It has a long history to draw on. The traditional ministries of the proclamation of the Word and the celebration of the sacraments has inspired, however tacitly, all the varied Christian ministries to the poor and the suffering. It has taken into account the whole of life in all its predictable phases together with the more dramatic turns. Death, for instance, is given its place, to be candidly recognised, accepted and approached through trust in him who is "the resurrection and the life" (Jn 11:25). Evil is more than sickness, and guilt is more than a depressive state. Such a theological approach meets life in its heights and its depths–and its breadth, as life typically journeys on through marriage, family and in the manifold relationships of a wider community composed of many generations. Since an underlying assumption of this way of thinking has been that the individual is

a social being, a large part of care was also directed to the social well-being of the community. Though there may not have been much of a developed theory, it is the case that a basically theological understanding of the person gave rise to hospitals, schools and charities of all kinds.

Even in Church-sponsored organisations and institutions of health care, there are inevitable tensions. The original expansive, holistic vision that gave rise to the various manifestations of health care now has to confront the requirements of professionalism, economic accountability – especially now that government resources are so massively involved – and, of course, the constraints of the new styles of management. It would be instructive to track the experience of such problems in practically any Church-sponsored hospital or nursing home, to say nothing of what might be discovered from the recent history of charities such as the Salvation Army, the St Vincent de Paul Society, the Brotherhood of St Lawrence or Caritas International.

The problem is to get some larger comprehension of what "health" means – at least in the contemporary setting. There would seem to be some agreement about a number of significant health issues: that smoking is bad for you, that speed kills, that nursing homes should be better, and that work-place safety should be ensured. The ease with which advertising campaigns can make their point underlines the difficulty of addressing more massive and more

subtle issues. For example, people may be tempted to drive carelessly if they have been uprooted from their fundamental relationships, say, with colleagues if they have just been made redundant, or if their marriage has just broken down or their families have broken up. It is a long path, I am sure, from symptoms to the diagnosis of disease, and then to see the disease as a possible symptom of a wider deeper breakdown of society in its primal relationships; and then to ask what health is and whose health is in question. The current trend to ever longer working hours where the expectation is that success—measured as promotion or even just retention of employment—requires significantly greater effort than was expected twenty, thirty, fifty years ago, may produce increased wealth but also it has also increased social problems. On recognising an increase in social dislocation and a decrease in social cohesion, the questions arise, who or what is to blame? Is it the lack of personal and communal efforts at relationships? Or the social demand for economic success and accountability?

There is a manifold holistic experience sedimented in the theological tradition. It awaits juxtaposition into the present particular context which, while being rich with the promise of new possibilities, will be on surer ground if it embodies, not only a critique of what was once taken for granted, but continues to add to the discipline. It now awaits its proper multi-disciplinary elaboration and extension. Post-war Europe came up with

impressive examples of "pastoral theology",[19] but it was yet to develop into the form of practical theology explained above, with its capacity for more specific focus on health care and clinical practice.

In the meantime, human beings are complicated creatures. A hundred organs maintained in harmony by at least eight interacting systems–neural, endocrinal, cardio-vascular, etc.–more than two hundred bones, six hundred muscles and billions of cells come together—somehow—to make each of us physically who we are. In the one and half kilos of brain matter in our heads there is more operational complexity than in the whole of the Andromeda Galaxy. In the neurones of the human brain, each cell communicates with at least a thousand others. Humans are not simple beings; human illness occurs in so many forms, and health specialisations are ever expanding to treat them. This is made more complex when situated within the current cultural sense of growing alienation and greater meaninglessness; of environmental degradation and the ecological concerns of our day. Any system of health care necessarily involves environmental considerations, and the ecological health of the planet itself.

---

[19] There are over two and half pages detailing this situation in the large multi-volume, F. X. Arnold, ed., *Handbuch Der Pastoraltheologie* (Feiburg: Herder, 1972)

To attach "public" to a health care system serves to connote the social and cultural values inherent in what has generally been called "the common good". On the social level, an economic and legal organisation is necessary if any health system is to operate, with the need of a government regulation to moderate such an economy if the flow of goods and services to all members of society is not to be impeded. However, such social organisation, if it ignores the basic cultural values by which the human community is ever being refreshed–the dignity of the human person, the pursuit of truth, freedom to seek the good, the cultivation of art, the transcendent concerns of religion and spirituality–will destructively turn back on itself to be just an economic entity governed by its own "rationalism" – or lack of it. At the heart of these cultural values is the freedom of individuals not to be subordinated to any other purpose, but to be supported in the self-realisation that can comes about in ways that are commonly called "religious" or "spiritual". If health care does not recognise this, then any given society suffers not only from physical illness to a greater or lesser extent, but also from a debility of the spirit, a culture-sickness. Faced with the problems of youth suicide and drug addiction, the prevalence of depression, and the isolation of the old in nursing homes, radical questions arise.[20] When there is no language to articulate the deep things of life and death, both carers and their clients are diminished, or

---

[20] For an extensive study of these kinds of issues see *Hardwired to Connect: The New Scientific Case for Authoritative Communities* (New York: Insitute for American Values, 2003)

even defeated, by the same experience of being voiceless. Hence, the concern of this thesis is to articulate a relevant sense of personhood and the relationships in which it consists.

A holistic care of the individual and the community is ever the goal of health care and of theology. But it can be pursued only in a genuinely interdisciplinary context. The monological dialects of any discipline or profession–medical, psychological, economic, political, philosophical and theological, can so narrowly frame the human reality that essential dimensions are ignored. A theological engagement with health care entails the learning of a new common language able to name and to foster the collaboration of science and religion, of government and Church, of economics and ethics, of management and hope. A basic, value-laden term in such a language is the relational person.

This summary reflection suggests three dimensions of the relationship of theology to health care:

1. This practical theology must seek to articulate a theology *of* health care, from the resources of the Christian tradition;

2. Theology, by pursuing its practical applications, seeks to be a theology *within* health care, attending to meaning, motivations, practices and

dilemmas that inform the present situation and understanding of health care.

3. Practical theology, consequently, seeks to be a theology *for* health care, in that it seeks to make contact with the experience and concerns of the patients and the health care providers involved in the enterprise, to contribute the resources of Christian tradition to the care of those who are suffering.

5. The Context of this Study

For each of us, health care is inescapably and intensely personal. One way or another each person is confronted by suffering, disease, accident, and eventual death, in ourselves and others. This subject of investigation was sparked by four perceptions of the limitations, in theory and in practice, that are in my view evident in contemporary health care. First, it was not clear, at least in my researching health care from a theological perspective, about just what a distinctive *theological* perspective amounted to, at least as a basis for reasoning in this increasingly complex area.[21] In other fields of theological inquiry into concrete situations facing communities and individuals, the

---

[21] The theology of Stanley Hauerwas stands out as an exception here. Hauerwas writes for Christians at the margins of mainstream thought. He is provocative and sensitive. He argues, in health care, that there are appropriate Christian stances which should not be compromised. However, recognition of his insights are not widespread outside the theological community. This study differs from his work in that rather than articulating a Christian theology which seeks to stand outside the mainstream, I actually look for points of engagement. A more recent contribution from Lisa Sowle Cahill provides a Catholic theological perspective on health care, L. S. Cahill, *Theological Bioethics: Participation, Justice, Change*, ed. J. F. Keenan, Moral Traditions (Washington, D. C: Georgetown University Press, 2005).

connections between theology and the given area seem more definite. For example, in the field of social ethics, the particular concept of social justice deriving from Judaeo-Christian sources tends to bring theology and social questions into a fruitful relationship, enabling the examination of issues such as responsibility, community, human rights and care for one's neighbour. A number of biblical and theological themes are immediately relevant to these areas. There are also similarities in the area of sexual ethics in which the values of the sacramental character of relationships, personal fidelity and procreation have immediate connections to the wider domain of theological understanding. But in health care ethics, this kind of thematic theological application is not apparent. The surprising aspect of this is that arguments in health care ethics presented by religious scholars or groups are limited almost exclusively to philosophical considerations, in terms of content and method. I concede that a unilateral or undifferentiated theological approach to health care ethics is undesirable, given the contemporary pluralist Western setting. But that is not the problem encountered by theologians representing a particular religious perspective or specific tradition who wish to participate in current ethical debates in health care. Theology and theological discourse, it appears, has no clear place, even with those who could be expected to be most committed to it and even aligned with it. Hence, in this thesis there is a need to argue for the validity of a religious and theological contribution. As I will make clear, a critically articulated theological world-view, at least for the

significant number of religious believers involved in health care, either as health care professionals or patients, can have a creative role in the construction of frameworks of meaning in which health care makes sense and in articulating or renewing its original vision in changing circumstances. The religious values motivating that vision of health care may suggest a beneficial critique of the overall system when a certain uncritical pragmatism is always the risk. Most of all, a theologically articulated religious perspective will uphold the dignity of the human person and defend against what threatens it.

Secondly, there is, as already noted, a paradox in the views of Christian ethicists, and particularly in those who share my own Catholic heritage. The sources and style of their argument is philosophical without any, or at least very limited, reference to the theological sources or central theological beliefs that will be the focus of attention in this thesis, namely, the Trinity and Christology. Examples of avowedly Catholic scholars who exhibit this tendency include Richard McCormick, Norman Ford, Bernadette Tobin and Luke Gormally. This tendency is not universal and there is beginning to emerge a greater number of explicitly theological writings on health care, particularly in terms of the ethics of health care. Examples of these include the recent contributions of Lisa Sowle Cahill and David F. Kelly. But these too do not explicitly link core doctrinal teaching with the enterprise of health care. In this sense they are confining their reasoning to a particular dimension

of theological discourse, rather than engaging in the activity of practical theology as this thesis does.

Why is it that theology, especially in its Trinitarian and Christological and eschatological perspectives, plays little or no part in thinking about health care and the dilemmas which occur within it? It is an odd thing that religiously committed ethicists so strongly favour philosophical argument that they appear less religious than the general population. Indeed, census and survey data reveal that the religious core beliefs and values are critical, especially when people face suffering, illness and the death.[22] If explicitly religious voices participating in health care are not heard then both the vision and ethical reasoning of health care are radically impoverished, even cut off from their deepest resources, in regard to those, above all the gravely ill, that the health system is designed to serve.[23] If the contributions of religious scholars and theologians to health care ethics are restricted to insights derived

[22] Data is more consistently available from the United States, for example: G. Barna, *State of the Church 2005* (Ventura, CA: The Barna Group, 2005), W. Charles Heiser, "Catholicism USA: A Portrait of the Catholic Church in the United States.," *Theology Digest* 50, no. 4 (2004). In Australia, data is less consistently available but can be found through the Australian Bureau of Statistics and the National Church Life Survey. Australian Bureau of Statistics, *Year Book Australia - Culture and Recreation - Religious Affiliation* [website] (ABS, 18 March, 2005 2005, accessed 08 December 2005); available from http://www.abs.gov.au/Ausstats/abs@.nsf/0/E4F6E98AA14943F3CA256F7200832F71?Open, NCLS Research, *Australian Spirituality* [website] (National Church Life Survey, n/a 2005, accessed 08 December 2005); available from http://www.ncls.org.au/default.aspx?sitemapid=6,

[23] Hedley G Peach, "Religion, Spirituality and Health: How Should Australia's Medical Professionals Respond?," *Medical Journal of Australia* 178, no. 2 (2003). Bruce D. Rumbold, "Caring for the Spirit: Lessons from Working with the Dying," *Medical Journal of Australia* 179, no. 6 (supplementary) (2003).

from non-religious or non-Christian perspectives, why is it that Christianity's historical, anthropological and ethical experience is deemed irrelevant, especially when the care of the sick and suffering was a mark of Christianity from the earliest times?[24] There seems to be a lack of confidence in the ability of theological reasoning or religious experience to claim any public status. In this sense there is a problem for the claim of pluralism—it seems that any source is permissible to inform health care except avowedly religious sources.

Thirdly, my observation that the health care system in Australia, together with information gleaned from reading about health care in other Western societies such as the United States and the United Kingdom, has become so managerialised and so systematically impersonal that economic considerations of measurable outcomes of success predominate to the detriment of personal care and the complex of relationships that affect the human person in health and in sickness. Lisa Sowle Cahill's recent work has been critical of these emphases in the American health care system;[25] while from a secular medical perspective Melvin Konner has presented a wide ranging, and now prophetic critique of contemporary Western medicine, covering Australia, Britain and other health care systems that reflects similar

---

[24] Daryl Pullman, "Universalism, Particularism and the Ethics of Dignity," *Christian Bioethics* 7, no. 3 (2001).

[25] L. S. Cahill, *Theological Bioethics: Patricipation, Justice, Change*, ed. J. F. Keenan, Moral Traditions (Washington, D. C: Georgetown University Press, 2005).

concerns.[26]   The justification for increasingly expensive technological innovation necessarily relies on publicly measurable successful outcomes in surgical repair and the cure of disease.   As a result, the person who is the recipient of such care can be reduced merely to the status of a success or failure in the process. Furthermore, the crisis-medicine which is the business of casualty/emergency wards, and the ability to respond to major accidents and natural catastrophes, is not structurally capable of pausing over the significance of the individual person's experience: the system's ability to respond rather than the individual's personal experience of threat or injury is rightly the main consideration.   But if health care is uncritically intent on curing a condition through surgical or other intervention or largely taken up with crisis-responses to accidents or catastrophe, it becomes increasingly desensitised to the personal reality of those it is designed to serve.   This is currently being demonstrated in Australia with a number of regionally based health systems being overstretched and the number of publicly (politically) unacceptable errors mounting.   The chief systemic failure is not a lack of expertise or deliberate choice to avoid meeting known needs. It is a failure to adequately recognise the needs of the persons involved in the various health situations, staff or patients. In short, the pathology, a reification of the person, becomes the focus, rather than the care of persons at their most vulnerable, in their experience of the situations of isolation, powerlessness, suffering, and

---

[26] M. Konner, *The Trouble with Medicine* (Sydney, NSW: ABC Books, 1993).

the risk of death. As a result, the understanding of health as wholeness can easily slip from view, even if the wholeness in question may vary, as with those who have lost a limb, those afflicted with Down's Syndrome or who are in palliative care, compared to those who require surgical intervention to ensure a return to somatic equilibrium. Specific treatments will vary, but the central goal of wholeness and integrity will not. These physical, biological goals of medicine are necessary, but they need to be pursued in the context of the persons who are the subjects of health care, especially by acknowledging the multiple and multi-faceted nature of the relationships in which the human person exists. There are genuine limits to biological existence that must be recognised, along with the transcendent character and orientation of the human person. To ignore any of this results in a truncated sense of the wholeness and integrity of the persons who are the subject of health care.

Gadamer stresses the need for a much more integrated approach, arguing that health care is misdirected when "the individual patient is objectified in terms of a mere multiplicity of data",[27] so that the unique value of the particular person is unrecognised and even discounted. He goes on to make a telling point, "[I]n the vast technical structure of our civilization, we are all

---

[27] Hans-Georg. Gadamer, *The Engima of Health: The Art of Healing in a Scientific Age*, trans. J. and Walker Gaiger, N. (Standford: Stanford University Press, 1996).

patients".[28] Gadamer highlights something vital for an understanding of the intersection between theology and health care, namely, that we are all "patients"—in a more radical sense, "sufferers". For all persons are vulnerable, and they are especially vulnerable when in the grip of illness, injury or diminishment. What a theological vision fundamentally offers to health care is the reminder that the promotion of personal existence is central to the goals of the activity, even as the pathological conditions involved look to healing and cure.

Finally, personal experiences involving my own family in situations of chronic illness and disease made me aware of the limitations of a widely influential approach to health care practice, based on "dominant principles", as it is elaborated in the work of Georgetown researchers, Tom Beauchamp and James Childress.[29] This approach had its origins in the North American *The Belmont Report*, a Presidential Commission on Bioethics in research.[30] Beauchamp and Childress claim the central principles in health care ethics should be autonomy (preserving the patients' right to choice), beneficence (doing good for the patient), non-maleficence (avoiding harm to the patient) and justice (meaning, distributive justice, especially pertaining to allocation of

---

[28] Gadamer, *The Engima of Health: The Art of Healing in a Scientific Age*.

[29] Beauchamp and Childress, *Principles of Biomedical…*

[30] National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* (Washington, D.C.: Department of Health, Education, and Welfare., 1979)

resources). These principles have proved useful for health care professionals in determining whether a course of action is ethical. Notwithstanding such usefulness, it is assumed that there is never a conflict between the principles. But in contemporary health care such conflict is frequent. In particular, the stress laid on the autonomy of the patient and the beneficence of the health care provider are inadequate when dealing with life-threatening or terminal conditions. As Jerome Arnett has noted, since these principles are not actually grounded in any system of morality, they can be used to justify a range of procedures: "[f]or example, euthanasia which fulfills the patient's wishes (autonomy), is seen as a healing act (beneficence) and saves resources for other societal needs (distributive justice)."[31]

When there is no fundamental moral and theological grounding, a calculus of purely utilitarian type holds sway, following the philosophies of Jeremy Bentham and John Stuart Mill. It expresses itself in this general principle: "actions are right as they tend to promote happiness, wrong as they tend to produce the reverse of happiness."[32] This kind of reasoning appears in a democratic guise by arguing, in any given setting, for the happiness of the majority of the population in order to determine goodness and rightness of an

---

[31] Jerome C. Arnett, "The Bioethics Movement: An Emerging Culture of Death," *Medical Sentinel* 7, no. 2 (2002).

[32] J. Speake and S. Mitchell, eds., *A Dictionary of Philosophy*, ed. A. Isaacs (London: Pan Books, 1979), 361

action. Among the objections which can be raised to this, is the most obvious. As a system, it ignores the needs of the marginalised and focuses exclusively on those who hold power or otherwise form the majority. As a result, it allows for the deliberate sacrifice of the disadvantaged minority in order to ensure the well-being of the majority. Within such a calculation, there is no place for any consideration of intention or motivation.[33] Classic models of utilitarianism still influence public health, even if with the modern variation often termed, "preference utilitarianism". This variation defines the best outcomes in terms of the satisfaction of the preferences of the individual and the majority. The chief contemporary proponents of this model are R. M. Hare and Jonathan Glover in terms of moral theory, and Peter Singer and Daryll Macer, in terms of the application of the theory. Singer has been particularly influential in health care ethics and I consider his views again later in the thesis. At this point it is sufficient to signal that Singer argues for an empirical approach to determining personhood. Its criterion resides in the capacity of an individual to feel pleasure or pain, to enter into complex social relations, and to have ongoing interests or preferences. But such criteria can be verified in animals, and this is used by Singer to confer on them a quasi-personal status, while at the same time excluding human beings who do not exhibit such evaluative criteria.

---

[33] Speake and Mitchell, eds., *A Dictionary of Philosophy*

These three perceptions form the motivation for this investigation and for the thesis. In my observations of health care and research about the field, I came to the view that a fundamental question underpinned my concerns: what is a person and what are the implications of this for health care? It is now necessary to formulate this in terms of a research question and the arguments which support my conclusions.

6. Framing the Question

My key question, then, is this: What does it mean to be a human person? Answering this question takes on a special urgency in the midst of contemporary debates about abortion, euthanasia, the use of scarce resources for life-saving treatments and, more recently, in discussions about reproductive technologies and genetic engineering.[34] All efforts to formulate a concept of the person as central to an ethical approach to these kinds of issues inevitably rely on particular anthropologies and the conceptions of human personhood they suggest.

Given the questions that sparked this research and thesis, arising as they do from perceptions of negative situations in the field of health care, let me now

---

[34] J. Christopherson, "The Human: Its Import for Ethical Decision-Making," in *Persons in Community*, ed. William H. Lazareth, (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 2004), 45

outline, in a more positive manner, the orientation of the thesis and the concept of the person that is central to it. It can be formulated simply: human persons are formed in and through a network of relationships. Central to this conception of persons as relational beings is the impossibility of ultimately defining them in terms of *what* they are as individual units, and the necessity of defining them only in terms of *who* they are in their complex relationality. Relationships then, not capacities or functions, are the core consideration.

Accordingly, in this thesis I seek to articulate an anthropology based on a relational understanding of personhood. Recognising this point gives rise to different forms of reasoning, to affect the various models of health care and the ethics that pertain to them. Admittedly, the development of a conception of health care based on a theology of relational personhood may not lead, in each and every case, to notably different outcomes when compared to non-theological or purely utilitarian approaches. On the other hand, there are different governing principles in the reasoning processes involved, along with different priorities and different scales of values. These different scales, measures and values may in some instances lead to different ethical decisions being made and different clinical outcomes. I contend that the more sensitive health care is to the personal and to the relationality that constitutes it, the more the system and its ethos and its modes of reasoning are affected. There is a problem for contemporary Western health care culture when decisions

affecting patients are left in the hands of professionals with no reference to the needs of the patients themselves. It is too easily presumed that the patient is an isolated individual characterised by a specific pathology or even syndrome, and so is considered in abstraction from the relational networks which are vital to personal identity, health and well-being.

A relational theology of personhood can open up a broad and fertile ground for the theological and ethical reflection on health care. In this respect, with James Childs, I argue that anthropology, especially in its theological foundations, and ethics belong together.[35] This thesis, therefore, operates on two fronts, namely, the exposition of a theological theory of relational personhood and the application of that theory to health care. Accordingly, it is this approach which means that the thesis is an exercise in applied or practical theology. I am seeking to bring into fruitful interaction systematic theology, moral theology, philosophical anthropology and best health care practice, even while admitting that these fields usually operate as separate specialised disciplines.[36]

---

[35] James H. Childs, *Christian Anthropology and Ethics* (Philadelphia: Fortress Press, 1978).

[36] William J. Hill, "Theology," in *The New Dictionary of Theology*, ed. J. A. Komonchak, M. Collins, and Dermot A. Lane, (Dublin: Gill and Macmillan, 1987), 1011 and Lonergan, *Method in Theology*.

Before clarifying the methodology further, let me highlight some aspects of the current debate on personhood. The presumed understanding in public debate and social commentary is that the person is an autonomous rational individual. This understanding of personhood appeals to the individual's capacity to demonstrate some concrete act of autonomy in a display of rational behaviour. According to this view, persons are essentially individuals, while the world in which they exist is fundamentally interpreted in what has been termed "a sociology of strangers".[37] This confronting expression suggests that persons are individuals, and only such individuals have a particular moral status. The place of relationships or the role of the community is, as a result, not recognised. Given such an understanding, other human beings are relevant only in so far as they assist or impede an individual's choices. The person is thus regarded as being in a state of separation from others, not in relation to them. In a former metaphysical idiom, the individual autonomous unit is the "substance" of the human being, while relationships are simply "accidents"—that is, contingent modifications of the underlying substantial reality.

On the philosophical level, such a notion of personhood has been criticised. The Thomist philosopher, W. Norris Clarke, while appreciating the

---

[37] C. S. Campbell, "Religion and Moral Meaning in Bioethics," *The Hastings Center Report* 20, no. 4 Special Supplement (1990).

underlying individuality of the human person, has developed this along far more explicitly relational lines than was the case in the classic metaphysical and Thomist tradition.[38] In accord with the flexible methodology of practical theology and of this thesis, Clarke appeals to inspiration drawn from a theological source of the relational understanding of the person, for in the doctrine of the Trinity,

> … lies concealed a revolution in man's view of the world: the undivided sway of thinking in terms of substance has ended; relation is discovered as an equally primordial mode of reality… and it is made apparent how being that truly understands itself grasps at the same time that *in* its self-being it does not belong to itself; that it only comes to itself by moving away from itself and finding its way back as relatedness to its true primordial state. [39]

On a more experiential and clinical level, George Khushf, draws attention to what he terms "the revelatory function of illness", as it discloses the "deep brokenness" always present in the human condition and the dependence on others that this entails. [40]

In other words, the experience of illness reveals the relationality of personal existence that lies too often concealed from the healthy and even from those

---

[38] W. Norris Clarke, *Person and Being* (Milwaukee: Marquette University Press, 1993).

[39] Josef Ratzinger, *Introduction to Christianity* (New York: Herder and Herder, 1970). And more fully developed in, Josef Ratzinger, "Concerning the Notion of Person in Theology," *Communio* 17, no. 3 (1990).

[40] George Khushf, "Illness, the Problem of Evil, and the Analogical Structure of Healing," in *On Moral Medicine: Theological Perspectives in Medical Ethics*, ed. Stephen E. Lammers and Allen Verhey, (Grand Rapids, Michigan: William B. Eerdmans, 1998), 34

involved in health care. Importantly, as Khushf makes clear, it is not that illness causes us to develop a relational aspect or orientation, rather it *reveals* our innate relationality and our deep need for the Other. Sickness and disease confront us with our essential dependency and need for others in order to survive, especially in more than a physical sense.

7. Representative Cases

Health care, especially in the twentieth century, has caused questions of personhood to take on new significance. In the Western context, particularly, health resources are scarce, various aspects of medical research and the application of expertise and technology are controversial, and the moral axioms of previous ages, such as the doctrine of the sanctity of life are now questioned. In order to demonstrate that personhood is of central importance in health care and to indicate why a relational approach to personhood is more appropriate, I refer to and analyse particular cases in health care. This application of the theoretical components of relational personhood to flashpoints in health care is the distinctive contribution of this thesis and marks it out as an exercise in practical theology.

While it is my contention that personhood is central to the activity of health care, it is most often cast into sharpest relief in cases that concern the

beginning and end of life. Case studies from health care are analysed at three levels. In the first category, two relatively recent cases in health care ethics are considered in substantial detail to give a practical focus to the issues of personhood in health care: the first, a case concerning the separation of conjoined twins and the second about voluntary euthanasia/medically assisted suicide. These cases are briefly described here in this chapter and will be developed in Chapter Three and then analysed in some depth in Chapter Six. The second category includes a number of cases in neonatal and end of life quandaries; these are helpful to indicate that the relevance of relational personhood is not limited to the specific major cases selected but have wider applicability. These cases are simply identified here and will be briefly outlined in Chapter Three. A detailed analysis of these cases will occur in Chapter Six. Finally, other cases are mentioned throughout the thesis to illustrate particular points being made at the time. At this stage it is helpful just to indicate the scope of cases that I use in the thesis.

The Attard Twins

The first case occurred in Britain in 2000, and involved the separation of conjoined twins, publicly known as Jodie and Mary (these pseudonyms were applied to protect the confidentiality of the parents and children at the time). Ultrasound in their home country of Malta revealed that the mother was pregnant with conjoined twins. Following the advice of their physician the

parents relocated from Malta to Britain for the birth of their daughters in order to increase the chances of a successful birth, and to give the twins the best chance of survival. After diagnostic tests in Manchester the parents were offered a termination which they refused. The twins were born on August 8, 2000. Post-natal tests indicated that separation would certainly result in Mary's death: her brain was primitive; the heart enlarged and poorly functioning; and the lung tissue was non-functioning. With this in mind the parents refused consent for the recommended procedure and indicated that they would take their daughters home. This was challenged in the British courts which subsequently gave permission for the surgery. Separation took place on November 7, 2000 resulting in Mary's death. Her sister Jodie survived and subsequently underwent a number of reconstructive operations, and returned to Malta with her parents. [41]

Nancy Crick

The second case concerns Nancy Crick, a 70 year old Australian widow who became an advocate for voluntary euthanasia/physician assisted suicide. Following treatment for bowel cancer she continued to experience a range of symptoms and required a colostomy. Over a period for time she sought advice from health care professionals and determined her preferred option

---

[41] Suzanne Rock and Nick London, "Amazing Gracie," (Leeds, Yorkshire: Granada Television, 2001)

was to end her life. Her public campaign to have voluntary euthanasia/physician assisted suicide legalised included media interviews and an internet diary. Crick ended her life on May 22, 2002 using barbiturates sent to her through the mail.

These cases are highly relevant to this thesis since they demonstrate the influence underlying concepts of the person have on decision-making in health care. In the first case, when faced with a serious ante-natal diagnosis the proposed course of action from health care professionals was termination which would have resulted in the deaths of both foetuses. Even though most risky procedures conducted on minors require parental consent, when the parents exercised their prerogative, this was challenged and a course of action that would cause the death of one child was sanctioned. The implications of this for personhood in health care are obvious. There are also relational perspectives which I think would have clarified features of the case and would, perhaps, have led to a different process of reasoning being applied. In the second case, the dominant Western view of the person as a rational autonomous individual was highly influential. Crick's claim to be able to end her life was based on the view that as a rational person she should be able to choose any course of action open to her.

Other relevant cases--Neonates

The two other neonatal cases are covered in some detail in the thesis. One concerns the Poarch twins, the first of whom died soon after birth and his sister died some months later. The other is a fairly well documented case of Baby Andrew Stinson who likewise was born early with a number of complications and died following some months of treatment. I make use of these cases to illustrate how the perspectives on personhood held by the various people involved in the care of the infants heavily influenced their treatment and preferred courses of action. In particular, the reasoning of the children's families is important in this thesis on relational personhood.

Other Cases—End of Life quandaries

The case of Nancy Crick also raises a number of issues relevant to this thesis which can be further illumined through consideration of other end of life scenarios. Three well-known and well documented cases of patients who were in some form of persistent vegetative state are considered in some detail in the course of the thesis: Nancy Cruzan, a young woman in a persistent vegetative state for eight years following a car accident; Tony Bland, a victim of the Hillsborough [Soccer] Stadium disaster who likewise was in a persistent vegetative state from April 1989 until 1993; finally, the case of Terri Schiavo, a Florida woman who collapsed in 1990 due to a suspected potassium imbalance which caused a heart attack and temporarily cut-off the supply of oxygen to her brain, resulting in her requiring artificial means of

nutrition and hydration. In each case the families were involved in the decisions to cease life-sustaining treatment. Each is controversial and each broke new legal and ethical territory.

Taken together, these cases and others mentioned incidentally in the thesis ground and focus the theoretical dimensions of relational personhood, ensure that the broad methodology is truly practical theology and demonstrate that a theology of relational personhood has a contribution to make in the discourse and practice of health care. These cases and the issues they raise will be outlined in some detail in the third chapter of the thesis and subject to detailed analysis in Chapter Six following exposition of my philosophical and theological position. They will also be mentioned at other points to illustrate aspects of my argument.

8. Methodological Approach

Despite the concerns I expressed earlier that religious participation in health care ethics is too often limited to philosophical considerations to the exclusion of the theological, I recognise that all modes of enquiry rely on an implicit philosophy. This is true of both health care and theology. For theology, the relationship with philosophy is well established, as "faith seeking

understanding" through a variety of philosophical resources. In the case of health care, the connection is less clear-cut.

Let me offer an example from the area of medical practice. Michelle Clifton-Soderstrom has pointed out that as medicine becomes increasingly scientific in orientation, methodology, and discourse, the distance between practitioners and patients is also increasing. Associated with this increasingly scientific orientation of medicine is the view that the uniquely female aspects of health care need to be controlled. Child-bearing, which in most pre-medicalised cultures is viewed as a natural process, is viewed in contemporary Western medicine in "quasi-pathological" terms.[42] The physician is the agent on whom all activity is focused; the woman is passive and needs to have her condition managed and controlled.[43] This tendency to view health care professionals as the agents, and patients as merely passive in the process of health care, implies a distinct philosophical stance, however unavowed. Dominant models of health care, especially when they are basically utilitarian, and their associated ethics, filter all health decisions through a lens focused on autonomy, beneficence, non-maleficence and

---

[42] I recognise that this is a provocative claim, even with supporting research; however, the kinds of language which are associated with pregnancy and birth do lead to such conclusions. For example, one cause of the inability to carry an embryo to term is described as an "incompetent cervix." More overtly is that the procedures for birth described in standard nursing and medical texts simply assume that this is first and foremost a medical procedure.

[43] M. Clifton-Soderstrom, "Levinas and the Patient as Other: The Ethical Foundation of Medicine," *Journal of Medicine and Philosophy* 28, no. 4 (2003).

justice. They are subject to the calculus of the greatest well-being for the greatest number, so that the emphasis is overwhelmingly on the activities and responsibilities of professionals according to particular professional codes of conduct. As a result, little credence is given to the response of the patient or recognition of his/her significance in the process—they are the subject of the activity, not a participant in the activity.

In the elaboration of a more relational and interactive model, this investigation relies on the work of two philosophers. Scottish philosopher John Macmurray (1891–1976) and Emmanuel Levinas (1906–1995), the Lithuanian/French philosopher, propose that relationships are fundamental to any understanding of persons and are vital to the development of any authentic ethic. Macmurray argues that all human relationships are linked to an archetypal relationship, that of mother and child.[44] Levinas highlights another aspect by presenting a more obviously asymmetrical view of person relations compared to Macmurray. The person we meet or care for breaks into our lives as the essential *other* who pleads not to be rejected and, ultimately, not to be killed.[45] While neither of these philosophers applied their thinking to health care, their emphasis on the relationships between

---

[44] John Macmurray, *Persons in Relation*, The Form of the Personal Volume 2 (London: Faber and Faber, 1961).

[45] Emmanuel Levinas, "The Face of a Stranger," *The Unesco Courier*, no. 7-8 (1992).

persons and the priority of the other would have a dramatic impact on the theory and practice of health care and the ethics governing it.

Further, the methodology of the thesis draws on the work of Alistair McFadyen (1961-), an English theologian who likewise has developed a philosophy of personhood focusing on the process of person formation.[46] He argues that through their relational interactions, including commitments, persons are bound to others, both as individuals and communities. These interactions take the form of communication. Information is offered, received by the other and reflected back. Through such communicative encounters persons are linked to their communities in a practical manner. As the communication in question is not simply a matter of information, but is self-revelation that invites a response of self-revelation, from this commitment to the other occurs. The process of person formation points to a "sedimentation of relations"[47] in the constitution of the person. McFadyen, in his philosophical-theological account appeals also to a trinitarian perspective, arguing that the intrinsic sociality of human persons reflects the inter-personal relations of the Trinity.

---

[46] His two principal works are, A.I. McFadyen, *The Call to Personhood: A Christian Theory of the Individual in Social Relationships* (Cambridge: Cambridge University Press, 1990). and, Alistair I. McFadyen, *Bound to Sin: Abuse, Holocaust and the Christian Doctrine of Sin*, Cambridge Studies in Christian Doctrine 6 (Cambridge, U.K.: Cambridge University Press, 2000).

[47] McFadyen, *The Call to Personhood...*

These philosophical approaches provide valuable lines of reasoning for the theological investigation pursued in this thesis. Indeed, theologians have not been slow to exploit these philosophical accounts in a variety of theological doctrinal and ethical contexts—for example, the Australian theologians, Glen Morrison[48] and Damien Casey,[49] and the British theologians John Swinton and Esther McIntosh.[50] Even the Orthodox theologian and Metropolitan of Pergamon, John Zizioulas acknowledges his admiration for Macmurray[51] and has recently been criticised for his reliance on the philosophy of Macmurray in his reading of the Cappadocians and construction of his theological anthropology.[52] At this stage and for the purpose of the thesis, it is sufficient to note that both Macmurray and Levinas, along with McFadyen, have an obvious relevance to the relational understandings of personhood and their pertinence to health care.

---

[48] Glen J. Morrison, "Emmanuel Levinas and Christian Theology," *Irish Theological Quarterly* 68 (2003).

[49] Damien Casey, "Levinas and Buber: Transcendence and Society," *Sophia* 38, no. 2 (1999).

[50] John Swinton and Elizabeth McIntosh, "Persons in Relation: The Care of Persons with Learning Disabilities," *Theology Today* 57, no. 2 (2000). John Swinton, "Constructing Persons: John Macmurray and the Social Construction of Disability," in *John Macmurray: Critical Perspectives*, ed. David Fergusson and Nigel Dower, (New York: Peter Lang, 2002)

[51] John Zizioulas, "Human Capacity and Human Incapacity: A Theological Exploration of Personhood," *Scottish Journal of Theology* 28, no. 5 (1975).

[52] Lucian Turcescu, "'Person' Versus 'Individual', and Other Modern Misreadings of Gregory of Nyssa," *Modern Theology* 18, no. 4 (2002).

After making these references to three main philosophical sources in the orientation of the thesis, we can now move to the theological approaches that have structured its methodology.

The philosophical perspectives provided by Levinas, Macmurray and McFadyen are given a theological specification by referring particularly to the relational theology of the now Greek Orthodox Bishop and scholar John Zizioulas. For him, relationship is an ontological category, pertaining to the structure and dynamics of reality itself.[53] Within a strongly trinitarian perspective, Zizioulas argues that all personhood is communal, for it derives from the trinitarian mystery of persons-in-communion. As a result, relationality is intrinsic to all realisations of personhood. This objective, realist account of relational personhood will be taken as a solid basis in the consideration of health care and its ethics in this thesis. The main value of Zizioulas's approach for this thesis consists in his emphasis on the ontological reality of persons, their essential co-existence in communion, and the trinitarian foundations for this ontology.

---

[53] J. Zizioulas, "On Being a Person: Towards an Ontology of Personhood," in *Persons, Divine and Human: King's College Essays in Theological Anthropology*, ed. C. Schwöbel and C.E. Gunton, (Edinburgh: T&T Clark, 1991) and, John Zizioulas, *Being as Communion* (Crestwood, NY: St Vladimir's Seminary Press, 1993).

The health care implications of each of these philosophical and theological approaches is, at one level, obvious. Yet only with McFadyen are such implications made explicit and then only briefly. Hence, to make these philosophical and theological implications explicit is the major purpose of this thesis, by calling on these different thinkers working in the field of interpersonal relationality, and by focusing the resources they provide on the field of health care. A key value is the ontologically transcendent character of the human person. By recognising that, and by developing it in the contexts to be elaborated in the course of the thesis, counters the tendency to eliminate certain groups or categories of humans from the moral status of persons.

After outlining the philosophical and theological perspectives of our methodology, it now remains to move on to indicate the outline of the thesis and the chapters it contains.

9. The Structure of the Thesis

Following on from this Introduction, Chapter Two makes a case for theological participation in health care. It notes that theology, as such, is only a fringe participant in the discourse and practice of health care, even though religious groups play a major role in the provision of health care through various religious institutes. I, therefore, argue that religion and theology have

significant contributions to make through their capacity to assist people to face the ultimate questions posed by illness, suffering and death. A religious community forms and preserves a sense of identity and hope in the midst of the health crisis and the suffering that it entails. Further, theology offers a critique to health care by presenting a vision of humanity that transcends the material and the biological, and promotes an ethic of interpersonal responsibility. By establishing a general case for theological participation in health care, the stage is set for Chapter Three which considers the concept of personhood in direct relation to health care and the development of the philosophical dimensions of the thesis in Chapter Four.

The third Chapter, *The Question of Personhood in Health Care*, as just noted, examines the way the concept of personhood applies in health care. Relational perspectives on personhood are not present in most constructions and analyses of health care. I argue that this diminishes the potential of health care as a discipline and practice. The individualistic approach to personhood which dominates the current thinking and foundations in health care is not helpful to patients, especially the most vulnerable. Any articulation of the situation of these people which denies the relevance of their relationships is likely to diminish their status and have dire consequences for them. I demonstrate that this is the situation with reference to particular health care cases.

Chapter Four elucidates the philosophical basis for the thesis through the thinking of John Macmurray, Emmanuel Levinas and Alistair McFadyen. Each of these thinkers advances a clearly relational perspective on personhood, though they hold different perspectives from each other. Mamurray looks to the archetype of the mother-child relationship to demonstrate the intrinsic dependence of persons on relationships for their very existence and to develop in any meaningful sense. Levinas likewise argues that the foundation of personhood is relationship but changes the focus from Macmurray's emphasis on nurture to one in which the relations are confrontational and demand responsibility for the other. McFadyen treads a mid-path between Macmurray and Levinas in the way he constructs relational personhood. The primary value of his contribution is his attention to the process of person formation through "call – response". Each of these scholars appeals to relational concepts of personhood. Hence, their insights assist this practical theology of health care due to the communicative models of relational personhood they develop in their respective ways.

The fifth chapter, *A Christian Vision of the Person*, forms the heart of the thesis. It takes up the philosophical insights of Chapter Four and develops them into a theology of relational personhood. After noting the pervasive model of relationality in present experience, I link insights from the contemporary

sciences to directly theological insights on relationality arising from Scripture and, more especially, from the Christian doctrines of the Trinity and the Incarnation. Here the theology of John Zizioulas is invaluable in explicating the relational character of the Trinity, and, consequently to personal existence. These doctrinal positions, I argue, are foundational for practical theology through their emphasis on the self-communication of God as the basis for the mission of Christ and the Christian community's participation in that mission. The dominant image in this chapter is one of communion, with all that implies for relationality and for responsibility for the other.

Chapter Six, *The Praxis of Health Care: Relational Personhood and Critical Cases*, returns explicitly to an examination of the significant cases outlined above. While these have been mentioned at other points in the thesis to illustrate particular aspects of my argument, in this chapter the focus is on the cases. I analyse them through two types of questions. The first type of question is critical and deconstructive, as I seek to expose the shortcomings of current thinking in health care and the ways in which persons and their care have been compromised. The second type of question seeks to demonstrate that a theological relational anthropology has a distinct and positive role to play in the theory and practice of health care. Such a vision of the human person provides support and inspiration for the goals of health care, in contrast to other kinds of thinking.

The penultimate chapter, Chapter Seven, *The Theological Contribution to Health Care,* binds together the arguments and reflections of previous chapters to articulate the theological contribution to health care. The central claims of this chapter are that theology mediates the significance of religious faith to the culture and practice of health care. This mediation implies three kinds of tasks: a critique of reductive views in health care; support for and deepening of fundamental meanings and values in health care; and the refinement of interdisciplinary collaboration between theology and health care.

Chapter Eight is the final chapter of the thesis and it presents the opportunity to bring together the reasoning and arguments of the previous chapters and represents these in the context of a practical theology of relational personhood. This chapter also permits the possibility of certain brief extrapolations of the implications of the position I have commended. The recent papal encyclical, *Deus Caritas Est,* is an exemplary instance of the kind of argument I make in this thesis about the practical importance of the concept of relational personhood I have been developing. Finally, by way of illustration I discuss the significance of relational personhood in terms of its dimensions and carriers of its meaning. I am then in a position to summarise the main features of the thesis and its argument.

To summarise: a relational anthropology which prioritises the needs of the vulnerable is fundamental if basic values in health care are to be sustained. What is set out in the chapters to follow is an approach to health care which is thoroughly theological while respecting pluralism. While it is critical of certain approaches in this area, my purpose is entirely constructive in terms of promoting an ethical practice that enhances human dignity and its flourishing. For throughout this presentation, I will promote the communal and interrelational character of personal existence that escapes the judgment of being "a sociology of strangers".

CHAPTER TWO: A CASE FOR THEOLOGICAL

PARTICIPATION

This chapter focuses on one of the major themes of the thesis: that theology

has a role to play in health care. This position is not unproblematic and in this

chapter the reasons for this are explored and my own position is elaborated.

In this chapter I argue that religion, and theology which is critical reflection

on religion, have a necessary and significant role for the vision and practice of

health. Here I use, "religion" in a general sense, to refer to that experience of

the transcendent and the ultimate in and through which people commonly

find meaning and hope. "Theology", on the other hand, is a form of

exploration and reasoning deriving from critical reflection on specific

religious beliefs and commitments within a given cultural context. Both

religion and the theologies it inspires shape the meanings and values

fundamental to human identity and the culture of the community. Religion

and theology are not the only means of engaging in this activity, but they

have a long history of doing so and continue to be important for many people

within and across cultures. Such meanings and values consequently affect the

vision and practices that enter into a system of health care and the ethics that

governs it.[54] Hence, this thesis is an exercise in practical theology—a branch

of theological reasoning arising from concrete circumstances and in a context

of mutually critical correlation.[55] I will be arguing against the dominant

perspective of contemporary Western thinking that only reductively secularist

views are admissible in health care and the ethics of health care, since this is

required in a modern pluralist society. Instead, I will argue that theology

plays a significant role in the lives of persons and, especially those who are

patients. This will mean that health care fails to fully attain its own goals

unless the role of spirituality and faith in the lives of patients is taken into

account in the practice of health care. In this investigation, it is not possible to

ignore the context formed by longstanding discussions in Christian ethics

concerning the distinctiveness of the Christian contribution to ethical

discourse. In terms of health care this discussion can be broadened beyond

ethics to general participation—what does Christianity offer health care that

cannot be gained from other, non-religious sources? For this reason, I first

outline the challenges faced by theological claims for a place in the discourse

of health care, particularly those concerning the meaning and values

animating systems of health care today. The next step is to indicate how

---

[54] Lisa Sowle Cahill, "Can Theology Have a Role In "Public" Bioethical Discourse?," in *On Moral Medicine*, ed. Stephen E. Lammers and Allen Verhey, (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 1998), 63

[55] Hugo Kamya and Maureen R. O'Brien, "Interprofessional Education in Theology and Social Work: Postmodern and Practical Theological Dimensions," *Teaching Theology and Religion* 3, no. 1 (2000).

theology, particularly one centred on relational personhood, addresses the challenges and enables a re-envisioning of a role for theology in health care concerns. This present chapter is most conveniently divided under the following five headings:

1. The New Situation

2. A Role for Theology in Health Care Ethics

3. Theological Frameworks of Meaning

4. Cultural and Social Systems

5. Theology and the Human Condition

1. The New Situation

Till comparatively recently in the history of modern bioethics, the only resources available to researchers and thinkers in this area were theological— or if medical, these too were strongly influenced by theological and religious traditions of thought and sensibility.[56] Albert Jonsen has shown that the origins of bioethics as a discipline were, in fact, entirely religious in nature.[57] The primary contributors to the foundation of the discipline were theologians or, at least, philosophers working unambiguously within religious paradigms.

---

[56] D. Callahan, "Religion and the Secularization of Bioethics," *Hastings Center Report* 20, no. 4 (1990).

[57] Albert R. Jonsen, *A Short History of Medical Ethics* (New York: Oxford University Press, 2000).

The 1970s witnessed a growing promotion of ideologically secularist perspectives that have come to dominate the field in the following decades.

Where previously a religious point of view in the area of health care was presumed to be Judaeo-Christian, the subsequent situation became more complex. A variety of new and other religious voices (Muslim, Hindu, Buddhist, for example) now needed to be heard and respected. A further complexity resulted when different Christian perspectives were also in evidence–as with distinct Catholic and Protestant models of ethics. Given the complexity and variety of religious voices, it is understandable that health care practitioners began to opt for what they understood to be a simple secular code of ethical guidelines independent of any particular worldview. A further reason for the rapid secularisation of ethical thinking in health care was that religious perspectives were not proving to be amenable to new directions that were emerging in applied ethics, especially in health care. In this encounter with religious opposition or critique, further kinds of justification had to be found for practices that significantly large segments of society found acceptable, even if they were rejected or criticised by churches and religious groups. The most notable example regards the ethics of abortion, given changing social attitudes to women's rights, pregnancy planning and prevention of the dangers associated with illegal and unsafe abortions. At the same time, changes to legal frameworks took place which

also expressed the changing social attitudes on these matters. The best known legal case is *Roe versus Wade* in the United States. Legal change can take other forms, as with the decision of New South Wales police—presumably with the approval of the relevant political authority—not to enforce the provisions of the Crimes Act pertaining to abortion.

Along with these factors causing a change of outlook, there was the obvious validity to a line of reasoning which found expression in the following terms: if health care is a responsibility of the whole community, and since most communities (in the Western world) are pluralist in composition, it is inappropriate to privilege a particular religious/theological view in the professional discourse and practices of health. In fact, such a position would be widely held by both religious and secularist thinkers, conscious of the pluralistic or multicultural state of contemporary globalised Western societies. However, an uncritical assertion of such a position has grave limitations. In the effort to abstract from any particular world-view, religious or otherwise, the proponents of purely secular approaches veer toward a position in which it becomes necessary to disqualify from participation in bioethical discourse the very frames of reference within which many people shape their sense of life, illness, death and moral responsibility. Consequently, this abstract secular outlook tends to minimise the vital importance of the range and depths of human experience that nourish a sense

of meaning, identity and hope. For example, Huey-Ming Tzeng and Chang-Yi Yin, reflecting on the impact of spiritual beliefs on the ability of people and societies to cope with infectious disease, demonstrate that education standards or sophisticated health care regimes do not have the degree of impact that is often assumed. Instead, the patients, health care providers and their families rely heavily on their traditional beliefs in order to cope with the actual health situation and integrate it into their understanding of the world. [58]

Nonetheless, it became increasingly the case that religious perspectives were simply assumed to not be part of public discourse in the health systems of many Western nations, perhaps especially Australia. It is acknowledged that religious groups may have something to say, usually in opposition to medical procedures affecting life at its beginning and end. But these are considered to have merely a "fringe status" compared to the established public policies in medical practice—now required to be secular and non-religious in their self-justification and manner of reasoning. In some social situations—in Australia, for instance—the fear of sectarianism provided further grounds for the purely secular approach that was envisaged.

---

[58] Huey-Ming Tzeng and Chang-Yi Yin, "Learning to Respect a Patient's Spiritual Needs Concerning an Unknown Infectious Disease," *Nursing Ethics* 13, no. 1 (2006).

Hence, the current cultural challenge in health care emerges out of an increasingly secularised society. But there was a challenge to religious participation in health care from another direction. The eminent moral philosopher, Alasdair MacIntyre, writing as far back as 1979, challenged theologians working in the field of health care ethics to answer three types of questions:

> First—and without this everything else is uninteresting—we ought to expect a clear statement of what difference it makes to be a Jew or a Christian or a Moslem, rather than a secular thinker, in morality generally. Second, and correlatively, we need to hear a theological critique of secular morality and culture. Third, we want to be told what bearing what has been said under the first two headings has on the specific problems which arise from modern medicine. [59]

MacIntyre's philosophical challenges sought to focus concerns that were beginning to be felt more generally within society, and their ethical implications for moral reasoning, not only in the field of health care. A suite of derivative questions is implied: how can a model of ethics that relies on a particular religious understanding of the world have a role in a multi-cultural and multi-faith community? Is such a model of reasoning capable of providing a critique of secular morality and culture by offering something beyond the horizon of purely secular forms of analysis? When the context is the ethics and conduct of health care, how is it possible to avoid divisiveness and sectarianism?

---

[59] Alasdair MacIntyre, "Theology, Ethics, and the Ethics of Medicine and Health Care," *Journal of Medicine and Philosophy* 4, no. 6 (1979).

In hindsight, these challenges have had a positive effect on theological ethics in the health care area. Throughout the history of moral reflection, the "Euthyphro dilemma" posed by Plato's Socrates has confronted ethics practitioners, especially those trying to work from a religious perspective. Euthyphro, the eponymous character of the dialogue, is challenged by Socrates on the role played by the gods in ethics. Socrates asks whether goodness is the result of conformity with the commands of the gods, or is goodness independent of the gods?[60] For Christians this question emerges in another form: If true goodness is to be found in conformity with God's will, then what is to be the moral response when it appears that God commands what is an evident evil, as with the dismemberment of children or genocide, to give some Old Testament examples (2 Kings 2: 24; Joshua 6: 17). If, on the other hand, goodness is a transcendent value by which to judge even God in such gruesome instances, then what role is there for God in ethics at all?[61]

While this debate is ancient in origin, it has been a regular feature of ethical discourse in Christianity. It has provoked the development of "natural law"

---

[60] Plato, "Euthyphro," in *The Last Days of Socrates*, ed. Hugh Tredennick, The Penguin Classics (Hammondsworth, Middlesex: Penguin Classics, 1954)

[61] For a good discussion of this debate see, James M. Gustafson, *Theology and Ethics* (Oxford: Basil Blackwell, 1981).

theory in Catholic ethics, [62] and has given rise to more recent debates on the distinctiveness of Christian ethics for the past thirty years or so. [63] The theological debate taking place within the field of Christian theological ethics in some measure mirrored the shift already taking place in secular bioethical discourse. For it raised doubts about the legitimacy of particular religious views, especially as articulated in the past of ancient Israel and its surrounding cultures. Such problems inevitably resonated in notions of health care applicable to the multi-cultural and multi-faith situation of most Western societies. [64]

The Euthyphro dilemma referred to above draws its force from an assumed dichotomy: Moral discourse must be viewed either completely from the perspective of God or completely from the perspective of humanity, thus leaving both viewpoints unrelated and opposed. [65] Either moral

---

[62] See various articles in, Charles E. Curran, "Natural Law in Moral Theology," in *Natural Law and Theology*, ed. Charles E. Curran and R. A. McCormick, Readings in Moral Theology, 7, (New York: Paulist Press, 1991), especially, Edwin F. Healy, "Natural Law," in *The Historical Development of Fundamental Moral Theology in the United States*, ed. Charles E. Curran and R. A. McCormick, Readings in Moral Theology, 11, (New York: Paulist Press, 1999)

[63] See for example, J. M. Gustafson, *Can Ethics Be Christian?* (Chicago: University of Chicago Press, 1975)., Charles E. Curran and Richard A. McCormick, *The Distinctiveness of Christian Ethics*, Readings in Moral Theology ; No. 2 (New York: Paulist Press, 1980)., Vincent MacNamara, *Faith and Ethics: Recent Roman Catholicism* (Dublin: Gill and Macmillan, 1985).

[64] It is interesting to note, as Dan Hardy does, that even the discussion on the place of theology in health care ethics, at least the discussion by theologians, is a theological discussion. The issues raised in the Euthyphro are important questions for theology, as are the debate over teleological and deontological models of ethics, for example. For further discussion and other examples see Chapter 3 of, D. W. Hardy, *God's Way with the World* (Edinburgh: T&T Clark, 1996).

[65] Gustafson, *Theology and Ethics*.

commandments come from the Divine, and thus leave little place for ethical reasoning or autonomy; or, human reason and autonomy determine morality so as to leave little place for the Divine. What is missing from this kind of antinomy, in either its ancient or contemporary forms, is a critical theological perspective on God's relationship to the human world and humanity's relation to God.[66] This perspective is exploited to dissolve a rigid dichotomy because it opens onto a point of intersection where God's will for the human good and human moral activity, necessarily involved in a given culture yet motivated by the service of God, are seen by religious faith to meet. In other words, rather than the will of God or some kind of divine fiat, on the one side, and human morality and moral responsibility, on the other, being parallel at best, or more likely mutually opposed, a genuine theological perspective holds that the will of God is that humanity exercise moral responsibility. That is, the two are intertwined and convergent. This is not to say that theological beliefs immediately deliver solutions to all moral dilemmas, any more than other forms of reasoning. The long experience of religious faith adequately attests to this, as in the problems raised by the Old Testament examples.[67] On the other hand, to return to the medical context of this investigation, any argument for the redundancy of religious views in health care fails to

---

[66] D. W. Hardy, "Created and Redeemed Sociality," in *God's Ways with the World*, (Edinburgh: T & T Clark, 1996)

[67] J. B. jr Tubbs, "Theology and the Invitation of the Stranger," in *Duties to Others*, ed. C. S. Campbell and B. A Lustig, Theology and Medicine, 4, (Dordrecht, NL.: Kluwer Academic Publishers, 1994), 44-47

acknowledge that many participants (patients, professionals and their families) in health care are people of faith for whom the claims of their faith are significant.[68] Moreover, the faith-stance of a follower of Jesus Christ (or Mohammed or the Buddha, for that matter) provides a "paradigm for individual self-understanding and a set of values by which to organize and sustain communal life."[69] Even if religious thinkers acknowledge genuine values in the claims of secular morality, this does not mean that their specifically religious views have nothing to contribute to debate and decision-making.[70]

J. B. Cobb jr. has responded to the questions that MacIntyre posed above. He argues that theology simply cannot fulfil the roles that MacIntyre demanded. For the ethical precepts of particular traditions are not, in principle, distinct or unique—compared to those offered, say, by philosophy and thinkers of a more secularist persuasion. Still Cobb allows that theology can make a distinctive contribution. He writes,

> Theologians generally will seek to set specific decision making in a wider context...They will want to see the people and communities involved holistically. They will not accept the problematic as given but

---

[68] See, for example, Thomas A Shannon, "Bioethics and Religion: A Value Added Discussion," in *Notes from a Narrow Ridge: Religion and Bioethics*, ed. D. S. Davis and L. Zoloth, (Hagerstown, Maryland: University Publishing Group, 1999), especially, 135 - 142 and, H. G. Koenig, "Religion, Spirituality, and Medicine: Research Findings and Implications for Clinical Practice," *Southern Medical Journal* 97, no. 12 (2004).

[69] Pullman, "Universalism, Particularism..."

[70] Cahill, "Can Theology..." 306

> will look instead for the assumptions beneath the description and for the context in which questions are being asked. They will press for broadening of context and the inclusion of more voices. They will question the wisdom of focusing exclusively on local problems when the conditions and practices generating those problems are not addressed. They will be sensitive to the nuances in personal relations and community life...not all theologians will do these things - and not only theologians will do them. But the involvement of theologians will increase the likelihood that these themes will be involved.[71]

So, instead of considering theology and health care as separate disciplines heading in different directions, it is better to conceptualise the relationship as an interweaving set of experiences, commitments and concerns.[72] In a pluralist culture, a variety of approaches to ethics, especially applied ethics, is appropriate. In fact, the current dominance of ideological secular models, particularly those of utilitarian and principle-based type, is vulnerable to the very criticism levelled by secularist thinkers against exclusively religious models of ethics in the past—that they have become exclusive and deny a voice to other perspectives in a pluralist culture.

I have already mentioned four areas of theological contribution to health care and ethics, namely, in regard to frameworks of meaning, a source of critique, an emphasis on the dignity of the human person, and as a corrective to the "sociology of strangers". It should be noted that religious forms of ethics do

---

[71] John B. Cobb, "Does Theology Make a Contribution to Bioethics?," in *Theology and Bioethics: Exploring the Foundations and Frontiers*, ed. E. E. Shelp, Theology and Medicine, (Dordrecht, Holland: D. Reidel Publishing, 1985), 306

[72] Hardy, *God's Way with the World*

not seek to supplant the valid values in the secular approach—after all, there

is no, say, "Catholic surgery" or "Hindu biology", since these are determined

by the best science and the best professional practice. Rather, arguments

arising from religious perspectives seek to complement scientific reason and

professional practice by calling attention to what can be so often bypassed —

the particular worldviews of patients and the communities that have formed

them.

So, after calling attention to the changing situation in which the

theological/religious perspective has been challenged, I now move to a more

positive consideration of theology's role in health care ethics.

2. A Role for Theology in Health Care Ethics

It is an historically demonstrable fact that the Christian vision and its values

have made a very significant contribution to ethical reflection and practice as

Western patterns of health care developed.[73] Moreover, in recent times

theologians such as Richard McCormick, Paul Ramsay, Stanley Hauerwas and

James Gustafson have been widely respected authorities in health care ethics.

A variety of Christian viewpoints have been influential in forming and

---

[73] For discussion on this see, for example, Jonsen, *A Short History of Medical Ethics*. Stephen E. Lammers and Allen Verhey, *On Moral Medicine: Theological Perspectives in Medical Ethics*, 2nd ed. (Grand Rapids, MI: William B. Eerdmans Pub., 1998).

supporting scientifically based models of health care. Christian thinkers have not been content to offer merely a theoretical or motivational contribution to complex medical issues: they grappled with particular cases, quite conscious of the fact that there was no simple "religious solution" in the midst of such complexity.[74] But one feature shared, despite differences of emphasis, by these theologians is their conviction that religious perspectives provide an horizon within which ethical thinking and decision-making in health care can be more critical and effective. It is appropriate, then, to examine more closely the kind of religious horizon or theological framework in question.

Modern medicine undeniably offers the sick and the suffering a range of often astonishing possibilities compared to the past. Human suffering from once routine diseases has been notably diminished. Yet, with all this has come a certain sense of powerlessness, disorientation and lack of control over our lives. Such a view is no longer simply anecdotal, or reports of a generalised observation. Empirical studies in Britain have now verified that this sense of powerlessness in the medical setting is pervasive among patients and their carers.[75] As Karen Lebacqz has observed, "it is not the rate of growth of biomedical technologies *per se* that make us feel 'squeezed'. Rather, it is the

---

[74] J. B. jr Tubbs, *Christian Theology and Medical Ethics, Four Contemporary Approaches* (Dordrecht, The Netherlands: Kluwer Academic Press, 1996).

[75] K. A O'Connell and S. M Skevington, "The Relevance of Spirituality, Religion and Personal Beliefs to Health-Related Quality of Life: Themes from Focus Groups in Britain," *British Journal of Health Psychology* 10, no. 3 (2005).

threat they present to the meaning structures of our world."[76] To the degree

these "meaning structures" are threatened, either for individuals or

communities, a theological construction of meaning and promotion of values

becomes more necessary in determining what health and wholeness consist

in. In fact, spirituality and religion are in many clinical contexts now being

recognised as vital for positive patient outcomes in terms of health, treatment

options and preparedness for death. This has been demonstrated in a number

of recent studies. For example, Yunus Dudhwala has described positive

developments in the recognition of the importance of spiritual care in the

British National Health Service.[77] Tzeng and Yin have indicated the need for

closer attention to religious beliefs and spiritual practices in the treatment of

infectious diseases.[78] Tan and his team have pointed to the importance of

spirituality and relationships in coming to terms with terminal pathologies

and death.[79]

In the broader contemporary context, the role of spirituality and faith is being

recognised as a significant factor in human development and in maintaining

---

[76] Karen Lebacqz, "Bioethics: Some Challenges from a Liberation Perspective," in *On Moral Medicine:Theological Perspectives in Medical Ethics*, ed. Stephen E. Lammers and Allen Verhey, (Grand Rapids, Michigan: William B Eerdmans, 1998), 88

[77] Yunus Dudhwala, "Winning the Lottery," *Nursing Management* 12, no. 6 (2005).

[78] Tzeng and Yin, "Learning to Respect..."

[79] H. M. Tan, A. Braunack-Mayer, and J. Beilby, "The Impact of the Hospice Environment on Patient Spiritual Expression," *Oncology Nursing Forum* 32, no. 5 (2005).

wellness.[80]   The semantic relationships between the words "health", "holiness" and "wholeness" are an indication of a desirable interdisciplinarity in the field of health care.[81] It is the case that there are sources of possible confusion when one distinguishes between faith—regarded as a particular religious stance—and spirituality, with its more open-ended connotation of generally desirable life-enhancing qualities. Starck, for example, maintains that there are two distinct worldviews at work, despite the fact that they are confused by many.[82]   What the literature does reflect, however, is that "spirituality" has certain common features, whether it is religious spirituality or what might be termed "humanist" spirituality. While "spirituality" has wide currency as a more acceptable term than "faith" or "religion" in secular settings, it is inherently elusive as to its meaning.   But a pragmatic understanding of the term is possible. In this understanding, spirituality is concerned with the search for meaning in the long term and in regard to the whole of life,[83] and inspires the development of values systems.[84]

---

[80] See, for example: David Hay, *The Spirit of the Child*, 2nd ed. (London: Jessica Kingsley Publishers, 2006)., P. Starck, "The Human Spirit: The Search for Meaning and Purpose through Suffering," *Humane Medicine* 8, no. 2 (1992). and, John Savolaine and Paul F. Granello, "The Function of Meaning and Purpose for Individual Wellness," *Journal of Humanistic Counseling, Education and Development* 41, no. 2 (2002).

[81] Ashley and O'Rourke, *Health Care Ethics: A Theological Analysis*.

[82] Starck, "The Human Spirit..."

[83] O'Connell and Skevington, "The Relevance of Spirituality..."

[84] Savolaine and Granello, "The Function of Meaning..."

Consequently, it influences perceptions of health and disease,[85] and even health outcomes for many patients.[86]

Liwliwa Villagomeza has provided a useful summary of the issues surrounding this topic. She argues that there are seven distinct, but overlapping features in the phenomenon of spirituality: connectedness, faith and religious belief, values systems, sense of meaning and purpose, sense of self-transcendence, sense of inner peace and harmony, sense of inner strength and energy beyond the material.[87] Whether or not these values or attitudes are all part of the "spirituality" of every patient, they are certainly hospitable to the recognition of the importance of religion/faith in the lives of believers, and so acknowledge the desirability of theological reflection on what is so central.

Religion and theological reflection still play a role in the lives of the majority of the world's population in assisting people to construct coherent structures of meaning in their lives. While a number of American studies point out that well over 80% of the population describe themselves as religious and

---

[85] Tzeng and Yin, "Learning to Respect..."

[86] Christopher K Daugherty and others, "Trusting God and Medicine: Spirituality in Advanced Cancer Patients Volunteering for Clinical Trials of Experimental Agents," *Psycho-Oncology* 14, no. 2 (2005).

[87] Liwliwa R. Villagomeza, "Spiritual Distress in Adult Cancer Patients: Toward Conceptual Clarity," *Holistic Nursing Practice* 19, no. 6 (2005).

belonging to religious communities, in Australia that number is lower. However, studies conducted in both Britain and Australia reflect that spirituality and religion play a similar role in health care to that which is the case in the US, regardless of formal religious affiliation or practice.[88]

The specific insights of Christian theology can enrich bioethical reasoning, even while still respecting the canons of scientific objectivity and rational discourse. This means neither that theological reflection is restricted to an idiosyncratic way of thinking, nor that moral reasoning must exclude religious beliefs and their attendant theological views. A patient-centred style of care does not appeal, in Paul Ramsay's phrase, to "some hypothetical common denominator".[89] On the other hand, Stanley Hauerwas's view appears extreme. He holds that Christianity should simply articulate its own health care ethics and not worry too greatly over how that is understood by non-Christians and non-believers.[90] Taken to extremes, this would suggest that theology is not required to adhere to scientific truth and reasonable argument. It also means that theological reflection would hang back from an

---

[88] O'Connell and Skevington, "The Relevance of Spirituality..." and Tan, Braunack-Mayer, and Beilby, "The Impact Of..."

[89] Cited in J. M. Gustafson, "Theology Confronts Technology and the Life Sciences," in *On Moral Medicine: Theological Perspectives in Medical Ethics*, ed. Stephen E. Lammers and Allen Verhey, (Grand Rapids, Michigan: William B. Eerdmans, 1998), 46

[90] Stanley Hauerwas, "Salvation and Health: Why Medicine Needs the Church," in *Suffering Presence*, (Notre Dame, Indiana: University of Notre Dame Press, 1986) I disagree with little of Hauerwas' content, but I think that part of the strength of Christian theology is its willingness to engage with the cultures in which it theologises.

engagement with the very culture(s) it seeks to influence.[91] If that were the case, theological reflection would be deprived of one of its principal sources, and incapable of transforming the culture it contests—especially as the task of theology is "to establish convictions about God and God's relations to the world. To make a case for how some things really and ultimately are…".[92] An abstractly theological approach would reduce theology to mere assertion, by removing it from the sphere of reasoned debate and confining it to the realm of private belief,[93] and so make it useless in the given reality of the health-care system.[94] In that event, theology would have failed the tradition it inherits, as both a religious and academic religious discipline.[95] As an exercise in practical theology this thesis eschews such a suggestion since the very foundation of practical theology is the view that religious and theological insights need to engage with and are shaped by the concrete cultures, histories and circumstances within which they exist.[96]

---

[91] Cahill, "Can Theology..." 58-59

[92] James M. Gustafson, *Ethics from a Theocentric Perspective*, 2 vols., vol. 2 (Chicago: University of Chicago Press, 1984). Cited in R. A. McCormick, "Theology and Bioethics," *Hastings Center Report* 19, no. 3 (1989).

[93] As demonstrated by Campbell in setting up his argument that theology has a role to play in bioethics, cf. C. S. Campbell, "Bearing Witness," in *Notes from a Narrow Ridge: Religion and Bioethics*, ed. D. S. Davis and L. Zoloth, (Hagerstown, Maryland: University Publishing Group, 1999)

[94] As Dena Davis has argued in, D. S. Davis, "It Ain't Necessarily So: Clinicians, Bioethics, and Religious Studies," in *Note from a Narrow Ridge: Religion and Bioethics*, ed. D. S. Davis and L. Zoloth, (Hagerstown, Maryland: University Publishing Group, 1999)

[95] See Campbell, "Religion and Moral Meaning in Bioethics.", D. S. Davis and L. Zoloth, eds., *Notes from a Narrow Ridge: Religion and Bioethics* (Hagerstown, Maryland: University Publishing Group, 1999) and, H. Tristram Engelhardt, ed., *Christian Bioethics, Vol. 5* (1999)

[96] Veling, "'Practical Theology': A New Sensibility for Theological Education."

Given the desirability of an "applied" or practical theological method designed to interact critically and creatively with, say, different professional or academic situations within a particular cultural milieu, there is still a problem to be faced. In the context of health care, the attempted imposition of ideologically secular language and an ethical framework that is independent of religion has exacted a price. A functional pragmatism has resulted, rendering it incapable of "conveying a sense of deep significance."[97] The philosopher Carl Elliott argues that such an attitude is itself pathological. It loses sight of the person as a whole being and of the relationships that sustain personal significance.[98] Moreover, the complex relationships that exist between patient and health professional are simply ignored or actively denied. To that degree, the person, in his/her deepest identity, is being rejected, and suffers harm as a result. As will be demonstrated in Chapter Three, the rejection of the other is a preliminary step toward "killing" this other, either metaphorically or in fact. Such rejection need not be deliberate or overt, but its initial stages can simply be ignoring the complex field of relationships which form individual identity and significance. In denying the complexity of relationships within which individuals find meaning, we begin the process of eliminating what is most significant to the person in question—

---

[97] C. Elliott, *A Philosophical Disease* (New York: Routledge, 1999).

[98] Elliott, *A Philosophical Disease*.

it may well constitute a first step to a theoretical or practical elimination of the value of personhood itself.

Hence the need in health care to focus on the complete field of relationships and relational encounters rather than trying to proceed from an exclusively "impartial and rational principle".[99] This entails a rejection of the notion that moral decisions can or should be made on the "basis of reason alone, quite apart from our loyalties and identities, quite apart from our particular histories and communities with their putatively partial visions of human flourishing".[100] Apart from the very limited view of reason implied in the phrase, "reason alone", or MacIntyre's question as to whose reason is to be regarded as the criterion,[101] the objection that theological perspectives in health care eschew rationality and scientific objectivity is unsustainable. What is not acceptable, however, is the attitude that "rationality", abstractly considered, alone provides sufficient basis for moral reasoning in dealing with what makes for human health and wholeness. To this degree, pure reason must be invited to be more reasonable in terms of its ethical sensibilities, by taking into account tradition and memory, community and

---

[99] Stephen E. Lammers and Allen Verhey, "Preface to the First Edition," in *On Moral Medicine: Theological Perspectives in Medical Ethics*, ed. Stephen E. Lammers and Allen Verhey, (Grand Rapids, Michigan: Eerdmans, 1998), xv

[100] Lammers and Verhey, "Preface to the First Edition," , page??

[101] Alasdair MacIntyre, *Whose Justice? Which Rationality?* (Notre Dame, Ind: University of Notre Dame Press, 1988).

narrative, affection and hope.[102] In this view, health care and the ethics that govern it, should, therefore, find its special focus in the care of persons. This has radically religious and theological implications. As Vaux expresses it:

> The search for redemptive meaning, principally fathoming meaning in human suffering and in satisfactorily construing the matter of theodicy (divine goodness in a world of suffering), is the primary ethical activity of theology and the essence of religion's contribution to medicine.[103]

If theology's "primary ethical activity", if the "essence of religion's contribution to medicine", is the search for meaning in suffering within the world of a good God's creation, then a theology of relational personhood makes a notable contribution. Later chapters will explore this area of relationality in detail, by paying particular attention to the interactions involved.

3. Theological Frameworks of Meaning

As indicated in the introduction to the present chapter, different theological traditions of intelligence and reasoning, in their interactions with culture and science, work to construct frameworks of meaning for people at critical junctures in their lives. The language, the skills, and orientation deriving from a theological perspective are aspects of a ministry of meaning, and,

---

[102] Martin E. Marty, "Foreword," in *Notes from a Narrow Ridge: Religion and Bioethics*, ed. D. S. Davis and L. Zoloth, (Hagerstown, Maryland: University Publishing Group, 1999), xi

[103] Kenneth Vaux, "Law and Lamb: Akedah and the Search for a Deep Religious Symbol for an Ecumenical Bioethics," *Christian Bioethics* 5, no. 3 (1999).

indeed, of ultimate meaning for persons and the communities in which they exist, and in the world they share with others. Theology is not the exclusive source of such frameworks since it is always in interaction with other cultural, social, professional and scientific resources. To this degree, it may both assimilate and critique other perspectives on health care in the course of history, as the various cases I refer to in the course of this exploration make clear.

The tradition of Christian theological reasoning, elaborating its basic meanings and values in various philosophical perspectives and in a variety of historical contexts, continues to develop. It operates in a horizon which demands continuing critical interaction with culture. On this point, Daryl Pullman would argue that it is not possible to separate Christian theology from the general cultural and philosophical milieux of the Western world.[104] In this regard, Christian theology is particularly attuned to the deep symbolic and mythic dimensions of culture. Related to this, Daniel Sulmasy makes a general observation. He considers that the exclusion of religious views from bioethical discourse does not make sense, for all cultural systems of values rely on a deep mythic structure and language.[105] He appeals to cultural

---

[104] Pullman, "Universalism, Particularism..."

[105] Daniel P. Sulmasy, "Every *Ethos* Implies a *Mythos*," in *Notes from a Narrow Ridge: Religion and Bioethics*, ed. D. S. Davis and L. Zoloth, (Hagerstown, Maryland: University Publishing Group, 1999), 227-246

anthropologist Clifford Geertz who defines the integrative function of the mythic as "the collection of notions a people has of how reality is at base put together".[106] This leads back to our specific question: How does theology function in this regard, by assisting patients to make sense of the isolating experience of illness, suffering and death? In addressing this question, the emphasis should be, in my view, on the relational field of meaning in which each person exists, and its significance for the sufferer. Any assumption that persons are radically isolated individual units enclosed in their own self-referential systems is to be questioned. The value of community, and its mythic resources, is paramount[107]–in ways not readily recognised, say, by "New Age" spiritualities.[108] At this stage it is appropriate to move on, therefore, to a closer examination of the language of myth in relation to these concerns.

In his exploration of the connection between values and a holistic or "mythic" orientation, Daniel Sulmasy maintains that "all ethical discourse depends on mythic narratives of one form or another".[109] He finds special value in the view of Hans Fries who writes:

---

[106] Sulmasy, "Every *Ethos* Implies a *Mythos*," 230

[107] McFadyen, *The Call to Personhood...*

[108] Susan Hollins, "Spirituality and Religion: Exploring the Relationship," *Nursing Management* 12, no. 6 (2005).

[109] Sulmasy, "Every *Ethos* Implies a *Mythos*," 231

> [M]yth is characterized by the fact that it sees the empirical world and its happening, and above all, man and his action, in the light of the reality that constitutes them, and makes them a unity, and at the same time transcends them.[110]

Sulmasy proceeds to examine how myth affects any ethical system. All morality requires a set of background beliefs on which values are based. The meaning of the human person, shared conceptions of the good, of freedom and of suffering, all require the commitment of a faith that assents to the mythic structure of reality in question, even if such "faith" is not necessarily of a religious kind, or even contrary to it.[111] The importance of fundamental faith has been noted in a number of areas of recent research in regard to the experience of suffering as a path to the discovery of meaning,[112] the relationship of health care to the quality of life,[113] and to psychological health.[114] The widespread acceptance of the value of this fundamental faith has, for example, occasioned plans for making spiritual care a core element of the British National Health Service.[115] The language used in these studies is generally acceptable to religious believers and theologians. Properly explained, terms such as symbol, myth, spirituality and so forth, are

---

[110] H. Fries, "Myth," in *Encyclopedia of Theology: The Concise Sacramentum Mundi*, ed. Karl Rahner, (New York: Crossroad, 1982)

[111] Sulmasy, "Every *Ethos* Implies a *Mythos*," 231

[112] Starck, "The Human Spirit..."

[113] O'Connell and Skevington, "The Relevance of Spirituality..."

[114] Savolaine and Granello, "The Function of Meaning..."

[115] M. Folland, "Hope for the Future," *Nursing Management* 12, no. 6 (2005).

sufficiently broad in their connotations to allow for a specification in particular religious traditions.

Examples of actual myths cited in the literature as relevant to health care are those that suggest comprehensive notions of, say, a "life-plan",[116] "life-span",[117] and "life as a journey".[118] Each of these symbol-laden expressions evokes a teleological sense of the human person—moving through life with a sense of purpose, and within a universe somehow hospitable to meaning and moral value. This may be further specified in the religious experience of pilgrimage with its links to the paradigmatic journey of faith, as in the biblical themes of Israel's Exodus or Christ's Passover from death to the glory of the resurrection.

Courtney Campbell is one ethicist who has argued that religions make a significant contribution to health care through the metaphor of *life as a journey.*[119] The myth is a representation of the existence of persons teleologically, that is, in terms of a life lived with a purpose and goal. In this teleological understanding, a "life-journey" takes into account the dreams, ambitions and hopes of a person's life and incorporates them within an

---

[116] Sulmasy, "Every *Ethos* Implies a *Mythos*," 236-238

[117] Sulmasy, "Every *Ethos* Implies a *Mythos*," 238-239

[118] Campbell, "Religion and Moral Meaning in Bioethics."

[119] Campbell, "Religion and Moral Meaning in Bioethics."

overall direction which gives purpose and meaning. This mythic conception captures the sense of beginning, growth, maturity, decline and ending, along with the discernment that the course of life frequently does not run smoothly. Life knows experiences of joy and disappointment, success and failure, connectivity and alienation. The "life as journey" notion challenges health care thinking to view health in terms of the whole of a person's existence, and not simply as a series of instances of crisis. All too frequently bioethical discourse is oriented to decision-making in which choices must be made and the actions chosen are right or wrong. If the sense of a life-journey is acknowledged, then the emphasis shifts to structures and patterns of meaning in the life of the person, rather than a series of disconnected and episodic decisions.[120] Here Campbell makes an important point:

> …accommodating questions of meaning in bioethics will require that we broaden its scope beyond our current fixation with problem-solving, for some problems cannot be solved but must still be faced. This broader vision involves directing attention not only to the means of medicine, such as procedures for obtaining informed consent or the regulation of research protocols, but also the purposes of medicine within the context of a life conceived as a journey. For on such an account health will be valued not merely for its own sake, but for the end it allows us to pursue, while sickness and illness may signify not only inconvenient interruptions, but also teachers whose meaning we share with others through stories.[121]

A sense of meaning shapes our approach to any human enterprise, including health care. Health care has the capacity to profoundly shape our sense of

---

[120] Lebacqz, "Bioethics: Some Challenges from a Liberation Perspective," 86

[121] Campbell, "Religion and Moral Meaning in Bioethics."

meaning in the way that models of health and illness, disease and wholeness are constructed.

4. Cultural and Social Systems

Myths that are focused more on the individual as in the American cultural experience may, in fact, intensify an individualistic approach to health care.[122] In contrast, within Australian culture, the myth of universal egalitarianism is more prominent and finds expression in a national health scheme. How much this is related to the Christian, humanistic or cultural values of justice for all, the dignity of each person, or a preferential option for the "underdog" or the "battler" can be endlessly argued. Whatever the foundational inspiration, there seems to be a general conviction in the Australian population that all people deserve the care and treatment they require. It is assumed that age, disability, socio-economic status, ethnic origins or religious commitments should have no place in medical decision-making, and that, children, the disabled and the elderly have a special claim on the health resources of the community.

An indication of the power of these national, mythic convictions is the political impossibility of being elected to government in Australia on a

---

[122] Sulmasy, "Every *Ethos* Implies a *Mythos*," 233-234

platform of abolishing the national health insurance scheme, *Medicare*. Even moves to limit access to particular treatments–for instance, the recent (2004-2005) proposal to limit or remove public funding for *in vitro* fertilization after a specified number of treatments–was so strenuously opposed that the Government shelved such plans. On the other hand, the reclassification of some treatments, particularly surgical procedures, as "elective" has had dramatic effects in the community without any opportunity for public comment or debate. For example, replacement of a broken hip is termed an "elective" procedure, in that it is not, in itself, life-threatening. Yet a patient with a broken hip could not possibly regard treatment as "elective" in any sense. Usually, those with access to private health insurance quickly arrange treatment, but those without private resources are reliant on public hospital waiting lists. Objections to the Australian Government's proposals to limit access to certain medical treatments were, of course, not made on exclusively religious grounds. There was a more general cultural reaction in that any lessening of the value of equality of all and the selective exclusion of any from health care resources was regarded as "un-Australian".[123]

---

[123] Examples include, Stephanie Kennedy, "Government Reviews Plan to Cut Ivf Funding," *The World Today*, May 5, 12: 18: 00 2005, Maxine McKew, "Friday Forum," *Lateline*, April 29 2004

5. Theology and the Human Condition

In other words, it is not simply the facts and experience of illness that are important in such tragic scenarios. The experience of illness exposes deeper aspects of the human condition.   Contemporary Western societies prize individuality and autonomy, yet experiences of illness are forceful reminders that humanity is radically interdependent. While this is most obvious when in the care of comparative strangers in, say, a hospital setting, it is also that family members exhibit extra care, friends sympathise or seek to offer assistance, work colleagues excuse lapses. In such critical times in human awareness, the normal space of our experiences is changed. Patients find themselves in a hospital, or hospice or nursing home. They have to reconcile themselves to long periods in a variety of waiting rooms on their way to the sick bed. Such spaces are not defined in the terms of the ownership and control that define our usual locations in the home or place of work, in which our personal choices in terms of arrangement and décor are involved, to reflect our individual touch, interests or moods. Instead, the space the patient occupies is experienced as alien, reflecting a loss of identity and autonomy, even if the ambiance is one of professionalism and personal care for the patient.[124] Patients remain, however, in what is experienced as a situation of vulnerability, given the level of intrusion into their personal space, and in the

---

[124] R. M. Zaner, "Encountering the Other," in *Duties to Others*, ed. C. S. Campbell and B. A Lustig, 4, (Dordrecht, NL: Kluwer Academic Publishers, 1994), 25

trust they must place in others in any system of health care. The essential relatedness of individual existence is highlighted in and through such experiences. At that point, religious and spiritual insights are more intensely focused, communicating a sense that both sickness and health are inescapable aspects of the human journey through life.[125] As "patients"–with its Latin root in *pati*, "to suffer"—persons suffer not only pain or a loss of physical well-being but in a sense also an exposure, not just to the particular medical problem, but also to reality in its totality, and the meaning and values it either promises or withholds. Inevitably, the patient—the *patiens*, "the sufferer"— suffers questions at the heart of selfhood and identity, as the journey of life takes an un-planned, and often unprecedented, turn. While decisions may have to be made about the kind of treatment or its duration, there persists the need to hold to a sense of meaning and responsibility in the whole context of personal existence.[126] And so, it becomes imperative to respect that meaning of life which has been deeply formed by personal intuitions and communal narratives—specifically for my purposes, in the religious context. Here, human life is "constructed and explained, clarified and communicated, in stories and narratives of Creation, alienation, and reconciliation."[127]

---

[125] Hollins, "Spirituality and Religion..."

[126] For greater discussion on this see, B. G. Epperly, "Prayer, Process, and the Future of Medicine," *Journal of Religion and Health* 39, no. 1 (2000).

[127] Campbell, "Religion and Moral Meaning in Bioethics."

H. Tristram Engelhardt Jr. points to the role of theology at this juncture. It can offer an understanding of the ultimate significance of suffering and death: "We all face the abyss of death and of ultimate purposes obscured. Against this abyss, theology can offer images and visions and conjecture meaning from a faceless night."[128] While not all human lives are explicitly religious in their self-understanding, all human lives are situated within broader structures of meaning within which they can be said to have (or lack) sense or purpose.[129] This is the case even if it corresponds to the equivocal sense in which Wittgenstein commented to M. O'C. Drury, "I am not a religious man but I cannot help but see everything from a religious point of view."[130]

Take the following thought-example, by way of contrast. An upper-middle class man is happily married, has a loving family, a successful career, and enjoys financial security. He is most likely gaining very positive messages about himself, in his sense of identity and the choices he makes. To that degree, he lives in a firmly grounded world of meaning in which his life-project can unfold. But what happens when he begins to feel vaguely unwell and, then, on seeking treatment, is told that his condition may be serious.

---

[128] H. Tristram Engelhardt, "Looking for God and Finding the Abyss," in *Theology and Bioethics: Exploring the Foundations and Frontiers*, ed. E. E. Shelp, (Dordrecht, Holland: D. Reidel Publishing, 1985), 90

[129] Elliott, *A Philosophical Disease*.

[130] Rush Rhees, ed., *Recollections of Wittgenstein: Hermine Wittgenstein--Fania Pascal--F.R. Leavis--John King--M. O'c. Drury* (Oxford: Oxford University Press, 1984), 79

Tests and admission to hospital follow. Despite private health insurance and the assurance of a good level of care, this man must now re-evaluate his life-goals and his place in the scheme of things. Ultimate questions, perhaps long repressed, inevitably surface: Who am I? Where am I going? What have I done to deserve this? Is death the end?

This kind of situation is not one which medicine or bioethics in its secular construction is well equipped to deal with. But religious traditions and their theological articulation can offer such resources. Symbolic expression and the trajectory of a life time are their common currency—in contrast to the more immediate concern of medicine that is necessarily—and often exclusively—narrowly focused on individual pathology. The religious dimension allows the ill to place their particular experience into the context of an entire life, such that the experiences of illness and healing, suffering and relief, incompleteness and wholeness can call on an ultimate frame of reference. For instance, a terminal prognosis is not simply a failure of the medical system, but part of the human life journey: all of us will die.

What Courtney Campbell called a "teleological account of human experience",[131] Villagomeza identified in the more secular idiom of self-transcendence. He describes this as "an expansion of personal boundaries

---

[131] Campbell, "Religion and Moral Meaning in Bioethics."

beyond the immediate or constricted views of oneself and the world".[132] Part of the function of religion is to communicate a sense of this "expansion of personal boundaries", while theology, for its part, attempts a critically coherent articulation of this self-transcendence in relation to a specific religious tradition.[133] Thus, a moral matrix and sense of meaning can be illumined by the theological explorations of Protestant, Catholic or Orthodox traditions of Christianity, or from the variety of religious commitments deriving from Judaism, Islam, Hinduism and Buddhism and so on.[134] Theology, therefore, does not exist in abstraction, but only as a reflection on the concrete reality of particular religious traditions in various cultures and contexts. To recognise these theological perspectives is to recognise that "each of us comes to that task [ethics in health care] with somewhat different presuppositions, hopes, fears, and experiences; and exploration and analysis of those differences is a vehicle for our moral and spiritual growth."[135] Theological perspectives, moreover, suggest a language that assists in the formation of a moral consensus consistent with differing faith commitments.

---

[132] Villagomeza, "Spiritual Distress..."

[133] For a discussion of the role and function of religion and theology specifically in health care see, Stanley Hauerwas, *Suffering Presence* (Notre Dame, Indiana: University of Notre Dame Press, 1986).

[134] O'Connell and Skevington, "The Relevance of Spirituality..." have generalised the views of religious and non-religious people in order to articulate themes of convergence and disagreement in relation to what they have termed spirituality and personal beliefs.

[135] Tubbs, *Christian Theology and Medical Ethics, Four Contemporary Approaches*.

In this sense, theology is itself a moral activity.[136] Such language does not need to be either sectarian or exclusive to a particular religious worldview,[137] even when an individual within a religious community is the point of reference.[138]

While the story of each individual is unique, a religious perspective exhibits, I suggest, five common features. First, a sense of transcendence and meaning in which the divine is central. Secondly, there is an impetus to an other-directed existence—a living for others with its demand for "self-dispossession, not self-possession".[139] Thirdly, fundamental religious beliefs shape the ultimate context of one's life. Fourthly, a religious faith means belonging to a community and being connected to others in a shared tradition. Fifthly, it is expressed in various forms of ritual, prayer and worship.[140]

For Christian theology, the path or *telos* of humanity is revealed in the person of Jesus Christ, in his life, death and resurrection. In McCormick's words, "Jesus Christ, the concrete enfleshment of God's love, becomes the meaning

---

[136] For further argument on this point see, for example, Hans Küng, *Eternal Life*, trans. Edward Quinn (London: Collins, 1984).pp. 192 - 196 and, Cahill, "Can Theology..." 58

[137] O'Connell and Skevington, "The Relevance of Spirituality..." and, Villagomeza, "Spiritual Distress..."

[138] Ninian Smart, *World Philosophies* (London: Routledge, 1999).

[139] Hardy, *God's Way with the World*

[140] Hollins, "Spirituality and Religion..."

and *telos* of the world and of the self. God's self disclosure in Jesus is at once the self-disclosure of ourselves and our world".[141] The Christian Gospel forms the narrative identity of Christian believers in their journey through life. It gives the world of experience a particular shape and movement, centred on Christ himself.

Symbolic language in its full mythic expression or narrative, then, is the means by which persons and communities articulate their faith commitments. Its power consists in communicating meaning, in life and in death, for oneself and with others, by inspiring hope even in situations of suffering and pain.[142] Such limit-experiences are at the foundation of religious perspectives on health care. Contemporary medicine, on the other hand, speaks what C. S. Lewis would term a "scientific language",[143] increasingly confining itself to what is measurable, quantifiable, and objective. As this scientifically limited language increases, there is a greater need for a more comprehensive way of thinking and speaking about health care. A horizon of transcendence allows for a fuller integration of all aspects of human and personal existence while

---

[141] R. A. McCormick, "Theology and Bioethics: Christian Foundations," in *Theology and Bioethics: Exploring the Foundations and Frontiers*, ed. E. E. Shelp, Theology and Medicine, (Dordrecht, Holland: D. Reidel Publishing, 1985), 100

[142] An excellent discussion of this line of thinking can be found in, Gerald P. Gleeson, "C. S. Lewis: Doctrine and Metaphor," in *Reflections on Faith and Culture*, ed. Neil Brown, Faith and Culture, (Manly, NSW: Catholic Institute of Sydney, 1981), 6-18

[143] Gleeson, "C. S. Lewis: Doctrine and Metaphor," 10

remaining open to the new, and to what can be envisaged only in hope.[144] As

Hans Küng notes, "the great religions are concerned about the same

perennially *young questions* of the great why and wherefore, which lie behind

what is visible and tangible."[145]   The answers to such questions are

appreciated as of central value to human existence.   While the religious

knowledge of God can never be exhaustive, David Ford emphasises that what

is known to faith affects "how [people] imagine reality, what they believe and

think, how they feel and behave, who they marry, and all sorts of other things

important to their identity".[146] James Wiggins, in his entry in *A New Handbook*

of Christian Theology, nicely summarises this point:

> Religion is concerned with ultimacy, with what matters most to people
> and before which they are willing to subordinate themselves, as they
> are unwilling to do in the face of anything else.   Experiences of
> connection with ultimacy evoke diverse expressions, which typically
> aim to call attention to, and recommend as desirable, such experiences
> to others ... groups recommend patterns of behavior implicit in the
> ethos into which the initiate has come. Patterned behaviors or rituals
> reinforce the sense of connection with the ultimate.[147]

The concept of *ultimacy* is the key. It refers to that which is last or final. Its

meaning does not consist in simply naming some religious quality in

experience, but by making connections with the ultimate in a series of

---

[144] Marty, "Foreword," ix

[145] Küng, *Eternal Life*.

[146] David F. Ford, *Theology: A Very Short Introduction*, Very Short Introductions (Oxford: Oxford University Press, 1999).

[147] J. B. Wiggins, "Religion," in *A New Handbook of Christian Theology*, ed. D. W. Musser and J. L. Price, (Cambridge: The Lutterworth Press, 1992), 401

experiences marked by completion or ending.[148] Because religion is about

ultimate meaning, it is, in principle at least, a public communication. Though

it looks to personal transformation, it is not a way of life more or less hidden

from the world, but a world-shaping influence, and indeed, in many cases,

owning a world-shaping mission. To exclude the public nature of religious

traditions from health care in the name of supposedly "public" norms is not

only an eccentric and ideologically-loaded use of such a term, but suggests a

narrowly rigid view of what the public life of society consists in. Lebacqz

rightly observes that to speak of norms in any context "always involve

appeals in the long run to basic value commitments and convictions and to

symbolic dimensions of human life".[149]

Here, research conducted by O'Connell and Skevington[150] offers helpful

examples of how patients seek to articulate their sense of meaning and

purpose in the midst of their health predicaments:

> I am optimistic because of my faith…I know where I am going ultimately because I have a strong belief in God and one day in the future I will go to heaven.

> I think there is a positive force outside the material world… I believe that "good" and "bad" are spiritual concepts.

---

[148] Gordon D. Kaufman, *An Essay on Theological Method*, 3rd edition ed. (Atlanta, Georgia: Scholars Press, 1995).

[149] Karen Lebacqz, "Religious Studies in Bioethics: No Room at the Table?," in *Notes from a Narrow Ridge: Religion and Bioethics*, ed. D. S. Davis and L. Zoloth, (Hagerstown, Maryland: University Publishing Group, 1999), 211

[150] O'Connell and Skevington, "The Relevance of Spirituality..."

> If there isn't something else, then what's the point?

> It's an indefinable thing. It's a very important thing but something you can say little about.

> It is connectedness… that encourages me in practice. [151]

Not all of these comments were specifically about the role that religion played in these people's lives, but they indicate an awareness of a self-transcending orientation in human existence. If such expressions of religious or spiritual conceptions of life have no resonance in health care discourse, the ability of those professionally in such care is being violently truncated. [152]

Take the following instance in Helge Kuhse and Peter Singer's book, *Should the Baby Live?*[153] The authors argue that the hegemony of Christian beliefs and morality has prevented rational decision-making in regard to infanticide. Their solution is to secularise moral discourse, and to eliminate the principle of the sanctity of life. This principle, they argue, has only a religious relevance; and so it is inappropriate and indefensible in a pluralist society. But their argument contains an essential contradiction—the denial of the very value, namely, pluralism, it seeks to respect. It assumes that no-one, at least no-one whose views need to be considered, actually holds to the sanctity of

---

[151] O'Connell and Skevington, "The Relevance of Spirituality..."

[152] Lebacqz, "Religious Studies In..."

[153] Helga Kuhse and Peter Singer, *Should the Baby Live?* (Oxford: Oxford University Press, 1985).

life as a fundamental value. [154] Further, Kuhse and Singer claim such a value is dependent on a religious view of the world that is unacceptable, since religious convictions should not be accorded any place in public life or health care. [155] Theological voices in health care challenge such positions, by affirming the transcendent value of the human person, no matter how incapacitated or diminished. For the human person is not reducible to some empirical measurements of function and autonomy, but is by nature indefinable and of an incommensurable value—indeed, a mystery. [156]

A theological framework supports a discourse on the meaning, purpose and the moral matrix of life. This is not to say that the discourse that draws on the theological and spiritual traditions must speak in a defensively sectarian voice. Though particular religious worldviews appeal to a distinctive ethos and call on the experience of a particular community and its tradition, they contribute to the resources of a pluralist society by enriching the overall quality of health care discourse. The ideological exclusion of such voices must be challenged, if only for the reason that such an exclusion is itself a product of a particular tradition, namely, secularistic rationalism of a

---

[154] Kuhse and Singer, *Should the Baby Live?*

[155] Kuhse and Singer, *Should the Baby Live?*

[156] Neil Brown, *The Worth of Persons: A Study in Christian Ethics*, Faith and Culture ; No. 7 (Manly, N.S.W.: Catholic Institute of Sydney, 1983). especially Chapter 4; and, J. M. Soskice, "Creation and Relation," in *Medicine and Moral Reasoning*, ed. K. W. M. Fulford, G. Gillett, and J. M. Soskice, (Cambridge: Cambridge University Press, 1994), 25

particularly reductive and agnostic kind. For a more open view of ethical reasoning—hospitable to the actual plurality of voices and modes of reason deriving from particular traditions—it does not appear to be very rational to exclude meanings and values that in fact deeply affect a large section of society. The obvious instance is the place of Christianity in the Western world. Christianity has been so fundamental to shaping the institutions (including health care itself), social structures, literature and art, philosophy and moral reasoning of the West, that to dismiss it would be to ignore a considerable part of the cultural capital on which Western society has depended for its basic values and ethical orientation.[157] Though Western society is now more secular in its outlook and more pluralist in cultures compared to the Christendom of the past, the Christian tradition is still a productive phenomenon in the life of individuals and societies. As this thesis demonstrates, it communicates a profound sense of human person and community, in a way that can affect all domains of life, above all that of health care.

6. Conclusion

To summarise: this chapter has argued that religious commitments and theological reflection assist people to face the ultimate questions inherent in

---

[157] Nicholas Capaldi, "What Is Bioethics without Christianity?," *Christian Bioethics* 5, no. 3 (1999).

the experience illness and suffering.[158]   Accordingly, I considered the new situation confronting health care in increasingly secular societies, while at the same time arguing for a role for theology in the present situation. I have sought to show how theological frameworks of meaning affect not only a sense of the human condition generally, but concrete cases and the response to them.

Early in this chapter I highlighted the views of Alisdair MacIntyre about the three areas which he believes theological perspectives in health care ethics must address—the distinctiveness of religious positions, a theological critique of secular culture and a demonstration of what theology offers to medicine— in order to set up a contemporary version of the Euthyphro dilemma. Religious and theological perspectives on the world are not and cannot be completely distinct from others which emerge within particular cultures and contexts. They emerge from the same milieux and while they bring to their reflection on the culture a set of religious beliefs and commitments, these need not radically differ from all the beliefs and commitments of those of other religious traditions or none. In terms of a critique of secular culture and morality and what religion and theology can offer to health care, the beliefs and commitments which theologians and people of faith bring to society, and in particular to health care, do critique contemporary society and health care.

---

[158] Sulmasy, "Every *Ethos* Implies a *Mythos*," 244

They tend to challenge the physicalist, materialist and rationalist views which predominate in the West today. Because they usually involve commitment to communities, they challenge the emphasis on radical individuality that drives much of contemporary society. In that religious views include a focus on or consideration of the transcendent, they challenge the vitalism too often evident in modern health care. Above all, what religion and theology offer to society and to health care is a coherent view of the human person as a relational being and they assist persons to achieve a sense of meaning.

This is to say that faith, spirituality and theology shape self-understanding in terms of ultimate purpose and identity. The religious contribution to health care, however, depends on its capacity to offer coherent accounts of meaning and value for human life, by participating in the larger cultural conversation to which it belongs and by addressing the moral dilemmas that arise. [159] In this regard, it is not a matter of appealing to authority, religious or otherwise, but of demonstrating the authoritative status of religious traditions in their ability to throw light on the ultimate questions facing every human being and every cultural era.[160]

---

[159] Charles Taylor, *Sources of the Self: The Making of Modern Identity* (Cambridge: Cambridge University Press, 1989).

[160] C. Elliott, "Putting Your Best Face Forward," *Psychology Today* June (2004).

While this chapter has indicated how theology constructs frameworks of meaning that enable patients to make sense of their experience and maintain their sense of identity, I will proceed to show that theology is in a position to offer a critique of health care from a perspective larger than the values of the material and the biological for human fulfilment. By promoting an ethic of personal dignity and interpersonal responsibility, the task of theology is to contest that individualistic and rationalist approach previously referred to as the "sociology of strangers."[161]

The next chapter investigates the second major implicit theme of the thesis: that concepts of person are of vital significance in health care. In the following chapter I examine a range of historical and philosophical perspectives on persons and personhood to set the stage for the development of my own philosophical and theological position. The cases nominated in the Introduction are further developed in Chapter Three to draw out their relevance in health care and for thinking about personhood.

---

[161] Campbell, "Religion and Moral Meaning in Bioethics."

CHAPTER THREE: THE QUESTION OF PERSONHOOD IN HEALTH CARE

In the previous chapter the challenges facing theological perspectives in health care were considered and a case was made for theological participation, within a pluralist framework. Before probing, in Chapter Four, the philosophical bases of relational aspects of personhood crucial to the theory and practice of health care, I first consider questions that arise at a number of "flashpoints" in the current practice of health care, the systems in which they arise, and some aspects of the history of the notion of personhood that have had their impact on how personhood is constructed. In all this, I hope to set the stage for the relational anthropology and the practical theology that will be the concern of chapters to follow. I present the material of this chapter under five headings:

1. Flashpoints in Contemporary Health Care

2. Systems and Anthropologies

3. Personal Being

4. The Language and History of Personhood

5. Some Practical Consequences

1. Flashpoints in Contemporary Health Care

Two relatively recent cases in health care ethics give a practical focus to the questions that concern us. These were briefly mentioned in Chapter One but it is now necessary to develop them further in order to demonstrate the influence of questions of personhood in health care.

The Attard Twins

As noted in Chapter One, this case occurred in Britain in 2000, and involved the separation of conjoined twins, publicly known as Jodie and Mary (these pseudonyms were applied to protect the confidentiality of the parents and children at the time). They were later revealed to be Gracie and Rosie Attard, the daughters of Rina and Michaelangelo Attard. [162] Ultrasound in their home country of Malta revealed that Rina Attard was pregnant with conjoined twins. The obstetrician at Gozo referred the case to St Mary's Hospital in Manchester where he had trained. The parents relocated from Malta to

---

[162] I have found in the course of writing, re-writing, editing and thinking about this case that I have experienced a growing level of disquiet about the use of their pseudonyms. While it is clearly a standard legal tool to preserve the privacy of those involved, it reaches a point where the pseudonyms also permit the twins, their parents and the very case itself to be objectified. Such an approach encourages tacit acceptance of the view that if it is a case of both dying but it is possible to save one, then everything should be done to save one... and simply allowing the other to perish. Analogously, I wonder if this is similar to someone saving a single child from famine or warfare and focusing on the act of saving rather than the situation of the many left behind. It does not diminish the success or joy at the saving act... but it does permit us to feel more comfortable with what we can now describe as the inevitability of what happened to the other(s). I think the anonymity of Rosie made it much easier for those involved to simply discount her and the network of relationships in which she was an essential participant. Her death, then, is personally tragic but inevitable and, hence, of no wider significance.

Britain for the birth of their daughters in order to increase the chances of a successful birth, and to give the twins the best chance of survival. Further tests in Manchester indicated significant difficulties in the pregnancy with the smaller of the twins not expected to survive to full-term. The parents refused the offered termination at this point on the grounds of their religious beliefs. The twins were born on August 8, 2000.

Post-natal diagnostic tests revealed that Rosie's brain, heart and lungs were not normally developed. The brain was primitive; the heart enlarged and poorly functioning; and the lung tissue was non-functioning. Gracie's brain heart and lungs were anatomically normal, with adequate circulation and oxygenation. Rosie was completely dependent on Gracie's capacity to breathe and oxygenate blood for both of them. The twins were joined at the pelvis with a fused spine and spinal cord. Medical advice suggested that as the twins grew, Gracie would be unable to sustain them both. After this investigation of the extent of the "joining", it was determined that separation would probably result in Gracie's survival, but would end Rosie's life.[163] The parents refused consent for the recommended procedure, citing their religiously grounded belief that they could not endorse a course of action that would bring about the death of one of their children and determined to take

---

[163] J. J. Paris and A. C. Elias-Jones, ""Do We Murder Mary to Save Jodie?" An Ethical Analysis of the Separation of the Manchester Conjoined Twins," *Postgraduate Medical Journal* 77, no. 911 (2001).

their children home to die. The physicians at St Mary's who challenged the parents' refusal in the courts, considered that, since both children faced certain death, every option should be explored to save the life of the child who had the possibility of surviving independently. Consequently, the hospital and the physicians commenced legal action to override the parents' decision and to remove them from any role in the decision-making process.

An initial ruling in the British High Court supported separation on utilitarian grounds. [164] This was followed by an Appeals Court ruling which upheld the original decision and rejected the parents' decision. It argued that the interests of each child should take precedence over parental wishes. While the intrinsic value of Rosie's life should be recognised, her right to life did not outweigh that of her sibling, for Rosie could not exercise her right to life in the same way as Gracie. Moreover, while this judgement came down in favour of separation, it could not remove the illegality of an action which, in and of itself, would result in the death of an innocent person. To overcome the potential of the doctors, hospital and National Health Service trust being charged with murder, the Court of Appeal ruled that the defence of "necessity" would be sufficient in this case to successfully defend such a

---

[164] Richard Nicholson, "Should Doctors Separate the Siamese Twins? - No," *The Independent*, 10 September 2000

charge.[165] The Court of Appeal further noted that there was no moral basis for its ruling.

Separation took place on November 7, 2000 resulting in Rosie's death. Gracie survived and subsequently underwent four reconstructive operations, and has returned to Malta with her parents.[166]

The case of Gracie and Rosie involves greater complexities than the usual issues around separation of conjoined twins. This case raises the question of personhood on several levels. For instance, some physicians had argued that Mary[167] was not a person, or, strictly speaking, a human being, but rather a teratoma—a parasitic collection of tissue or an abnormal growth.[168]

Questions inevitably arise in these kinds of situations: what constitutes personhood and the value of human existence? What is the nature and limits of consent which imply particular views of personhood? How does an implicit worldview affect medical decision-making? How far is professional judgment in health care to be the all-determining consideration, and what is

---

[165] Alexander McCall Smith, "The Separating of Conjoined Twins," *British Medical Journal* 321, no. 7264 (2000).

[166] Rock and London, "Amazing Gracie,"

[167] Given the point of this argument and my view expressed in n 162 above, it is appropriate to use the pseudonym applied to Rosie in this and other similar instances.

[168] Riddell, "Pity Us, but Pity Jodie More," *The Observer*, 10 September 2000

the duty and limits of care owed by medical professionals, the State and those intimately connected to patients?

The decision made by the British Courts was self-confessedly utilitarian in orientation and application.[169]   In terms of such a pragmatic calculus, the outcome of the sanctioned medical procedure was successful. One child was enabled to live, even if the death of her sister resulted. As Swinton argues, this situation reflects the general Western social perspective on disability and impairment. It allows that such situations, however personally tragic, are not socially significant.[170] If the choice facing the parents were as simple as saving one healthy child through the removal of a child who had no future, it still would have been a tragedy for any parent. The judge in the initial Court case recognised this in his judgement.[171]   Facing such a situation, what parent would not think, "I am killing one of my children?"

The situation facing the Attards, however, was much more difficult than that acknowledged by the courts or the health professionals involved. The initial prognosis for the surviving twin indicated some significant degree of disability most likely in terms of highly circumscribed mobility, incontinence

---

[169] Nicholson, "Should Doctors Separate the Siamese Twins? - No,"

[170] Swinton, "Constructing Persons..." 239-248

[171] "Case of the Siamese Twins," in *Johnson J.* (Supreme Court of Judicature Court of Appeal (Civil Division), 2000)

and infertility. Faced with this prognosis, the Attards were concerned that there were few disability services in their homeland, and that they did not possess the financial resources to provide adequate, ongoing medical treatment.[172] Prior to the commencement of legal action, it was suggested that one option for the parents was to place the surviving twin for adoption in Britain in order to secure her medical care in the future, even if this would mean not seeing her again.[173] It was recognised, too, that there was a possibility of Gracie herself not surviving.[174]

In this invidious position the parents opted not to choose between their children, but to accept the limits of the situation, and to act in accord with their Catholic principles. They considered any decision on their part to authorise an action which would kill one of their children would be morally wrong. While there was no explicit questioning of the personhood of either child by most people involved in the case, clearly very different ideas of personhood were in conflict. The parents accepted the essential equality of their daughters, while some of the physicians argued that Mary was simply a teratoma. The judges argued for the status of Mary as a person, but they limited any effective recognition of her personhood by enabling surgery

---

[172] Paris and Elias-Jones, ""Do We Murder Mary to Save Jodie?" An Ethical Analysis of the Separation of the Manchester Conjoined Twins."

[173] Jeremy Laurance, "Parents of Siamese Twins to Fight Judge's Ruling," *The Independent*, 31 August 2000

[174] "Case of the Siamese Twins,"

designed to end her life to take place. That they recognised the personhood of Mary is evident, for included in the judgement to legitimise this surgical procedure was a recognition of the possibility of a murder charge. The Court of Appeal noted that such a charge could not be simply negated and, hence, this required that the Court of Appeal rule that the defence of necessity would be sufficient to defend such a charge.

Here we face the question: would not a more relational anthropology of human personhood have given greater prominence to other factors in the case? It would have led to a more sensitive recognition of the Attards' position, and demanded further discussion of the relationship between Gracie and Rosie. However, it has to be acknowledged that a different way of thinking may have led to different outcome–both children may have died and based on the medical advice available at the time, this is the likely outcome without surgical intervention. But such a negative outcome would not have meant that the decision was wrong on ethical and moral grounds. A relational anthropology does not automatically resolve ethical dilemmas, nor promise positive medical outcomes. But what a relational anthropology can allow for is a more complete analysis of ethical situations. In the case under consideration, the courts and physicians were in fact making a moral decision even if it was denied that morality entered into it. Medical necessity was the value dominating every other consideration, especially that of the moral

decisions of the parents. Their personal dignity was, to all intents and purposes, publicly violated.

Nancy Crick

The second case is that of Nancy Crick, an Australian woman who ended her life in 2002. Nancy Crick was a 70 year old Australian widow who lived with one of her sons, in close proximity to other members of her family. In 1999 she underwent surgery for bowel cancer. Following surgery she continued to experience discomfort, pain, nausea and vomiting. As a result of the surgery she had a colostomy, a bag that functions as a collection receptacle for faeces.[175] Nancy determined that she would end her own life when her efforts to seek medical assistance to die were deemed to be unlawful. She sought advice from Dr. Philip Nitschke, a prominent euthanasia and "right to die" advocate, about how to deal with her suffering.[176] Crick refused further investigative or alleviative surgery; found the palliative care regime that was trialled less than satisfactory; and continued in pain and discomfort. From February 2002 until her death in late May 2002 Crick took part in a public campaign to highlight the cause of physician assisted suicide and the related

---

[175] Nancy Crick, *The Diary of Nancy Crick* [website] (2002, accessed 26 August 2003); available from Http://pandora.nla.gov.au/pan/24513/20020424www.proctection.net.au/nancycrick/htm

[176] Rodney Syme, *Nancy Crick* [website] (Voluntary Euthanasia Society of Victoria Inc., 2002, accessed 26 August 2003); available from http://www.vesv.org.au/docs/crick050602.htm

issue of euthanasia.[177]   Part of this campaign was an internet diary which

enabled Crick to chronicle her thinking and state of health. She was sent the

barbiturate cocktail she used to end her life by someone accessing her website.

Following Crick's death an autopsy confirmed what she had been previously

told by physicians: she was free of cancer. It also revealed that her bowel was

twisted, which had been suggested as a probable cause of her symptoms. It

has also been suggested that her body weight was not 27 kilograms as

claimed but nearly double that and that she was gaining weight, presumably

following a more appropriate care regime instituted during her final hospital

admission.[178]

These cases raise questions as to the beginning and end of life, and the nature

of personhood. Both have a bearing on health ethics dealing with consent and

responsibility. In the case of the conjoined twins, a specific issue was the

parental obligation to make choices in the best interests of their children.

Cultural considerations about what constitutes acceptable care adequate are

also in play, along with the role of religious beliefs in making moral decisions.

The personhood of the conjoined twins – at least that of Rosie who was to die

– was called into question on the grounds that Rosie did not have a

---

[177] Syme, *Nancy Crick* (accessed)

[178] David van Gend, "Nancy Crick's Death Not in Vain," *Human Life Review* 28, no. 3 (2002).

functioning heart, and that her brain development was limited. An attack on the personal integrity of the parents is also apparent when they were characterised in the media, and implicitly by the health professionals involved, as ill-educated, superstitious peasants. In the other case, the presumption that Mrs Crick was a competent, rational and self-determining person was presented as the basis for her "reasonable" decisions to refuse legitimate health advice and to want to end her life. Moreover, her case raises other searching questions: while it is generally accepted that the wishes of rational autonomous persons regarding their treatment should be accepted, it is unclear how health professionals and the wider society should react to erroneous beliefs (e.g. Crick's belief that she had cancer, despite medical evidence to the contrary). Does her erroneous belief and her refusal to accept remedial surgery or continuing palliative care require that the law should permit medically-assisted suicide, or that medical practitioners carry it out?

Clearly, conflicting anthropologies are at work in the thinking of the various parties concerned. These cases pose a challenge reaching into the very nature of personhood itself. I make constant reference to these cases in this and subsequent chapters. Other ethical cases more usually associated with the personhood debate, such as abortion, long-term life support, the status of the severely intellectually impaired, will also be considered where appropriate.

2. Systems and Their Anthropologies

Flashpoints in health care ethics occur when human beings are either not yet conscious (for example, an unborn foetus), or when individuals are, through illness or injury, no longer conscious. The decisions which confront health care professionals, families and even the patients, either at these crisis-points or in anticipation of them, give rise to discussion about who or what is a person. Contemporary health care is familiar with quandaries arising out of the question of personhood, in, say, determining death, or the status of human embryos at various stages of foetal development, and the treatment of patients in a persistent vegetative state. In such situations, the question of personhood and the moral status of the individual affect decisions regarding what kind of health care the system offers.

Every system of health care reflects an underlying anthropology and a particular understanding of personhood—however implicit this might be. For example, a recent analysis of the health care system in the United States suggests it is predicated on the assumption that persons are autonomous individuals who do not want the state interfering in their lives. This has given rise to an essentially private system of health care that relies on a contractual understanding of the interaction between patients and health care

providers.[179]   It implicitly assumes a free-market model of health.[180]   This

assumption holds that all physicians are open to treating all potential patients

and that these patients can exercise free choice in the treatment they need.

But this assumption cannot be justified.   Autonomy is more limited and

circumscribed than the American model concedes.   Autonomy is, in fact,

limited due to a lack of knowledge, different standards of education, present

need, or socio-economic circumstances. In such a system, persons are free to

choose, but not equal in their capacity to access the treatment(s) available.

The system implicitly assumes that patients are consumers of health care and

can equally choose to meet the payments required as is the case in all the

other goods and services offered by society.   There is little discussion of

waiting lists for types of treatment in the U. S., since the financial costs and

the "market" determine the availability of most types of treatment.   That is,

many of those who are most needy and most vulnerable would not be

considered eligible for most kinds of treatment; hence there are no significant

delays for those who can pay for treatment.

In the United Kingdom, a similar system prevailed until 1948.   However, in

recognition of the overwhelming need for national health strategies and for

---

[179] A good commentary on the US health system can be found in, Kate Traynor, "More Americans Than Ever Lack Health Insurance," *American Journal of Health-System Pharmacy* 62, no. 24 (2005).

[180] Alwyn Cassil, "Commision Balances Patients' Rights with Free Market," *AHA News* 33, no. 42 (1997).

the promotion of high standards of health, the National Health Service (NHS) was developed to provide universal health coverage to all citizens at no or minimal cost (except for pharmaceuticals and dentistry).[181] This model assumes that health is a public good. It is in the interests of the nation to ensure that there is a minimum standard of health for all members of society. It therefore accepts that it is the primary responsibility of the State to treat all citizens equally. In this system, the NHS is the principal employer of doctors, especially family doctors or general practitioners. These act as gate-keepers of the system by determining which patients are referred to specialists or hospitals. Patients in this model cannot simply pick and choose health care providers or treatment options. The implicit anthropology of the NHS model is that persons are equal but, in fact, may have their effective freedom diminished; they have choices but within fairly strict limits. In contrast to the U.S. system, there are significant waiting lists for some types of treatment since medical need and availability of the service determine access.[182] This may mean that access to expensive treatments is more limited by design since everyone in need of regular treatment can access it.

---

[181] For a detailed history of the NHS see the NHS Website: *History of the Nhs*, (The Department of Health, accessed February 9 2006); available from http://www.nhs.uk/england/aboutTheNHS/history/default.cmsx

[182] For a recent discussion of the issues facing the NHS and the competing philosophies at work see, D. G. Green and others, "For and Against: Social Insurance -- the Right Way Forward for Health Care in the United Kingdom?," *British Medical Journal* 325, no. 7362 (2002).

A quite different system operates in Australia where a model of universal health insurance (Medicare) works in concert with a network of public, essentially government-operated hospitals, and an otherwise private model of health care provision.[183] A levy based on income is used to partially fund Medicare, with the remainder of the costs of this scheme, the funding of public hospitals and the associated Pharmaceuticals Benefits Scheme (PBS) are derived from consolidated revenue (general taxation) and patient contributions to the costs. In this model of health care, the health care professionals are effectively private individuals who provide a service to patients at whatever cost they choose, so that a proportion of the costs is reimbursed to the patient through the Medicare scheme. Physicians, under this scheme, can choose to charge the patient nothing and simply claim the rebate directly from the Government. While a high rate of "bulk-billing" prevailed initially, it is now reduced to 75% of patients nationally, and as low as 47% of patients in some geographical areas.[184] Bulk-billing is largely restricted to those receiving some form of social security, except in areas where there is a high availability of doctors. Those who find themselves at the geographical, financial and social margins are also likely to incur higher

---

[183] For a discussion of the situation in the Australian health context see, Richard B. Scotton, "Medibank: From Conception to Delivery and Beyond," *Medical Journal of Australia* 173, no. 1 (2000).

[184] Department of Health, *Medicare Statistics - December Quarter 2005* [website] (Australian Government, February 10, 2006 2006, accessed February 13 2006); available from http://www.health.gov.au/internet/wcms/publishing.nsf/Content/medstat-dec05-contents See Table E

health care costs. Patients in the public hospital system can elect to be treated as public patients, at no cost to themselves; but, given the significant waiting lists for non-urgent/life-threatening treatments, there are strains in the system. On the other hand, they can be treated as a private patient in either a public hospital or private hospital to avoid the growing waiting lists, but at a cost to themselves or to their private health fund. An added complexity is that most private hospitals do not have the facilities for very serious or intricate surgery. This means the public hospital system disproportionately bears the burden of expensive treatments while private facilities are able to maximise profitability.

This system differs from both that operating in the US and in the UK and has a quite different anthropological model underlying it. When Medicare (1984-) and its short-lived predecessor, Medibank (1975-1978) were proposed and introduced, Australians responded to the political debate surrounding the allocation of public resources in a distinctive fashion. The adoption of universal health insurance scheme enjoyed widespread support, since assisting all of the community, but particularly those who could not otherwise afford to access quality health care, was an acceptable ideal.[185] However, professional bodies representing doctors mounted a campaign, arguing that nationalising health care would remove patients's choice in regard to providers. The success of this campaign was such that the doctors were left in

---

[185] Scotton, "Medibank: From Conception..."

the role as private providers, with the Government funding the patient rather than employing the medical professionals, as is the case in Britain.

The underlying principle was equality in health care, but not at the cost of negating patient choice. Yet the assumptions about the capacity of most people to choose to access particular health care providers were not well founded. Choices about particular providers are limited due to capacity to access (proximity) and lack of knowledge concerning the resources of particular providers, while, at the same time, there is no obligation on any individual health care provider to treat any particular patient. This was demonstrated in a most controversial manner during the early phases of the HIV/AIDS pandemic where significant numbers of highly skilled surgeons working in a private capacity refused to operate on those with HIV or who were suspected of being in a high-risk category.[186] The task of treatment, especially in public hospitals then fell to a much smaller group of physicians willing to act in this role, or who had no choice because they were junior doctors and trainee specialists in the employ of the hospitals.

Anthropological assumptions regarding personhood not only stamp the system as a whole, but also affect decisions that are internal to the system.

---

[186] Department of Community Services and Health, *Consultation Paper No. 5: Report of the Working Panel on Testing for Hiv/Aids* (Canberra, Australia: Department of Community Services and Health, 1989)

For instance, abortion on demand, is permissible in certain countries, regions and jurisdictions only because it is assumed, at least legally, that the foetus is not a person, and that its moral status and attendant rights are operative only after birth. Hence, in the conjoined twins case, the physicians could offer the parents a termination without concern over legal questions, but this was a significant issue after birth despite the outcome being the same for one of the twins. Decisions on termination in such situations are centred on the moral rights or autonomy of the person of the mother. A second example is found in the growing international debate over voluntary euthanasia. Arguments supporting access to voluntary and medically-assisted euthanasia are linked to the concept of the person as an autonomous rational agent. In a third example, the decision of staff in hospital emergency units to act always for the preservation of the life of accident victims who are not able to exercise freedom, reflects an understanding of persons as of special worth, whose lives should be preserved even in the face of severe injury. Finally, the specialised field of palliative care also operates with assumptions concerning personhood. It recognises that death must be accepted as a part of life, and so aims to provide the conditions in which dying patients and those who will mourn their passing can come to terms with illness and approaching death.

An anthropological attitude can be notably deficient, as with the model of health care decision-making known as "quality-adjusted-life-years" (QALYs).

This term refers to the attempt to "combine expected survival with expected quality of life in a single metric: if an additional year of healthy life is worth a value of 1 (year), then a year of less healthy life is worth less than 1 (year)".[187] In this cost-benefit approach, the older a person is, the greater the predictable benefit must be before treatment is approved. In terms of treatment offered, a younger person will always take priority over an older. There are exceptions, as when the young are severely disabled, or when the older person is a figure of some social or cultural significance. This model, and the attitudes it assumes and engenders, does not readily accommodate the old, infirm, disabled and marginalised.[188]

In the case of a decision against treatment on the basis of age, it is necessary to challenge the assumption that older people are less able to benefit from treatment than those who are younger. The QALYs system works like an economic equation. It would be valid if it is assumed that the only variable is the person's age, say, when it is assumed that an eighteen year old benefits from a heart transplant more than a fifty-five year old. Other factors, however, deserve consideration, such as life-style, the length of time a replacement heart is likely to function, or the effects of anti-rejection drugs

[187] John La Puma and Edward F. Lawlor, "Quality-Adjusted Life-Years: Ethical Implications for Physicians and Policymakers," in *Bioethics: Basic Writings on the Key Ethical Questions That Surround the Major, Modern Biological Possibilities and Problems*, ed. Thomas A Shannon, (Mahwah, New Jersey: Paulist Press, 1993), 404

[188] La Puma and Lawlor, "Quality-Adjusted Life Years..." 409

over time—which tend to contest the simple assumption that health care is more cost-effective for the young than the old, and that the elderly are simply a drain on scarce health resources. Then, there is the question of cosmetic surgery. While this form of elective surgery is predicated on the view that autonomous agents should be able to determine what is done to them, the removal of a healthy limb simply because the patient requests it, may well be professionally and morally repugnant to the surgeon. Such a request could arise from a pathological condition, namely, apotemnophilia or body dismorphic disorder.[189] Clearly, larger considerations come into play.[190] Implied in all these quandaries is the question, what is a person?

3. Personal Being

Who is a person? And what are the criteria by which any answer to this question is measured? Common sense and the reality of social communication suggest a response like the following: I am person, you are a person; he, over there, is a person; she, in the chair in front of me, is a person; but, the chair is *not* a person! Answers of this kind reflect an almost *a priori* conviction that I am a person and that those like me are persons. In other

---

[189] n. apotemnophilia, *Oxford English Dictionary Online*(Oxford University Press, 2003, accessed February 13 2006); available from http://dictionary.oed.com/cgi/entry/00316647?single=1&query_type=word&queryword=apote mnophilia&first=1&max_to_show=10

[190] Editor, "Amputations That Are Legal but Unacceptable," *The Scotsman*, 22 August 2000

words, there is an element of self-reference in applying the term "person" to another. In doing so, I acknowledge the moral status of the other while, at the same time, claiming my own moral space. In other words, to designate another being as a person involves recognising a level of equality with oneself and a shared moral status. Often the question is answered by identifying what is not a person, for example, a chair, cat or parrot. There is a greater degree of clarity in excluding some particular beings or categories of beings from person-status than in determining the defining qualities or attributes of persons themselves.

Simply equating human-ness with personhood presents some problems. Scholarly debate on this issue is divided into those who, like Roslyn Weiss or Norman Lillegard, argue that being a member of the species is the base level of personhood;[191] and those like Peter Singer who argue against such a biological equation.[192]   Some of those resisting a baseline determination predicated on species membership suggest that the future may open the possibility of encounters with life forms from other planets who are not members of the human species, but may be persons in every meaningful sense. Others, such as James Sennett, hold that we are already encountering

---

[191] For example, Roslyn Weiss, "The Perils of Personhood," in *What Is a Person?*, ed. M. F. Goodman, (Clifton, New Jersey: Humana Press, 1988) and, very differently, Norman Lillegard, "No Good News for Data," *Cross Currents* 44, no. 1 (1994).

[192] Peter Singer, *Rethinking Life & Death: The Collapse of Our Traditional Ethics* (Melbourne: Text Publishing, 1994).

the emergence of new personal entities brought about by the development of artificial intelligence in "super-computers".[193] Many environmentalists and animal rights advocates, including Peter Singer, argue that only human arrogance would hold that membership of the species conveys a personal moral status, since many other animal life-forms on earth could merit such a designation.[194] On the other hand, the tradition of Christian theology would hold that God and angels are also persons, though they are clearly not human.

But why not simply equate human-ness and personhood? The adjective, "human", can be applied to a wide range of activities, attitudes and also the constituent parts of a human being. For example, the cells of my body are undeniably human but are not persons; the bones in a cemetery are human but no longer persons; sperm and ova are also human but are not persons. Human personhood includes biological existence but cannot be reduced to these biological dimensions of components of human-ness. Biological dimensions are necessary but not sufficient criteria for determining human personhood. But if person-status hinges on more than biological membership of a species, then some human beings may have their moral status called into

---

[193] James F. Sennett, "Requiem for an Android?: Lillegard Traps Us in a False Dilemma," *Cross Currents* 46, no. 2 (1996).

[194] Peter Singer, *Unsanctifying Human Life*, Helga Kuhse ed. (Oxford: Blackwell Publishers, 2002).

question, for example, foetuses, and those afflicted with intellectual impairment or dementia. Almost any criterion further than the specifically biological data of being a living cellular organism of the human species, e.g, self determination, an ongoing sense of self, the capacity for interpersonal relationships, will cause problems when it comes to the consideration of the status of a foetus or the severely mentally impaired.

On the other hand, the single biological criterion for personhood must prove insufficient when considering the living reality of an actual person, not only as a biological entity, with the capacity for reason, for self determination, the ability to form relationships, etc. A criteriological account is better focused, I would argue, when those at the margins or boundaries of person-status are considered, rather than concentrating exclusively on those whose person-status is beyond question, since it is those at the margins who are in danger of being discounted or excluded from moral protection. While the maxim "hard cases make bad law" would discourage consideration of border-line cases, not to consider such instances would lead to excluding them from moral protection.

It is commonly accepted that all human beings who have been born have the moral status of persons and should be treated equally. Yet there is a contrary view. Peter Singer, Helga Kuhse and John Harris argue that severely injured

or impaired humans beings should not be granted such status or the resulting protections. A corollary to this philosophical argument is being considered in several Australian jurisdictions where health professionals are asking for review of how much treatment should be afforded very premature neonates. At one level this is a discussion which results from our new capacities to extend life: health professionals are asking what factors other than the ability to keep a body functioning should be considered in actions taken to preserve neonatal life. On the other hand, this discussion will not be about all neonates at a certain level of gestation, say 22 weeks. At this point other factors such as the circumstances of delivery, birth weight, condition of the lungs and level of disability, will be relevant. The assumption of equality of all living humans either before the law or in health care is not justified. Equality would mean that all humans would have the same access to health treatments and care; and that where some form of differentiation is necessary, either in terms of priority or rationing, the objective assessment of health status and health needs would determine access and priority. However, philosophers like Singer demonstrate that inequality is part of current health care practice based on the judgement that the gravely injured and congenitally impaired are suffering or enduring a life that is not worth living. Singer, for example, agrees with what he sees to be current social, philosophical and medical practices that do not hold all human life as equally valuable or worth

protecting.[195] Because limiting the use of scarce medical resources may cause pain and suffering, voluntary and involuntary euthanasia should be permitted in response to such situations.

A principle of exclusion is in operation by those who favour this style of argument, for the person-status they presume for themselves is what they seek to deny to others. It appeals to its addressees by asking them to imagine themselves as victims of disability, disease, dementia, or injury and old-age and to compare such an "intolerable" state to the quality of life they are currently enjoying.[196] Arguments of this kind encourage society to accept as necessary the flaws and limits in the health system in order to justify some form of rationing and prioritising, and so to distance ourselves from those who are marginalized as a result.

There are two defects in this kind of reasoning. First, the fact that healthy persons may recognise that life would be different in the event of grievous illness or severe disablement does not necessarily mean that life, as a consequence, would not be worth living. Secondly, the argument presumes that persons are individuals with no relationship or responsibility regarding

---

[195] Helga Kuhse and Peter Singer, "Should All Seriously Disabled Infants Live?," in *Unsanctifying Human Life*, ed. Helga Kuhse, (Oxford: Blackwell Publishers, 2002) and Peter Singer and others, "Double Jeopardy and the Use of Qalys in Health Care Allocation," (2002)
[196] Jonathan Glover, *Causing Death and Saving Lives* (London: Penguin Books, 1977).

others. This disregard of others, or regarding them as primarily strangers and rivals, denies the constitutive character of relationships in the lives of persons.

Alison Davies represents an interesting case of a person who was born with severe *spina bifida* (congenital malformation of the spine). She suffers considerable and prolonged pain and has had to undergo repeated surgery. She is doubly incontinent, confined to a wheelchair and continues in uncertain health. On the other hand, she completed her school education at a mainstream school, graduated with honours in sociology, works full-time. She is married to an able-bodied man, and has travelled internationally. Her response to suggestions that her quality of life is so poor that she should have been permitted to die at birth or even be euthanased, is: "Who could say I have no worthwhile quality of life?"[197]   Quite clearly in this case, no-one would seriously argue that such a person ought now be euthanased. But for others whose relational networks are not yet established and who, effectively, have no voice in the decision-making process, results could be different.

4. The Language and History of Personhood

Meanings and values have a history, and this is especially the case with the meaning and value carried by the term, "person". This term, in various

---

[197] Cited in, Rosalind Hursthouse, *Beginning Lives* (Oxford: Basil Blackwell Ltd., 1987).

languages, ancient and modern, holds a peculiar density of meaning.[198] The

Latin term, *persona* (meaning originally an actor's mask) underwent many

developments. The Latin term itself derives from the Etruscan word, *persu*,

signifying "face".[199] These two meanings, "face" and "person" are linked in

other ancient languages, as in the Hebrew *panim* and in the Greek *prosopon*.[200]

This connection between the person and the face extends still into

contemporary medical experience. Physicians' reports in the conjoined twins

case centred on the infants' demeanour and facial expressions as evidence of

their life and status. One physician commented that Rosie's face was clearly

human with responsive features, while another held that her expression was

insufficiently animated for her to be recognised as a person—and hence there

were no serious ethical responsibilities toward her.[201]

The Aristotelian definition of the human being, *zoon logikon* (*animal rationale*)

was useful for many centuries as locating the human both within biological

nature—as "animal"—but as transcending it on the level of the spiritual

("rational"). How human beings differed from one another, or what the

---

[198] Stanley Rudman, *Concepts of Person and Christian Ethics*, New Studies in Christian Ethics (New York: Cambridge University Press, 1997).

[199] Karl Rahner, ed., *Encyclopedia of Theology: A Concise 'Sacarmentum Mundi"* (London: Burns and Oates, 1975), 1207

[200] H. G. Hubbeling, "Some Remarks on the Concept of Person in Western Philosophy," in *Concepts of Person in Religion and Thought*, ed. H. G. Kippenberg, Y. B. Kuiper, and A. F. Sanders, (Berlin and New York: Mouton de Gruyter, 1990), 9

[201] "Case of the Siamese Twins,"

reality of personhood was, were questions that did not arise in the Aristotelian context or for many years following.

Whatever the linguistic origins of the term or category of person in Greek, Etruscan and Latin usage, the development of the understanding of person in late Republican and the Imperial Roman culture gave to the term a conceptual framework which established it as a category for philosophical reflection in its own right. In Roman jurisprudence, the status of a *persona* as legal entity in society had several important influences. Firstly, the term became closely associated with the use of an individual's name, to suggest that the name and image are aspects of a human being's social presence.[202] Mauss traces the development of the legal term principally through trials related to people usurping the name of a family or individual. This was viewed by the Roman courts as an attempt at impersonation and a violation of the integrity of the individual.[203] This usage tended to move the meaning of the term from an individual role or function to the objective character—at least in a social sense—of the individual. Juridical usage and philosophical reflection combined in the late Republican and Imperial period to introduce a more explicitly moral perspective. Mainly Stoic thinkers developed a sense of the

[202] M. Mauss, "A Category of the Human Mind: The Notion of Person; the Notion of Self," in *The Category of the Person: Anthropology, Philosophy, History*, ed. Michael Carrithers, Steven Collins, and Steven Lukes, (Cambridge: Cambridge University Press, 1985), 15-17

[203] Mauss, "A Category of the Human Mind: The Notion of Person; the Notion of Self," 17

individual as "conscious, independent, autonomous, free and responsible".[204]

This conception, while clearly moral in the sense now understood, remained also strongly juridical. While at first glance this view is similar to the later Enlightenment emphasis on psychological autonomy, it still largely derived from the constitutive role of law, and one's juridical status before the law. The State was the source of the individual's status. The ontological status of the individual as a person awaited a later development.

This development emerged in Christian theological discourse, indirectly flowing from Christian doctrinal questions regarding the Trinity and the Incarnation. Nonetheless, a background influence was always the Church's biblical inheritance from the Scriptures of Israel—the Old Testament as it came to be termed. The inherited Jewish tradition understood the human as called into being by God, and existing in a relationship with the Creator.[205] Humanity is created in the "image and likeness" of God (Gn 1:26). The Jewish theological perspective differed from the more ontologically-attuned philosophy of the Greeks in two ways. First, each human being is created in the image and likeness of God; and secondly, each human being is related to

---

[204] Mauss, "A Category of the Human Mind: The Notion of Person; the Notion of Self," 18

[205] H. G. Kippenberg, "Name and Person in Ancient Judaism and Christianity," in *Concepts of Person in Religion and Thought*, ed. H. G. Kippenberg, Y. B. Kuiper, and A. F. Sanders, (Berlin: Mouton de Gruyter, 1990), 109-112

others, above all in the covenant-community of Israel.[206] In other words, to be human was to be in relationship, with God, with the community, and the whole of creation.

As Christianity appropriated its Jewish inheritance and sought to articulate its faith within the Greco-Roman world, the development of the idea of person became crucial to its project.[207] While the word, "person", derives from Greek and Roman sources, the concept of a unique subsistent individual in relation to others derives from the Christological and Trinitarian controversies of the Patristic period.[208] As a result, in contrast to the Greek notion of the cosmos, a contemplation of the universe as divine creation and communication, of manifold relationships, began to structure a Christian world-view.[209] Indeed, theologians commonly maintain that the concept of "person" is a specifically Christian idea. Gil Bailie has argued that only in Christianity did the term acquire the rich and profound meaning that we glimpse today, even if the depth of meaning in the Christian theological conception of personhood is still to be fully understood and articulated.[210]

---

[206] Rudman, *The Concept of Person...*

[207] Rudman, *The Concept of Person...*

[208] Pannenberg cited in David Coffey, *Deus Trinitas: The Doctrine of the Triune God* (New York: Oxford University Press, 1999).

[209] Zizioulas, *Being as Communion*.

[210] Gil Bailie, "The Christological Truth About History, the Paschal Truth About Human Culture, the Eucharistic Truth About the Human Person," *Australian EJournal of Theology*, no. 5 (2005).

A widely influential definition of person appears in the writing of the Christian thinker, Boethius (480 CE – 525 CE): *persona est naturae rationalis individua substantia*, "a person is an individual substance with a rational nature."[211] This definition became standard right up to the medieval period.[212] It proved consistent with a range of Christian theological views, even though, strictly speaking, as Aquinas would point out, it was not applicable to the three persons of the Trinity–who were not "individual substances"![213] However, it did carry the Christian conviction that "person" is a real instance of being, ontologically categorisable as objective and independent reality.[214] It was refined for theological usage in several ways during the medieval period.[215]

Yet even prior to Boethius, Christianity was moving toward an ontological understanding of personhood. Colin Gunton draws attention to the distinction made by Irenaeus of Lyons (c. 130 CE – c. 200 CE) between image and likeness as the beginning of the process that led to reason becoming "both

---

[211] Boethius, "Contra Eutychen et Nesotrium" Section III, col. 1343D – 1344A, from *Patrologia Latina* Database, Volume 64.

[212] Hubbeling, "Some Remarks on the Concept of Person in Western Philosophy," 10

[213] For example Cassiodorus, cited in Mauss, "A Category of the Human Mind: The Notion of Person; the Notion of Self," 20

[214] Zizioulas, "On Being a Person: Towards an Ontology of Personhood," 33

[215] Brian M. Nolan, "Person, Divine," in *The New Dictionary of Theology*, ed. J. A. Komonchak, M. Collins, and Dermot A. Lane, (Dublin: Gill and MacMillan, 1987)

a chief ontological characteristic and a criterion of difference between human and non-human".[216] The fundamental aspect of human persons is that by which they are the image of God. This cannot refer to the body since God is incorporeal, and so must reflect the mind or soul.[217] The accent, therefore, tended to be placed on the independent spiritual status of each person, with little emphasis being placed on its communitarian relevance.

At the height of the Medieval period, Aquinas, in replying to the question as to whether "person" should be applied to God, wrote:

> 'Person' means that which is most perfect in the whole of nature, namely what subsists in rational nature. Now since every kind of perfection should be attributed to God, because his nature contains every perfection, it is fitting that the word 'person' should be used of God; nevertheless it is not used in exactly the same sense of God as of creatures, but in a higher sense.[218]

For Aquinas, the divine persons are immaterial and constituted by pure relationships. But human persons are embodied, since the spiritual soul is essentially related to the body.[219] On the other hand, the human person is related to God whose image is realised in the human through spiritual

---

[216] Colin Gunton, "Trinity, Ontology and Anthropology: Towards a Renewal of the Doctrine of the *Imago Dei*," in *Persons, Divine and Human: King's College Essays in Theological Anthropology*, ed. C. Schwobel and Colin Gunton, (Edinburgh: T&T Clark, 1991), 48

[217] Gunton, "Trinity, Ontology and Anthropology: Towards a Renewal of the Doctrine of the *Imago Dei*."

[218] Thomas Aquinas, *Summa Theologiae*, trans. Ceslaus Velecky, 60 vols., vol. Volume 6 (The Trinity 1a. 27 - 32) (London: Eyre & Spottiswoode, 1964).

[219] B. Davies, *The Thought of Thomas Aquinas* (Oxford: Clarendon Press, 1992).

faculties of intellect and will, especially through the gift of grace through which the divine persons dwell in the soul. Thus, the spiritual being participates in the knowing and love proper to God's own life.[220] For the moment, let it be noted that in this Thomist tradition, "person" signifies what is most perfect in the whole of nature, and thus provides the basis for the ontological dignity of the human being in its relationship with God.

Cardinal Cormac Murphy-O'Connor draws on this tradition when commenting on the case of the conjoined twins mentioned above. Each twin is a person due to her individual being, despite being conjoined; hence, no direct action may be taken which violates their dignity, integrity or the life of the one or the other. The Cardinal argued that, while the duty to preserve life was important, it does not entail measures to preserve life at all cost, nor allow the direct killing one of the twins in order to save the other.[221] The Cardinal thus gave expression to a concept of personhood that is the basis of a range of moral precepts rooted in human dignity and the sanctity of life.

---

[220] Thomas Aquinas, *Summa Theologiae*, trans. Fathers of the English Dominican Province, 3 vols., vol. 1 (ST 1 QQ 1 - 119 and ST 2/1 QQ 1 - 114) (New York: Benziger Brothers, Inc., 1947).

[221] Cormac Murphy-O'Connor, *A Submission by Archbishop Cormac Murphy-O'connor, Archbishop of Westminster, to the Court of Appeal in the Case of Central Manchester Healthcare Trust V Mr and Mrs a and Re a Child (by Her Guardian Ad Litem, the Official Solicitor)* (London: Roman Catholic Diocese of Westminster, 2000), Submission to the Court of Appeal

While the ontological value of personhood was a special development in the history of Christian thought, the idea of the personhood took a new turn with the advent of the Renaissance and the Enlightenment. History entered into the period of "modernity", a term connoting the various philosophical, cultural and scientific changes at this time. The Reformation, occurring at an early stage in this modern period, had the effect of fracturing the religious landscape of Europe and strengthening the position and role of nation-states. All this heralded changes in philosophy, theology and the scientific scope of human endeavour, along with a flourishing interest in classical thought, literature, art and architecture. Graham Ward[222] and Stephen Toulmin[223] have given their respective surveys of this period and its beginnings. It is further marked by exploration and colonisation. Major European powers (Spain, Portugal, France, England, Germany, Belgium) engaged in competition to discover new lands, to claim ownership of these territories, and to reap the new sources of wealth available. Linked to the colonising efforts were a variety of views about the personhood of the native peoples. Some nations treated the local inhabitants as equals, while others declared that they had no status as persons, as with the British legal doctrine that declared Australia a *terra nullius.*

---

[222] Graham Ward, "Introduction," in *The Postmodern God*, ed. Graham Ward, Blackwell Readings in Modern Theology, (Malden, Mass.: Blackwell Publishers Inc., 1997), xvii-xxiii

[223] Stephen Toulmin, *Cosmopolis: The Hidden Agenda of Modernity* (Chicago: University of Chicago Press, 1990).

Modernity was particularly characterised by an optimistic brand of humanism, in reaction to what was perceived as the pessimism of the later Middle Ages and the scholastic period.[224] It was believed that humanity could, through the power of reason, discover answers to all problems in a world surveyed from the height of humanity's lofty position.[225] This led at least one philosopher to argue that humanity was "the center of nature, the middle of the universe, the chain of the world."[226] The "Renaissance man" was an ideal of someone with extraordinary capacities, combining the power of human reason and creative scope of freedom. Secular forms of power, authority and legitimacy were linked to the edifice of the nation-state within a trade-based economy. As a result, the traditional social order yielded to new allegiances. Religious world-views had to contend with the rise of a materialist culture, based on individualism, rationalism and a concept of instrumentality that looked to continuous development,[227] and ongoing change.[228] While development and change were part of previous philosophical and social movements, the modern phase was ideologically

---

[224] Simon Blackburn, "Humanism," in *The Oxford Dictionary of Philosophy*, ed. Simon Blackburn, Oxford Reference on-Line, (Oxford: Oxford University Press, 1996)

[225] *Humanism*, [Internet encyclopaedia] (Stanford University, 2001 2001, accessed 29th August 2003); available from http://www.utm.edu/research/iep/h/humanism.htm#Character%20of%20the%20Movement

[226] Marsilio Ficino, *Platonic Theology*, trans. M. J. B. Allen and J. Warden, 2001 - 2002 ed. (Cambridge, Mass.: Harvard University Press, 2001).

[227] Stuart Hall and Bram Gieben, eds., *Formations of Modernity*, ed. Stuart Hall, Understanding Modern Societies: An Introduction (Cambridge: Polity Press, 1992), 6

[228] Zygmunt Bauman, *Postmodernity and Its Discontents* (Cambridge: Polity Press, 1997).

disconnected from what had gone before. Its mode of thinking is encapsulated in the idea of the European West,[229] the representative grand narrative of success, the triumph of reason and the inevitability of progress linked with the growth of capitalism. It presumed a world of endless linear progress in which the unsuccessful and the most vulnerable had no place.[230]

Philosophical development both mirrored and affected this ideology of a new beginning. Particularly important are Rene Descartes (1596 – 1650) and Immanuel Kant (1724 – 1804).[231] Each, however unwittingly, contributed to the understanding of autonomous and individualist personhood that has become problematic in health care ethics today.

Rene Descartes, with his fundamental principle, *Cogito, ergo sum* ("I think, therefore I am"), necessarily implied that personhood resided in rational self-consciousness.[232] His desire for certainty was the foundation of the exaltation of rationality and the model of "person as rational agent." Though he may not have intended a rejection of the metaphysical concept of ontological personhood, his philosophy has become the basis of a radical mind–body

---

[229] Hall and Gieben, eds., *Formations of Modernity*, 277

[230] Bailie, "The Christological Truth…"

[231] Gunton, "Trinity, Ontology and Anthropology: Towards a Renewal of the Doctrine of the *Imago Dei*"

[232] Singer, *Rethinking Life & Death: The Collapse of Our Traditional Ethics*.

dualism.[233]   The immaterial mind displaced the Medieval hylomorphic substantial unity of matter and spirit, by reducing the value of the material component of humanity to something extrinsic.[234] Thinking is the core human activity, and hence the qualifying attribute of personhood.[235] The person, in this perception, is fundamentally an individual: a "thinking thing" (*res cogitans*) certain only that *I am a thinking thing*.[236] Agency as the capacity to make choices and exercise control is the critically important feature: ultimately, I do not *discover* what is real, but *invent* what is real. I cannot be certain of other persons (they could be demonic apparitions), only of myself and, therefore, as disengaged and apart from others. Control is a matter of self-control. Individual choice is not reliant on the decisions of others who, like the material world itself, have only an extrinsic, secondary status.[237] How such a form of thinking affects health care, I will examine in due course. But, first, let me turn to Kant, the other dominant philosophical figure already mentioned.

---

[233] Bernard Williams, *Problems of the Self* (Cambridge: Cambridge University Press, 1973).

[234] Rom Harré, *One Thousand Years of Philosophy* (Oxford: Blackwell Publishers, 2000).

[235] John Macquarrie, *In Search of Humanity: A Theological and Philosophical Approach* (New York: Crossroad, 1983, 1982).

[236] Desmond FitzGerald, J., "Rene Descartes - the Human Person as a Dualism," in *Images of the Human - the Philosophy of the Human Person in a Religious Context*, ed. Hunter Brown et al., (Chicago: Loyola Press, 1995), 172

[237] For further discussion of the influence and effect of Descartes on modern thought see Taylor, *Sources of the Self: The Making of Modern Identity*., Roger Scruton, *Modern Philosophy, a Survey* (London: Sinclair-Stevenson, 1994). For a clear and succinct outline of the implications of Cartesian thought for bioethics see Epperly, "Prayer, Process, and the Future of Medicine."

Immanuel Kant proposes an ethic which is a development of the Cartesian view of person. It is based on the concept of duty rooted in reason. Only rational beings can have reverence for law as an expression of a universal moral imperative.[238] For Kant, persons are ends in themselves.[239] Yet the apprehension of the moral law is the determining factor of true personhood, both for oneself, and in my obligations to others.[240]

The strength of Kant's view is that it provides individual persons with intrinsic moral rights.[241] This is recognised by health care in practice, particularly in countries in which a universal system operates. It is only at the boundaries of life, and when resources are scarce, that questions are raised about the status of some persons. The vast majority of patients are always considered as ends in themselves. Note, however, that the Kantian position is not primarily intent on the rights of others, but on one's obligation to act in such a way as to contribute to the well-being of all persons, oneself and others. Yet, by focusing on rationality and self-consciousness, Kant constricts the community of persons to the autonomous, the independent and the adult.[242] Though he does not deny the moral status of infants, the unborn, the

---

[238] Rudman, *The Concept of Person...*

[239] Hubbeling, "Some Remarks on the Concept of Person in Western Philosophy," 12

[240] Mary Anne Warren, *Moral Status: Obligations to Persons and Other Living Things* (Oxford/ New York: Clarendon Press/ Oxford University Press, 1997).

[241] Warren, *Moral Status: Obligations to Persons and Other Living Things*.

[242] Warren, *Moral Status: Obligations to Persons and Other Living Things*.

disabled or the infirm, he does not provide any explicit basis for accrediting them with person-status. By so emphasising rational self-determination, his views can be exploited to limit personhood to those who exhibit such a form of consciousness. [243]

5. Some Practical Consequences

In both these philosophical approaches, the self is a psychological ego, occupying an inner space in which the essential "I "exists as separate from the external world of others. [244]   The features of this psychological self[245] are strongly individualistic, with an emphasis on the independence and uniqueness of each identity.[246] Personal existence becomes a project, to map and occupy an interior space in which the person can exist, by functioning psychically and rationally. Thus, the ontological criterion (philosophically or theologically considered) of personal being becomes increasingly replaced by the criteria of function.

---

[243] Paola Cavalieri and Peter Singer, "The Great Ape Project," in *Unsanctifying Human Life*, ed. Helga Kuhse, (Oxford: Blackwell Publishers, 2002), 136

[244] Graham Ward, *Theology and Contemporary Critical Theory*, ed. David Jasper, 2nd ed., Studies in Literature and Religion (Basingstoke, Hampshire: MacMillan Press, 2000).

[245] Steven Collins, "Categories, Concepts or Predicaments? Remarks on Mauss's Use of Philosophical Terminology," in *The Category of the Person: Anthropology, Philosophy, History*, ed. Michael Carrithers, Steven Collins, and Steven Lukes, (Cambridge: Cambridge University Press, 1985), 66

[246] J. S. La Fontaine, "Person and Individual: Some Anthropological Reflections," in *The Category of Person: Anthropology, Philosophy and History*, ed. Michael Carrithers, Steven Collins, and Steven Lukes, (Cambridge: Cambridge University Press, 1985), 124

From this point of view, consider Nancy Crick, an autonomous, rational person, who sought to end her life and to involve others in her decision. Her independent choice, not the basis of her choice, was taken to be the determining factor. It is irrelevant to this way of thinking that Nancy Crick was not terminally ill, nor that she was ignoring sound medical advice. We might justifiably presume that neither Kant nor Descartes would have held that Crick was acting rationally. Nonetheless, the way that "reason" might be currently interpreted from a perspective of Cartesian or Kantian individualism would suggest that she was not acting irrationally: the patient in this case had made an "autonomous decision". When the focus is on the rational, autonomous person in the Cartesian or Kantian tradition, the autonomy of rational persons can be so exalted that any request they make must be acted on, as is argued in positions favouring voluntary euthanasia and assisted suicide. However, matters are never so straight forward. On the one hand, a person expressing a desire for self-harm would usually be considered to be exhibiting signs of mental instability or incapacity. On the other hand, if one claims that life is intolerable due to a real or perceived health condition, then this is automatically assumed to be a rational choice. In the former instance, the choice would be considered unreasonable, and it may even be deemed appropriate to restrain the person from acting on their choice/request. In the latter instance, the current pro-euthanasia position argues that the choice should always be acted on. The Crick case has sharply

divided the community on the issue of "the right to die". According to

pollsters, a majority of the community supports voluntary euthanasia.[247]

However, the reaction to the Crick case suggests that proof of the illness being

terminal is required.[248]

The case of Nancy Cruzan is also instructive in this regard. Cruzan was a

young woman in a persistent vegetative state for eight years following a car

accident. She was unable to respond or even to swallow, but did not require

ongoing mechanical respiration. As a result she was provided with nutrition

and hydration via a nasal-gastric tube. Cruzan's parents had attempted to

have their daughter's feeding tube removed. The State of Missouri took the

view that in the absence of evidence of what the patient would have wanted,

the state has an obligation to preserve her life. The "proxy consent" of

parents on behalf of children was deemed not to apply in this case, despite the

general presumption that parents have the best interests of their children at

heart. If Cruzan was genuinely alive, then any act which would result in her

death could not be in her interest; if she were not alive, then she had no

interest to defend.[249] It was determined by the U. S. Supreme Court that

feeding and hydration could only be ceased if there were "clear and

---

[247] Ian Ireland, *Choice, Quality of Life and Self-Control: Summary Arguments in Support of Euthanasia* (Canberra: Parliamentary Library, 1996-1997), 10, Research Note 12

[248] M. Otlowski, "Discussion: The Nancy Crick Case," *Monash Bioethics Review* 21, no. 3 (2002).

[249] John Robertson, "Cruzan: No Rights Violated," *Hastings Center Report* 20, no. 5 (1992).

convincing evidence" that this is what the patient would have wanted.[250] Following the Supreme Court judgement, several members of Cruzan's family and some of her friends recalled her comments suggesting that she would not want to be kept alive in such a situation. Singer, commenting on this case, argues that the choice of Cruzan's parents should have been sufficient to cease feeding her.[251] While not supporting this line of argument, the case does reinforce the Kantian position on rational autonomy, but limits it to the actual person concerned and does not extend it to proxy consent.

All of the above serves to indicate that philosophy has practical consequences; and in this case, the narrowness of its conceptions of personal existence is not the resource needed in moral dilemmas that have arisen. Similarly, while neither philosophical tradition advocates abortion,[252] their respective emphasis on autonomous rationality, irrespective of a larger social setting, can be used to justify terminations based on a the right of the mother to choose the fate of what is regarded as her personal property or, at least, as her exclusive sphere of responsibility. Clearly, radical philosophical and existential options are involved. The confused philosophical inheritance that implicitly or explicitly affects health care and its morality is in need of further critique and clarification.

---

[250] Gregory E. Pence, *Classic Cases in Medical Ethics* (New York: McGraw-Hill, Inc., 1995).

[251] Singer, *Rethinking Life & Death: The Collapse of Our Traditional Ethics*.

[252] Hursthouse, *Beginning Lives*.

6. Conclusion

Moral decisions rely on assumptions concerning ways of reasoning applicable to any case in question. More fundamentally, the nature of the human person becomes an urgent question. Anthropological assumptions determine decisions and outcomes. If it is assumed that patients are persons definable as rational agents, then it must be allowed that they are capable of understanding the information given,[253] that they are free to give consent to any procedure which they believe to be in their best interests, and that the decision is theirs alone. But on this presumption, a consideration of the relational aspect of the person concerned is not apparent. Indeed, in Australia, the National Health and Medical Research Council policy states that family members should not be used as interpreters.[254] While this is no doubt aimed at precluding the possibility of wrong information being given and conflicts of interest arising, the implication is that the personal relationships of patients have no direct bearing on the decisions made. I have already cited Carl Elliot's reflections on the damage this assumption can cause, when he cites the case of his grandfather, dying separated from those

---

[253] National Health and Medical Research Council Health Care Committee, *Guidelines for Medical Practitioners on Providing Information to Patients* (Canberra: National Health and Medical Research Council, 1993)

[254] Health Care Committee, *Guidelines for Medical Practitioners on Providing Information to Patients*

he cared about and who cared for him.[255] The situation of the conjoined twins, Rosie and Gracie, is similar. Little consideration was shown by the medical professionals involved of the relational implications of their choices. While some of the judges in the case alluded to the complex relationships involved, these were ultimately discounted.[256] A very individual and rationalistic view of the human person was presumed. If, however, greater attention is paid to more relational types of philosophy, while calling on explicitly theological positions, it is possible to enrich the theory and practice of health care with a new vision as to what constitutes a human person, which, in turn, will enrich the context in which moral decisions are made. The next chapter lays the foundation for the task of developing a relational theology of personhood by exploring the contributions of John Macmurray, Emmanuel Levinas and Alistair McFadyen. These thinkers provide the more relational philosophies which inform this practical theology of health care.

---

[255] Elliott, *A Philosophical Disease*.

[256] "In Re a (Children)," in *Ward, LJ. Brooke, LJ. Walker, LJ.* (Supreme Court of Judicature Court of Appeal (Civil Division) on Appeal from Family Division, 2000)

CHAPTER FOUR: PERSON AS RELATIONAL SUBJECT:

PHILOSOPHICAL AND THEOLOGICAL BASES

In this chapter, I elaborate the relational character of the human person as integral to the vision and values of health care. I proceed then to consider what must certainly be of paradigmatic significance for any health care system, the relational reality of the persons involved, either as agents or patients within it. To this end, I have selected three thinkers who have notably contributed to a more relational understanding of the human person. In so doing, this thesis is an exercise in practical theology as it presents and applies aspects of philosophical and theological theory to the concrete circumstance of health care. The philosophic emphasis follows a well-established tradition in Catholic theology. For example, von Balthasar, who devotes two of the seven volumes of *The Glory of the Lord*[257] to metaphysics, explains,

> For although theology thinks and develops on the basis of its own presuppositions, it makes use of the human-philosophical forms of consideration and results of investigation at every step on this path… The entire fullness—the gold, frankincense, and myrrh of human thought–is not too much to be presented to the Word of God which has become nature. [258]

---

[257] H. U. von Balthasar, *The Glory of the Lord: A Theological Aesthetics*, ed. J. and Riches Fessio sj, J., trans. various translators, 7 volumes vols. (San Francisco: Ignatius Press, 1982 - 1991).

[258] H. U. von Balthasar, "On the Tasks of Catholic Philosophy in Our Time," *Communio* 20 (1993).

Indeed, he concludes the fifth volume of his great work with a chapter, "The Christian Contribution to Metaphysics," in which he argues that the Christian is called to be the guardian of metaphysics, responsible for the development of a comprehensive and contemporary metaphysics for our time.[259] That is evidently an ambitious undertaking, but in this present instance, my aim is more modest: in the context of health care, to elaborate and apply the meaning of personhood in its fullest relational expression.

After an introductory remark on the all-pervasive relational character of reality, I will present the relational understanding of the human person as it is elaborated in the writings of John Macmurray, Emmanuel Levinas and Alistair McFadyen in turn. In the next chapter I present an explicitly theological grounding of this approach, and then proceed to the practical implications of such philosophical and theological positions for the cases already mentioned, and a number of others as well. Hence, the chapter will be presented under the following five headings:

1. A Relational World

2. Macmurray: Persons in Relation

3. Levinas: The Person as Other

---

[259] von Balthasar, *The Glory of the Lord.*

4. McFadyen: Person in Process

5. Conclusion: Philosophical Convergences

1. A Relational World

"Relationality" has become an all-pervasive feature in the contemporary sense of reality. For example, in the domain of sub-atomic physics, it is necessary to allow, not only for the fundamental constitution of matter in terms of the micro-entity as particles, but also as waves. This suggests an analogy for considering the human person, not only as an individual substance, but as the intersection of relationships. Similarly, ecological science, and the concerns it inspires, stresses the interactive habitat or ecosphere in which each living being exists. That too suggests, in an extension of meaning, the "ecology" and whole living milieu into which each human being is born, lives, acts and dies. At its most basic level the nature of the universe is an unfolding series of connections and relationships.[260]

More philosophically speaking, the reality of each being, above all, the human person, is conceived of, less as a self-contained, independent entity as is the case in classical metaphysics, and more in interaction with the totality of the community of which it is a part. W. Norris Clarke develops the classic

---

[260] Diarmid O'Murchu, *Quantum Theology* (New York: The Crossroad Publishing Company, 1997).

Thomistic approach along these lines. In his *The One and the Many: A Contemporary Thomistic Metaphysics,*[261] he suggests adding the category of "system" to the traditional list of Aristotelian categories of being (substance, plus the nine accidents of quantity, quality, action, passion, relation, time, place, posture and vesture). The category of system is a new form of unity that resides in all members of the given group at once, as in families, teams, churches, social groups, ecologies, and, by extension, a hospital or a whole health care system.[262] Thus, a system is "set of relations forming a new unified order or "togetherness", being together."[263] It is a primordial dimension of reality. The same philosopher highlights the relational character of personhood in his *Person and Being*: "relationality is a primordial dimension of every real being, inseparable from its substantiality…."[264] This is eminently verified in the kind of being that we name as "personal". As the interlocutors chosen for this chapter all indicate, personal beings are intrinsically relational. As Macmurray puts it, "the personal cannot be thought of as the form of an individual self, but only through the mutuality of personal relationship."[265] That is, the person cannot be identified or known except in the context of relationships. In this way "personal" can be seen to be interpersonal and

---

[261] W. Norris Clarke, *The One and the Many: A Contemporary Thomistic Metaphysics* (Notre Dame, Indiana: University of Notre Dame Press, 2001).

[262] Clarke, *The One and the Many*.

[263] Clarke, *The One and the Many*.

[264] Clarke, *Person and Being*.

[265] John Macmurray, *The Self as Agent* (London: Faber and Faber, 1957).

dynamic by nature—interpersonal because attention must always be paid to the relational nexus within which the individual exists; dynamic, because interpersonal relationships evolve through the communications which take place between persons.

But not only does science and philosophy point us in this direction. History has played its part in provoking a deeper reflection on the meaning of human personhood. The tragedies of the 20th Century raised the question of the value of the human person under threat from violent, totalitarian ideologies. In reaction to the philosophical abstractness of past thinking on human nature, the concreteness and irreplaceable uniqueness of each human person, and the irreducible value of the "I", have come into clearer focus. However, this too would vanish into abstraction unless it gave critical attention to the structures—or as Clarke would term them, the "systems"—that shape human life, be they social, economic, political, cultural. This transpersonal reality, the systemic "It" can either enrich human development or violently compromise it. The system in which people exist, though it is objectified as an "It", is always implicitly inviting an expression of our common humanity as a socially and culturally formed "We". But this more relational and inclusive sense of personal existence leads to a range of questions which pierce to the level of conscience: With whom are *you* in solidarity? Who do you stand with? Who do you speak for? Here the various versions of the option for the

poor, of solidarity with victims, of history seen "from the underside" have

been articulated. In the context of ecology and cosmology, this "We" is being

invited into an awareness of its embodiment in the interconnected, multiform

life of the planet itself. The human person is newly perceived as an

"earthling" in the great temporal and spatial genesis of the cosmos itself. The

growing appreciation of such an "It", the planetary web of life and the cosmic

process that has given birth to it, inspires a fresh expansion of the "We", the

person, within a community, within a world of relationships. Here, the words

of Einstein are resonant:

> A human being is part of the whole, called by us the "universe", a part
> limited in time and space. He experiences himself, his thoughts and
> feelings, as something separated from the rest – a kind of optical
> delusion of his consciousness. This delusion is a kind of prison for us,
> restricting us to our personal desires and to affection for a few persons
> nearest to us. Our task must be to free ourselves from this prison by
> widening our circle of compassion to embrace all living creatures and
> the whole of nature in its beauty.[266]

Einstein's expression of "our task" is eminently relevant to my concern to

express a notion of personhood that can be of paradigmatic significance in

health care. Ever increasing "know-how" is continually in need of a larger

wisdom, born of renewed humility before the vastness and complexity of

reality, in all its relationships and connections. A holistic sense of the person,

to say nothing of a holographic sense of the universe, is repelled by what is

---

[266] Albert Einstein, quoted in M Nagler, *America without Violence* (Covelo, Ca.: Island Press, 1982).

often criticized as medical science's mono-dimensional, fragmented, mechanistic, instrumental relationship to the patients it seeks to cure. [267]

The term, "paradigm" has come to carry a rich variety of associated meanings, values and even intuitions. To speak generally, it is connotes the fundamental symbolic sense of reality which structures the methods and priorities of action. The need for a *new* paradigm occurs when the former one no longer works. The map has become too inaccurate, or incomplete or roundabout. So it is necessary to begin to look for a new point of entry into the unknown, one more open to the varied possibilities of the journey, and more sensitive to the terrain to be covered.

The observations made so far in this thesis suggest that something resembling a new paradigm in systems of health care has become necessary. For example, taken-for-granted conceptions of autonomy, independence, individuality, scientific objectivity and authority, do not always serve the patient well. The professional and personal witness of numerous health care practitioners continues to be dedicated, caring and proficient. But the new world of medicine, taking shape in the egalitarian culture of Western democracy—and therefore increasingly beholden to governments—is a

---

[267] See, for example Joseph Fletcher, "Technological Devices in Medical Care," in *On Moral Medicine: Theological Perspectives in Medicine*, ed. S. E. Lammers and A. Verhey, (Grand Rapids, Mi: W. B. Eerdmans Publishing Company, 1998)

radically new culture in which health care must operate. All agree that people should be treated in a medically competent and professional manner in accord with the best practice of the day, if and when the resources are available. Despite the economic and social problems, the organisation of resources to that end achieves considerable success, at least in major urban areas. But is there not another resource, more difficult to summon up or to renew? It takes us beyond a professionally competent relationship to see in this patient, this suffering other, a human being of absolute worth. When a person-centered care is at work, health practice deals not only with illness, not only with bodies, not only with individuals, but with a relational person, with all the social and spiritual dimensions that this entails.

This brief reference to various relational perspectives in our current worldview sets the stage for an examination of the three thinkers who are especially relevant to our thesis.

2. Macmurray: Persons in Relation

John Macmurray (1891 – 1976) was a Scottish philosopher who held academic positions at Manchester University, Witwatersand University (Johannesburg), Balliol College (Oxford), University College, London and Edinburgh University. He stands out among British philosophers of his generation due

to his refusal to accept the dominant empiricist framework once he determined that it was an essentially mechanical thought-form. In contrast he developed throughout his life a philosophical system which he termed "organic" and which found expression in a deeply personalistic philosophy.[268]

Macmurray, in opposition to the mechanistic orientation of the empirical philosophy of his day, made three particular contributions which distinguish him from the mainstream of British philosophical thought. Firstly, the systemic or organic nature of his thought made connections with the sciences, the arts, social and political theory and religion. This contrasted with the narrow focus of the linguistic analysis of the then dominant school of British Empiricism. Secondly, he saw human existence as constituted by personal relationships. For him, the self exists only in the context of relationship with others, so that philosophy must have practical rather than a theoretical orientation where this latter is concerned more with the epistemologically objective and independent status of the human individual. Thirdly, he recognised the influence of religion, particularly Christianity, on his philosophy. Macmurray argued that concepts and practices associated with dignity and personal values were inextricably linked to religious influence

---

[268] Jack Costello sj, "The Life and Thought of John Macmurray," in *John Macmurray: Critical Perspectives*, ed. D Fergusson and N. Dower, (New York: Peter Lang, 2002)

and religious practice.[269]   Here, his approach is clearly in contrast to the
secular rationalist views developed in most twentieth century philosophy.

Despite this religious depth to this thinking, Macmurray, at least during his
academic life, did not engage in formal Christian worship; nor was he a
practising member of any Christian denomination. In the course of his career,
he moved from being a devout evangelical preacher, training to conduct a
Christian mission in China, to being robust critic of much of formal Christian
piety; and, as a result, developed his own philosophical approach. While a
student at Glasgow University, he began by applying the scientific method to
the interpretation of the Bible and formulations of Christian doctrine. As a
consequence, he abandoned formal membership in a Christian church for
over fifty years. Though he did not deny his Christian faith, he subjected the
traditional interpretations and doctrinal formulations of Christianity to critical
scrutiny.

An entry in his diary in 1912 captures both the intensity of his faith and his
need to develop his particular religiously philosophical perspective:

> Ah, Lord God, pity my feeble faith in thy Almightiness; the groping of
> my blind hands in the blaze of Thy Light of light. Give me eyes that I
> may see Thee; a heart that I may know Thee, a will that I may follow
> Thee. I am sore stricken, unless thou succour me… the God who
> created needs, hungers, cries, in the human heart must needs fill them.

---

[269] Macmurray, *The Self as Agent*.

> To fear that faith cannot be found would be a denial of God… So thus far I know and believe. The noblest lives are linked with the highest beliefs. Faith is the social glue. When we cease to believe, we cease to live—either to man or God. Unbelief is spiritual death and intellectual death. It abolishes Love and enthrones suspicion—paralyses governments, religions, friendships, all societies of men. "We must believe or die." Thus faith is possible or life is impossible. It is my duty to find the faith which satisfies the need.[270]

This quotation signals his "dark night", but also his conviction that the centrality of faith fixed on Jesus was more important than any formulation or practice of that faith. His break with institutional expression of Christianity came during leave from war service in 1917 when he gave a sermon to a London congregation centring on the need for charity and reconciliation toward the Germans. He interpreted the antipathy of the congregation following this sermon, not as a rejection of him personally, but of the Gospel itself.[271]

His account of the personal is of central importance for this thesis. This personalistic theme became the organising principle for his life's work and for his understanding of the world. He wrote to a friend in 1925 that "if the world is to be comprehended, it must be in terms of personality."[272] This early assertion received a full exposition in the Gifford Lectures of 1953 and

---

[270] Macmurray quoted in Costello sj, "The Life and Thought…" 5

[271] Costello sj, "The Life and Thought…" 9

[272] Costello sj, "The Life and Thought…" 14

1954 under the title of "The Form of the Personal", published in two volumes under the titles *The Self as Agent* and *Persons in Relation*.[273]

John Macmurray, though not generally considered as a "postmodern" thinker, makes a distinctive contribution to the philosophical understanding of the human person—in critical opposition to the influential thinkers of modernity.[274] His two principal objections focus on the egocentric and the theoretical character of modern philosophy, as inherently idealist, dualist and passive:

> Modern philosophy is characteristically *egocentric.* I mean no more than this: that firstly, it takes the Self as its starting-point, and not God, or the world or the community; and that, secondly, the Self is an individual in isolation, an ego or "I", never a "thou". This is shown by the fact that there can arise the question, "How does the Self know that other selves exist?" Further, the Self so premised is a thinker in search of knowledge. It is conceived as the Subject; the correlate in experience of the object presented for cognition.[275]

In place of egocentricism Macmurray proposes an understanding of the Self as an agent in relationship with other Selves. His stance is decidedly practical; philosophy must shift its thinking focus from the theoretical to the practical.[276] This shift of emphasis is shared by post-modern thinkers who

---

[273] Macmurray, *The Self as Agent.* and John Macmurray, *Persons in Relation* (Atlantic Highlands, N.J.: Humanities Press, 1991).

[274] Ward, *Theology and Contemporary Critical Theory*.

[275] Macmurray, *The Self as Agent*.

[276] Macmurray, *The Self as Agent*.

give primacy to a more relational understanding of the self, while stressing

the priority of action over theory.[277]

Macmurray conceives of persons as agents. The agency in question is

constituted through relations with other persons, whether this interaction is

positive or negative.[278] The great advantage in his approach is that it allows

for the recognition of the personhood of those who are pre-rational or unable

to be fully rational. In the following words, he takes us to the heart of his

approach, in reference to the infant:

> In the human infant… the impulse to communicate is his sole
> adaptation to the world in which he is born. Implicit and unconscious
> it may be, yet it is sufficient to constitute the mother-child relation as
> the basic form of human existence, as a personal mutuality, as a "You
> and I" with a common life. For this reason the infant is born a person
> and not an animal. All his subsequent experience, all the habits he
> forms and the skills he acquires fall within this framework, and are
> fitted to it. Thus human experience is, in principle, shared experience;
> human life, even in its most individual elements, is a common life; and
> human behaviour carries always, in its inherent structure, a reference
> to the personal Other. All this may be summed up by saying that the
> unit of personal existence is not the individual, but two persons in
> personal relation; and that we are persons not by individual right, but
> in virtue of our relation to one another. The personal is constituted by
> personal relatedness. The unit of the personal is not the "I" but the
> "You and I".[279]

---

[277] For a brief but excellent summary of the main tenets of postmodernity see David Batstone
and others, eds., *Liberation Theologies, Postmodernity, and the Americas* (London: Routledge,
1997), 9

[278] J. Aves, "Persons in Relation: John Macmurray," in *Persons, Divine and Human*, ed. C
Schwöbel and Colin Gunton, (Edinburgh: T & T Clark, 1991), 123

[279] Macmurray, *Persons in Relation.*

Macmurray contests what he claims is a widespread assumption that human beings are all born as animals—essentially instinctual, non-rational beings— that, over time develop into rational persons.[280] He argues that humans, unlike other animals, are not born already able to interact with and adapt to their environment. Instead, humans are born with the basic skills and orientation necessary for communication with other humans. In order for the human baby to develop further skills for survival, communication with an older/adult human is essential—a position verified in recent paediatric and psychological research.[281] For Macmurray, interpersonal communication is constitutive of human persons. Through communication with a significant other, the child acquires the basic skills for engagement with other persons and the skills for increasing communication.[282]

In the earlier published part of the Gifford Lectures, *The Self as Agent*, he discusses how human beings learn to perceive other persons. The other is experienced, not through observation, but through physical engagement, especially touch. In the experience of resistance to one's movement, touch and will, the existence of the Other is disclosed. In thus becoming aware of

---

[280] Macmurray, *Persons in Relation*.

[281] For example in paedatrics see T. Berry Brazelton, "Saving the Bathwater," *Child Development* 61, no. 6 (1990). In infant psychology see Colwyn Trevarthen and Kenneth J. Aitken, "Infant Intersubjectivity: Research, Theory, and Clinical Applications," *Journal of Child Psychology and Psychiatry* 42, no. 1 (2001).

[282] Macmurray, *Persons in Relation*.

the Other, self-awareness occurs.[283]   Participation in relationships and receiving communication from another demand the tangible presence of the other.   Interpersonal relationships are not possible if one party is merely an observer.   Macmurray suggests that the breakdown in social values and cohesion derives, at least in part, from Descartes' *Cogito*.   To counter this stance of the impartial observer seeking knowledge, Macmurray proposes the relationally engaged person.   The archetypal relation is that of "mother and child".   It expresses the essential form of all other relationships.   It includes mutual need, the enablement of a capacity for future relationships and a physical basis.[284]

The relation between parent and child in Macmurray's thought points to the essential nature of communication.   It requires the capacity to seek and respond to the other—even if this is not intentional.   Such communication can only occur within the structure of a relationship even if only one party is able to supply the meaning and intention in the communication.   Macmurray argues that this is evident in a baby's cry of distress for no reason of physical need.   The baby does not know or understand its communication—its "mother" does and in responding in a personal way the parent calls forth the personhood of the child.   But this personhood is not merely potential, for it is

---

[283] Macmurray, *The Self as Agent*.
[284] Macmurray, *Persons in Relation*.

actual personhood even if in nascent form. Macmurray's basic point is that the mutuality of interpersonal relationships is the dynamic constitutive of personhood. No person can come into existence except through the relationship of others. The initial relationship between mother and child will develop into more explicit and wider relationships, each of which constitutes a new register of personal existence.

Macmurray's insight into infant inter-subjectivity and communicative orientation is now being validated in pediatric and neonatal psychology, psychiatry and medicine.[285] His understanding of persons as a community of beings-in-relation provides an important challenge to the way society constructs the meaning of disability;[286] clearly this will have wider applications in the health care domain. As soon as persons are recognised as being relationally constituted, it follows that each person is responsible for the constitution of the personhood of all in a given field of inter-relational exchange. Disability is an issue of community concern which must be addressed, not a personal tragedy which others can choose either to care about or ignore. The way in which society deals with disability demands a

---

[285] Colwyn Trevarthen, "Proof of Sympathy: Scientific Evidence on the Personality of the Infant and Macmurray's 'Mother and Child'." in *John Macmurray: Critical Perspectives*, ed. D. Fergusson and N. Dower, (New York: Peter Lang, 2002), 80-83

[286] Swinton, "Constructing Persons..." 239-247

more positively involved and holistic approach, rather more than that of labelling the other as a pathology.

There are, nonetheless, ambiguities; for, in the Mother-child relationship, the child can be affirmed through the gift of love, and be affected by the possibility of losing it.[287] This negative possibility is realised when the child experiences fear and the lack of love, with the result that a distortion enters into the interpersonal field of communication. But since such a relationship is abusive, it should not be considered as the norm, even if the power of relationships to thwart, hinder and damage the persons involved should not be ignored. Nothing in Macmurray's approach need minimise the problems here; nonetheless, he is presenting interpersonal communication in a more positive light.

Macmurray is attempting to present an archetype of relations in his concentration on mother and child. His emphasis, therefore, is on nurture to an ideal degree. But it would distort his approach to interpersonal relationships to leave it there. Admittedly, in the interaction between mother and child, there is a recognisable asymmetery. The mother is in a position of obvious power over the dependent child, as would be the case for an unborn foetus. However, as Macmurray has pointed out, the sacrifices she makes for

---

[287] Aves, "Persons in Relation: John Macmurray," 125

her child give a certain power to the apparently vulnerable one in the relation. It is also the case that the mother too is in a situation of vulnerability.[288] Her health condition following birth and her new role as mother of this child, place her in a situation in which all things are new and all responses have to be re-learned. That is, she is called by the infant into a new relationship and, in a sense, a new depth to her personhood.

This is not to suggest that such relationships are purely instrumental or functional, and evaluated only for pragmatic value for one side or the other. The terms, mother and child, can be reduced to a purely functional significance, and so leave out a consideration of the persons involved. Nonetheless, the relationship concerned must be taken in its profound existential significance, for it constitutes the persons concerned in a defining interaction: it alters the shape of both their lives. The mother-child relationship serves, in Macmurray's philosophy, as the paradigm for all personal relations. He observes that, this interpersonal relationship "has no purpose beyond itself; in which we associate because it is natural to human beings to share their experience, to understand one another… in expressing and revealing themselves to one another."[289]

---

[288] Macmurray, *Persons in Relation.*

[289] John Macmurray, *Reason and Emotion* (London: Faber, 1962).

It must be conceded that most relations are instrumental in some sense, as they shape social cooperation to a particular purpose—ideally, the common good of all. For example the relationship between shopkeeper and customer, or between doctor and patient, relies on a certain amount of trust if the requisite goods and services are to be supplied. While such relations are necessary for communal living, they are not constitutive of personhood in Macmurray's sense. For him, there must be a deeper form of communicative relationship. It is not based on the exchange of particular goods, but on a reciprocity of communication in which the "selves" involved in are co-constituted.[290] He summarises his position in the following way:

> I am not alone in the world; there are other agents, and if they will not allow me to do what I desire to do I cannot do it. Moreover, there are few things which I can desire to do, and none of personal significance, which do not depend on the active co-operation of others. We need one another to be ourselves. This complete and unlimited dependence of each of us upon the others is the central and crucial fact of personal existence. Individual independence is an illusion; and the independent individual, the isolated self, is a nonentity. In ourselves we are nothing; and when we turn our eyes inward in search of ourselves we find a vacuum. Being nothing in ourselves, we have no value in ourselves, and are of no importance whatever, wholly without meaning or significance. It is only in relation to others that we exist as persons; we are invested with significance by others who have need of us; borrow our reality from those who care for us. We live and move and have our being not in ourselves but in one another; and what rights or powers or freedom we possess are ours by the grace and favour of our fellows. Here is the basic fact of our human condition; which all of us know if we stop pretending, and do know in moments when the veil of self-deception is stripped from us and we are forced to look upon our own nakedness.[291]

---

[290] Macmurray, *Persons in Relation*. McFadyen, *The Call to Personhood...*

[291] Macmurray, *Persons in Relation*.

Macmurray did not draw explicit connections between his philosophy and health care. Still, a number of applications come to mind. Firstly, establishing that relationality is constitutive of personhood changes the focus of contemporary medicine from the treatment of particular pathologies to care directed toward the flourishing of persons. Secondly, as a human activity, health care needs to be re-animated with an interpersonal and nurturing approach. Thirdly, his philosophy calls for greater attention to those at the margins, the vulnerable who are unable to assert their rights or themselves. In a community of persons-in-relation, there is an obligation on those in positions of [relative] power to care for those who are more vulnerable. These insights have considerable resonance with the approach of Emmanuel Levinas to whom I now turn.

2. Levinas: The Person as Other

Emmanuel Levinas (1906 – 1995) was born in Lithuania and became a French citizen in 1930. His Jewish background influenced both his philosophy and his academic commentaries on the Talmud. Having spent most of World War II in a concentration camp, he was deeply affected by his first-hand experience of the Holocaust. After his early work centred on phenomenology, he developed his original ethics-oriented philosophy. Levinas, like

Macmurray, rejects traditional metaphysics and epistemology to focus on one-to-one human relationships as archetypal for all relations—the face-to-face encounters between persons. Commenting on the face of the Other, he writes,

> The first thing which is evident in the face of the other is this rectitude of exposure and defencelessness. In his face, the human being is most naked, destitution itself. And at the same time, he faces. It is a manner in which he is completely alone in his facing us that we measure the violence perpetrated in death. Third moment of the epiphany of the face: it makes a demand on me. The face looks at me and calls me. It lays claim to me.[292]

In the face, the Other is stripped bare before me in a vulnerability that cannot be hidden. It calls forth immediately an ethical response, as "the face looks at me and calls me". Ultimately, this claim is, "do not kill me".[293] An essential asymmetry is involved in this kind of relationship. There is a kind of primordial fear present as the self faces the possibility of being negated by the Other. But this apprehension in the presence of the Other must not turn back on itself, for it becomes the basis for responsibility to and for the Other.

As with Macmurray's philosophy, the self is known and knowable only in relationship with the Other. For Levinas, however, this Other is far more "other" than is the case in Macmurray's philosophy which places greater

---

[292] Emmanuel Levinas, *Is It Righteous to Be? Interviews with Emmanuel Levinas*, ed. Jill Robbins (Stanford, California: Stanford University Press, 2001).

[293] Silvia Benso, "Of Things Face-to-Face with Levinas Face-to-Face with Heidegger: Prolegomena to a Metaphysical Ethics of Things," *Philosophy Today* 40, no. 1 (1996).

emphasis on the symmetry of one self related to another. Instead of focusing on the nurturing quality of relationships, Levinas presents the encounter with the Other with a self-transcending emphasis. This relationship is, therefore, asymmetrical and experientially disruptive, calling to responsibility. The objective Other always has priority over the subjective self.[294] It is not a matter of an untroubled affective exchange between an I and a Thou in a common field of experience, but more a question of coming up against a disruptive difference—between the suffering Other and the ego-self it confronts.[295] For Levinas, the Other is met in its vulnerability—biblically describable as "the stranger, the widow, the orphan to whom I am obliged".[296] Given his experience of the Holocaust, Levinas cannot possibly presume that nurture is the fundamental determinant of person to person relationships, as though one is drawn out of oneself and into relationship through the symmetries of love—as Macmurray suggests. The relationship that Levinas portrays implies a radical challenge to personal identity.[297] The authentic personal self can be constituted only when confronted with the suffering Other facing "me" with a summons to moral responsibility, as if to ask the question, "Where are you?" The ego is challenged to become a responsible

---

[294] Glen Morrison makes the point that the designation Other refers to the personal other, as distinct from a general other. It corresponds to the translation of the French term Autrui as distinct from autre. See Morrison, "Emmanuel Levinas and Christian..."

[295] Casey, "Levinas and Buber: Transcendence and Society."

[296] Emmanuel Levinas, *Totality and Infinity: An Essay on Exteriority*, trans. Alphonso Lingus (Pittsburgh: Duquesne University Press, 1981).

[297] Ward, *Theology and Contemporary Critical Theory*.

self when faced by the Other who pleads, in effect, not be abandoned or killed.[298]   This responsibility to, and for, the Other reached to the most extreme point:

> … in responsibility for the Other, one is, in the final analysis, responsible for the death of the other. Is not the rectitude of the other's look an exposure par excellence, an exposure unto death?. . . This is probably the foundation of sociality. . . the fear for the death of the other is certainly at the basis of the responsibility for him.[299]

Relational encounters between persons contain the risk of rejection, and even the possibility of ultimate rejection, where the Other is dismissed or even killed. The Holocaust remains an archetypal experience of people forced into a "condition inferior to that of things, an experience of total passivity".[300] The victims of the *Shoah* show the face of the suffering Other—calling for an ethical resistance to the organised murder that took place. The previously indifferent ego is offered the possibility of expiating the evil that the Other has suffered.[301] Only by embracing this responsibility for the suffering Other can the self begin to bear the image of the God responsible for the universe. At this point, Levinas' thought resonates with a Christian understanding of

---

[298] Levinas, "The Face of a Stranger."

[299] Emmanuel Levinas, *Ethics and Infinity, Conversations with Philippe Nemo*, trans. Richard A. Cohen (Pittsburgh: Duquesne University Press, 1999).

[300] Emmanuel Levinas, *Difficult Freedom: Essays on Judaism*, trans. Séan Hand (Baltimore: The Johns Hopkins Press, 1997). Cited in, Morrison, "Emmanuel Levinas and Christian..."

[301] Morrison, "Emmanuel Levinas and Christian..."

the role of Jesus taking on himself the sins of the world and giving himself for its salvation.[302]

The Other is never, therefore, a projection of the self. For the Other confronts the self with a disruptive and pleading alterity that eludes all previous horizons and projections.[303] In the presence of the Other, the self is not reinforced in its selfish indifference, nor is the Other possessed or bounded by the ego's subjectivity. It calls forth a self-denial that is the genuine mark of an ethical response which is without limit, "to give to the other taking the bread out of my own mouth, and making a gift of my own skin".[304]

As already mentioned, Levinas' ethic resonates with the New Testament as in Parable of the Last Judgement (Mt 25: 31 – 46) and the Good Samaritan (Lk 10: 27 – 37). For example, the encounter with a neighbour or stranger in need calls forth a response. The moral imperative arises from the specific need of the Other.[305] In the Parable of the Good Samaritan, the needs of the one who is injured determines how the Samaritan responds. In the Parable of the Last

---

[302] Emmanuel Levinas, *Entre Nous, Thinking-of-the-Other*, trans. M. B. Smith and B. Harshav (New York: Columbia University Press, 1998).

[303] Levinas, *Totality and Infinity...*

[304] Emmanuel Levinas, "Ethics as First Philosophy," in *The Levinas Reader*, ed. Séan Hand, (Oxford: Blackwell Publishers, 1989), 138

[305] Jeremy Waldron, "Who Is My Neighbor?: Humanity and Proximity," *The Monist* 86, no. 3 (2003).

Judgement, the needs of the Other are spelled out: food, clothing, shelter, tangible care. When "faced" by the Other, the self is "dislocated".[306]

In the context of heath care practice, it easily happens that the patient becomes faceless, and simply categorised as a case. But Levinas would have us appreciate the patient as irreducibly Other, whose vulnerability calls forth a far more personal and relational response.[307] He argues in *Totality and Infinity* that all sense of meaning emerges in our relational encounters with the other. Seeing the face of the other stripped bare, as it were, leads to recognition that existence can be understood only in relational terms, as the Other summons the true self into being:

> To begin with the face as a source from which all meaning appears, the face in its absolute nudity, in its destitution as a head that does not find a place to lay itself, is to affirm that being is enacted in the relation between men…[308]

Levinas' approach to the self in relation to the Other cannot but suggest theological and ethical perspectives. For him ethics is a "first philosophy", and a "first theology."[309] Ethics is primary, and prior to any mode of

---

[306] Myra Bookman and Mitchell Aboulafia, "Ethics of Care Revisited: Gilligan and Levinas," *Philosophy Today* 44 (2000).

[307] Rahel Naef, "Bearing Witness: A Moral Way of Engaging in the Nurse-Person Relationship," *Nursing Philosophy* 7 (2006). Naef uses Levinas' ethic as the basis for her claim that bearing witness is "an ethical way of practising nursing...", 147.

[308] Levinas, *Totality and Infinity…*

[309] M. Purcell, "'Levinas and Theology'? The Scope and Limits of Doing Theology with Levinas," *Heythrop Journal* 44, no. 4 (2003).

ontological or epistemological thinking: what comes first is the Other in need, not a philosophical exploration of reality or of the necessary conditions for knowing it. Relationality, in this sense, is the first and most basic consideration.[310] Levinas criticises theology for its tendency, as with philosophy, to place the emphasis on theory rather than praxis. He suggests that attempts to define God end in limiting both God and the focal importance of neighbour. Purcell notes Levinas' mistrust of theology, for it

> tends to value *theoria* over *praxis* … attempts to circumscribe God, and thus offends and does violence to God's absolute transcendence… in its attention to itself and the God whose mystery it endeavours to probe, it has—unlike the God whom it seeks to understand—been inattentive to the neighbour to whom God always inclines an ear.[311]

On the other hand, Levinas never formally excludes religion and theology from his philosophy.[312] In fact, as Glenn Morrison cogently argues, Levinas' focus on the priority of the neighbour and the paschal significance of suffering for the Other leads to a philosophy of Christian praxis.[313] The priority of the Other—as neighbour, stranger or even enemy—in the Christian moral life remains a definite point of convergence between the philosophy of

---

[310] Clifton-Soderstrom, "Levinas and the Patient..."

[311] Purcell, "Levinas and Theology..."

[312] Richard A. Cohen, *Ethics, Exegesis and Philosophy: Interpretation after Levinas* (Cambridge: Cambridge University Press, 2001).

[313] Morrison, "Emmanuel Levinas and Christian..."

Levinas and Christian theology.[314]   A renewed ethical perspective can redeem

theology in Levinas' estimation.[315]

Yet when the basis of a universal view of humanity and personhood is located

in a metaphysical consideration of, say, form, substance or existence, it can

diminish the dramatic, urgent appearance of *this* Other in the given

particularity of his or her existence: "metaphysics is enacted where the social

relation is enacted – in our relations with men. There can be no "knowledge"

of God separated from the relationship with men. The Other is the very locus

of metaphysical truth, and is indispensable for my relation with God".[316]   In

regard to the biblical tradition, he remarks, "The Bible is the priority of the

other in relation to me. It is in an other that I always see the widow and the

orphan.   The other always comes first".[317]   Morrison explains that the

formulation of personhood in Levinas is expressed through a dialectic of

passivity and activity, not that of being and nothingness.[318]   In other words, if

personhood is based on a metaphysic of substance, what results is a

determination in terms of absolutes—an entity either exists or not.   But

Levinas contends that existence is relational; and that passivity—properly

---

[314] Glenn Morrison, "A Critical Review of Michael Purcell's Theological Development of Levinas' Philosophy," *Heythrop Journal* 44, no. 2 (2003).

[315] Purcell, "Levinas and Theology..."

[316] Levinas, *Totality and Infinity...*

[317] Emmanuel Levinas, *Of God Who Comes to Mind*, trans. B. Bergo (Stanford: Stanford University Press, 1998).

[318] Morrison, "A Critical Review..."

understood—receives a theological emphasis. He bases his interpretation on the word of God, "Here I am" (Exod 3:4). God is self-revealed in such a way that acceptance or rejection is possible.[319]   In this way, the "passive" experience is prior—that is, before any intention, action, or even recognition—thereby impelling the recognition of the transcendent "otherness" of the Other.   In this moment of recognition there occurs the summons to responsibility: "the epiphany of the face is ethical."[320] To sum up, the face of the Other provides a hermeneutic for all ethical analysis and decision-making. It is the occasion and the reason for determining my actions; it is the criterion by which my actions are judged.   The face of the Other challenges my reflection and my passivity, instead calling for action and responsibility to meet the needs which I perceive through the vulnerability of the Other.

Levinas and Macmurray share a number of features in their thinking. They challenge metaphysics and epistemology in similar ways: both see persons-in-relation as preferable to the understanding of personhood deriving from the ancient and medieval periods and also to that of the Enlightenment; each gives priority to action over theory; both see an ethical responsibility to the vulnerable in which the action is determined not by the protagonist but by the need of the vulnerable Other. Implicit in the thinking of both philosophers is

---

[319] Levinas, *Of God Who...*

[320] Emmanuel Levinas, *Outside the Subject*, trans. M. B. Smith (Stanford, CA: Stanford University Press, 1994).

the concept of a process of person formation; however, neither develops this aspect sufficiently for this thesis. I turn to the work of Alistair McFadyen for this aspect of the thesis. McFadyen does reason through a process of person formation — one that is complementary to the work of Macmurray and Levinas, though he does not make use of the thinking of either.

3. McFadyen: Person in Process

Alistair McFadyen (1961—) is an English Anglican theologian working in the University of Leeds. His major contributions are found in the two books, *The Call to Personhood* and *Bound to Sin*. These books appeared a decade apart and treat the related topics of theological anthropology and the experience of sin. In *The Call to Personhood*, McFadyen articulates "a theory of the practice of the various dimensions of personal life and of person-making."[321] *Bound to Sin* explores the theme of sin as a "fundamental distortion of the conditions of sociality through which we are called into personhood."[322] Of special interest for this thesis is McFadyen's formulation of the process of person-formation. Where Macmurray has established the essentially relational dynamics of personhood and Levinas articulated the priority of the Other as the ethical dimension in all relationships, McFadyen pays special attention to the person-

---

[321] McFadyen, *The Call to Personhood...*
[322] McFadyen, *Bound to Sin...*

forming process through the temporal unfolding of relationships. He speaks of the person first of all as:

> An individual who is publicly identifiable as a distinct, continuous and integrated social location from whence communication may originate and to which it may be directed; who has the capacity for autonomous engagement in social communication, and who has unique identity sedimented from previous interaction. [323]

He thus introduces his interactive notion of personhood and the "sedimentation" of relational interaction that determines it. He then goes on to indicate the intrinsic character of the process of personal formation as a unique identity:

> A person's being and communication are not therefore externally determined, but are generated by this unique identity. This, in turn, is not something purely private, for it has been derived from the history of relations which has taken place around this particular social location and in which this person has participated as a subject. A person is thus not simply "thrown up" by a process of communication going around him or her over which he or she has no control, but is born and nurtured through a process which seeks his or her engagement as a subject.   It is through the person's own participation in and interpretations of this history of interaction that it takes a particular character, becomes centred on the person in a particular way and builds up an idiosyncratic identity.[324]

In this formative, interactive process, the person's unique social identity is constituted in both its subjective and objective fashion, at once as active and passive. As McFadyen summarises it,

---

[323] McFadyen, *The Call to Personhood...*

[324] McFadyen, *The Call to Personhood...* ibid.

> As a unique social location, a person is a unique point of view or experience to which communication may be directed and from which it may be experienced/received in a unique way; and a unique point of action from whence communication may originate. As a unique location, a person may also become the subject or object of communication in ways unique to him or her.[325]

McFadyen's attention, then, is directed to the communicative processes through which persons come into being. Constituted through interactive relationships, they are centres or "locations" of communication in both an active and passive manner. Somewhat in contrast to Macmurray and Levinas, he accents individual consciousness in the ongoing communicative process. In that exchange, persons continually interact and come to possess a more "sedimented" identity. For McFadyen, personal communication is dialogical in its dynamic structure, with moments of openness and closure, information and reception, all governed by the moral codes appropriate to the level and nature of the relationship[326]:

> Interpersonal relations take place within a given social context. They are therefore interpersonal exchanges conducted within a communication code (social "language") given with that context. The communication code is a semantic system regulating exchange values within a moral order (social orders may be considered moral orders because they regulate values in this way). It routinely structures (codifies) communication and relations according to the system of values operating in a given social context and governs the way distinct groups and individuals may be recognised and addressed and may enter into relation with others.[327]

---

[325] McFadyen, *The Call to Personhood...*

[326] McFadyen, *The Call to Personhood...*

[327] McFadyen, *The Call to Personhood...*

Thus, the social context of the values embedded in the relationship regulates the kind of communication which takes place. The kinds of communication which take place between parent and child are different in form, content and style, to those with employers, service professionals and strangers. As relationships develop, the kind of communication also changes, until the new social context emerges. Structures of communication are dialogical—involving the offer, exchange and reception of communication. Such dialogue is not just a stream of information, however, for it also involves both openness and closure within the communication, as a result of choice or other factors. For example, a conversation between a father and his four year old daughter makes possible the exchange of quite complex information, emotion and nuance. But there are limits to the language and ideas that can be communicated, on the side of either party. Yet, over time, a growing openness and receptivity can develop, along with new concepts, language and experience. An appropriate closure remains a feature, for some matters or modes of communication may not be, or cease to be, suitable to, say, a father's conversation with his young daughter.

While McFadyen implies that both openness and closure are involved, there is a logical priority to the idea of a "call"—in line with Levinas' understanding of passivity. If communication is to occur, there must be this initiating call prior to any possibility of dialogue. This broadly corresponds to Levinas'

apprehension of the face of the Other where a response is elicited prior to intention.[328] The self and the other must be open to be addressed and to respond, but without any prior determination of content or quality of the communication that is to occur. This mode of communication mirrors the pattern of God's initiative in grace, since it does not determine how the God-given gift is to be received. By not forcing the character of the response, God both preserves and addresses human freedom. When a response is coerced, the freedom of the other is diminished and the capacity for future openness is limited. McFadyen contrasts this theological concept of the graciousness of God to the destructive character of sexual assault on children and to the evil of the Holocaust. In both situations, free communication is precluded by the coercive power of the evil. However, it is not just that evil violently reduces its victims to silence and powerlessness, but renders whole areas of the life of the victim incommunicable.[329] Perpetrators of child abuse typically seek to manipulate their victims with the words, "this is our secret" in order to ensure silence and non-communication: "It is not merely that the core dynamic of abuse is that of a distorted and distorting relationality. . .; it also encloses and traps the child in its distortions. The borders of the relationship are closed, binding the child, and often the adult survivor, in and to the

---

[328] J. Hatley, *Suffering Witness: The Quandary of Responsibility after the Irreparable* (Albany, NY: State University of New York Press, 2000).

[329] McFadyen, *Bound to Sin...*

relationship's abusive reality".[330] In this manner, an aggressive, totalitarian ego seeks to overcome any vestige of the independent or transcendent other.[331]

McFadyen's basic insight discloses how individuals have their identity confirmed, reinforced, shaped and modified through interpersonal encounters. He recognises that there are limits to communication. What the *I* receives in responding to the invitation is an echo of what has been communicated. The completeness of the communication is inevitably affected by the extent of the limits in play. In the ideal situation, the relationship is one of openness to the other's communication. In this case, the communication contains both new information and also something deeper: a sense of the self as mediated and qualified by some other.[332] Far from diminishing the self involved, such communication strengthens self-identity, clarifies it, and locates it in a communitarian network of acknowledgment.[333]

McFadyen recalls how, in the case of the Holocaust, distorted relationships preceded the policy of the Final Solution. The more there was a breakdown in the process of healthy, transparent interpersonal relationships, and the more

[330] McFadyen, *Bound to Sin...*

[331] Morrison, "A Critical Review..."

[332] McFadyen, *The Call to Personhood...*

[333] E. P. Hahnenberg, *Ministries: A Relational Approach* (New York: The Crossroad Publishing Company, 2003).

there was silence about the unhealthy social relations that were becoming the accepted norm in the community, the more possible the Holocaust became. The movement toward genocide was the result of the gradual rejection of relations with particular others, such as the disabled, the mentally ill, homosexuals, Gypsies, Jews and other non-Germans.[334] McFadyen observes that "the holocaust was the product of a society in the grip, not of irrational violence and uncontrollable passion, but of a highly rational project for the betterment of society."[335] This rejection of specific others became both systemic and pathological in Nazi Germany. This instance demonstrates that rejection of the other does not simply distort one relationship. What occurred was a restriction of the social capacity to engage openly and freely in all relationships. Life came to demand the exclusion of the other, with the self defending its identity by shutting out the unwelcome other as an alien presence. As a result, the perception of the other is doubly distorted. The exclusive self implodes in on itself, in its incapacity to relate; and the self of the excluded are systematically deprived of a healthy social identity and sense of self. McFadyen continues: "Nazi policy towards and ideological representation of the Jews was a means for energising and securing German identity, and so tells us at least as much about German as it does about Jewish

---

[334] McFadyen, *Bound to Sin…*

[335] McFadyen, *Bound to Sin…*

identity in Nazi intentionality."[336] If dehumanising communication becomes systemic as in the cases of religious bigotry, secularism, racism, and sexism— let alone the extreme instance of genocide, then the social capacities for growth and healthy interaction dwindle. It might well be observed that similar kinds of linguistic structures and ideological representations are now directed against Muslims—often represented as "Islamic extremists". To the degree this is the case, there are grounds for pessimism. Even if all the pre-conditions for another Holocaust do not exist, still an ideological manipulation of patterns of relationships is unhealthy in the extreme. Distorted relationships poison inter-subjectivity so that the other is regarded as worthless or an object of fear. When there is no possibility of inter-subjectivity, communication is reduced to a monologue. The flow of information is one-directional. The life of a given community becomes stunted, as a rigid, violent one-way direction of communication is taken for granted. Such a situation necessarily biases any effort to understand contemporary terrorism. If, however, the terrorists are viewed, not simply as the perpetrators of mindless acts of violence, but as attempting to communicate their moral judgment on a society that has incited them, because of real or perceived grievances, to this desperate course of action, then greater attention to all possible avenues of communication is required. Urgent questions arise: why have more formalised, non-violent modes of

---

[336] McFadyen, *Bound to Sin...*

communications become so ineffective? Have more interpersonal processes of communication become frozen in unwieldy bureaucracies and a legalism that has grown deaf to the persons at risk?

This is not to say that bureaucratic and contractual communications are irrelevant to interpersonal communication, for an intersubjective exchange can obviously develop around them. A decent kind of relationship can develop over time with, say, a shop-owner in a country town. On the other hand, an exclusively commercial relationship can have a negative effect by minimising the possibility of genuinely interpersonal encounters. Here, McFadyen speaks of a "sedimentation" resulting from communication of every type:

> The general social context… determines the ways in which people may be routinely recognised and addressed and enter communication, and so orders the pattern of relations around each individual from which a unique personal identity is sedimented, along with the understanding that one is a person, a subject of communication, by virtue of the socially recognised fact that one is a single, continuous centre of interaction.[337]

This "sediment" of past relationships either assists or hinders further communication. Someone who has received a flow of positive feedback is more likely to expect to receive positive responses from the invitations of others. At the other extreme, those who have regularly received negative

---

[337] McFadyen, *The Call to Personhood…*

feedback are more likely to expect rejection in their overtures to the other.

Each experience of communication becomes sedimented in the consciousness

of the persons involved, so as to permanently determine the patterns of

communication and the quality of interpersonal relationships.

As individuals enter into increasing numbers of dialogic relations, they are

bound ever more closely to their communities while, at the same time,

increasingly formed as unique individuals. No two individuals have the

same pattern of dialogic encounters. Through the communicative

relationships proper to each one, the more unique the individual becomes.[338]

This does not mean, as Harriet Harris points out, that the uniqueness of the

person regresses into a limitless number of relationships.[339] Since the nature

of being is relational, there can be no existence which is not also essentially

relational. In this perspective, the dialogic nature of person-formation

accounts not only for the formation and development of the individual

subject, but also for the distortion of communication with its adverse effects.

When this distortion is serious, it affects the kind of person each one is, along

with capacity for openness in future dialogic encounters.[340] McFadyen refers

to the biblical account of the Fall as an expression of the distortion which

---

[338] McFadyen, *The Call to Personhood...*

[339] Harriet Harris, "Should We Say That Personhood Is Relational?," *Scottish Journal of Theology* 51, no. 2 (1998).

[340] This is the central tenet of McFadyen, *Bound to Sin...*

occurred through human rejection of God's call to ever closer relationship[341].

Sin is the closure, complete or partial, in the lines of communication and the

possibilities of encounter, either with God or other human beings.[342] The

capacity to give or receive from the other is thereby constricted. Participation

in the community is compromised, and self-enclosure increased. When all

meaning becomes self-referential, the self-transcending, or "ex-centric"

character of human identity in relation to what is other, necessarily suffers.[343]

5. Conclusion: Philosophical Convergences

Each instance of interpersonal communication calls the persons involved

beyond themselves. In this regard, there are a number of variations on Martin

Buber's "I-Thou" model of interpersonal relations.[344] Where John Macmurray

privileges the "mother-child",[345] McFadyen puts the emphasis on "call –

response".[346] But these authors are not blindly idealistic about the positive

nature of all relations. Both recognise the power of relations to deform those

concerned. Buber had conceded the potential of objectifying the Other, so

that the relationship would be more like "I-It", rather than "I-Thou".[347]

---

[341] McFadyen, *Bound to Sin...*

[342] McFadyen, *The Call to Personhood...*

[343] McFadyen, *The Call to Personhood...*

[344] Martin Buber, *I and Thou* (Edinburgh: T & T Clark, 1937).

[345] Macmurray, *Persons in Relation.*

[346] McFadyen, *The Call to Personhood...*

[347] Buber, *I and Thou.*

Similarly, Macmurray accepts the possibility of the mother-child relationship being abused.[348] For his part, McFadyen sees the distortion as taking on a monological style of communication.[349] While these negative possibilities are treated differently in each case, these authors are in fundamental agreement: instead of being life-giving and expansive, relationships can be limiting and alienating. McFadyen adds a further precision: bad relationships do not mean that persons are not formed relationally, but, rather, that the formation process is distorted.[350] Whether the relationships are good or bad, encouraging or limiting, persons become what they are in and through their interaction with others. Though the capacity for self-determination remains, it nonetheless takes place in an interactive field of relationships.

Faced with an invitation to dialogue, be it offered either implicitly or explicitly, an individual can either enter into the communication with some degree of openness to the other, and so affirm the other as a person, or treat the other merely as an object. In that case, all that is considered in the communication is the "I" or, for that matter, the exclusive "We", outside of which the other has no significance. Communication ceases to be dialogical. It is restricted to a monologue in which the active party receives and responds

---

[348] Macmurray, *Persons in Relation.*

[349] McFadyen, *The Call to Personhood...*

[350] McFadyen, *Bound to Sin...*

merely to echoes of itself.[351] As noted above, distorted patterns of relations do not diminish the relational nature of persons; it is simply, and tragically, that the communication process is defective.[352] For anyone caught up or drawn into a monological form of encounter, the resultant relations are oppressive. Even so, relations continue to shape the self and the other, and reveal an inherent connection with the other.[353] Responsibility for the other is not thereby diminished, regardless of the pattern of current relations, for responsibility is prior to any specific relation.[354] On a more hopeful note, distorted relations still remain open to the possibility of transformation and redemption.[355] Here, Levinas' insight has its special value. Relationships mean responsibility for the Other however disfigured it might appear.[356] Confronted by the Other, especially in its vulnerable state, self-transcending responsibility is always possible.

No one of these theories of person-in-relation is beyond criticism, at least in this exercise of practical theology in the domain of health care. Macmurray's philosophy can appear to be too optimistic and ideal. Levinas' emphasis can

---

[351] McFadyen, *The Call to Personhood...*

[352] Thomas A. Smail, "In the Image of the Triune God," *International Journal of Systematic Theology* 5, no. 1 (2003).

[353] Emmanuel Levinas, "Ideology and Idealism," in *The Levinas Reader*, ed. Séan Hand, (Oxford: Blackwell Publishers, 1989), 247

[354] Levinas, "Ethics as First Philosophy," 83

[355] McFadyen, *Bound to Sin...*

[356] Levinas, "ethics as First Philosophy," 83-86

be so fixed on the Other, that there is little room for the subjective,[357] and the developmental side of personhood.[358]   McFadyen's emphasis on the "sedimentary" effect of relationships, apart from employing an unusual metaphor—since "sediment" does not imply any buoyancy to relational life—does not attend sufficiently to the ontological datum of the person, as when he writes,

> The centred way in which we organise ourselves as persons does not arise out of internal processes or out of any qualities or attributes… rather it takes shape through our communication and relation with others. We cannot be personal centres in ourselves….[359]

If "we cannot be personal centres in ourselves", this poses quite serious metaphysical and theological problems.   Is there an endless regression of relationships leaving the individual person as a metaphysical vacuum, as the skins of the onion are peeled away, as it were, with nothing at its centre?   On the basis of what, then, does one person relate to the other?   In what does the transcendent value and dignity of the person consist?   Norris Clarke would point to the need for an ontological perspective where the person is actualised and expressed in the world through their ontological structure as the basis for

---

[357] Casey, "Levinas and Buber: Transcendence and Society." p. 75 and, James P. Mackey, *The Critique of Theological Reason* (Cambridge: Cambridge University Press, 2000). e.g. "The very title of his major work, 'Otherwise than Being,' surely suggests that otherness consists in some kind of entity that is transcendental with respect to Being, even if that then turns out to be a kind of nothingness...", 89.

[358] Bookman and Aboulafia, "Ethics of Care Revisited: Gilligan and Levinas."

[359] McFadyen, *The Call to Personhood...*

the value and dignity of the person.[360] Clearly McFadyen, on the other hand, has placed his emphasis on an interactive psychology of person-formation, even if the objective basis of the respective personal "components" in the formative process remains elusive.

So, while no one of these approaches gives or pretends to give a full account of the many dimensions of personhood, there still remains a convergence and complementarity of great value for the relational personhood that this thesis is presenting.   Macmurray presents the inter-subjective communication inherent in personal existence. Levinas, for his part, by prioritising the Other in the relationship, prevents it from collapsing into solipsism. McFadyen's view is, in a sense, midway between these two approaches, with his emphasis on the often dramatic exchanges involved in the personalising process. Theologically speaking, all three (Macmurray,[361] Levinas,[362] and McFadyen[363]) face us with the question, "Who is my neighbour?"—with reference to biblical texts, "You shall love your neighbour as yourself," (Lev 19:18) and the parable of the Good Samaritan (Lk 10:25-37).

---

[360] Clarke, *Person and Being*.

[361] Julian Stern, "John Macmurray, Spirituality, Community and Real Schools," *International Journal of Children's Spirituality* 6, no. 1 (2001). John Macmurray, "Prolegomena to a Christian Ethic," in *John Macmurray: Selected Philosophical Writings*, ed. Esther McIntosh, The Library of Scottish Philosophy, (Exeter: Imprint Academic, 2004)

[362] Levinas, *Of God Who...*

[363] McFadyen, *The Call to Personhood...*

Accordingly, the next chapter will explore further the theological grounding of relationality and tease out the practical application of these philosophical and theological positions to a number of cases after that.

CHAPTER FIVE: A CHRISTIAN VISION OF THE PERSON

In the previous chapter I explored three different perspectives on the relational aspects of the human person. John Macmurray, Emmanuel Levinas and Alistair McFadyen developed their ideas in their respective ways, influenced by the differing contexts in which they were working. Yet they share a concern to express personal existence in a manner at once more fresh and also less bound up with metaphysical language compared to previous accounts. Their work opens up possibilities for a more inclusive and relational sense of the other, especially for those who have often been violently regarded as sub-personal or non-human, because of debility, powerlessness or membership of some minority group. Each of these thinkers enriches the understanding of the relationality that is constitutive of personhood and community. This deeper and broader understanding is relevant to many areas of contemporary life, above all to the area of human services and social welfare, and, in the present instance, to the practical and theoretical discourse concerning health care. The approach I have been elaborating restores persons to the centre of health care, in a way that affects its vision and the values motivating its decisions, especially when faced with the complexity of contemporary medical dilemmas. Relational models of personhood place the person at the centre of all exchanges and seek to redress

an imbalance in the social constructions which have prized the objective, the scientific, and the empirically measurable over the more mysterious reality of the person and the relationships in which it co-exists with others in a community.

In the previous chapter, I briefly discussed the need for a new "paradigm" for our understanding of the human person, with its implications for a fundamental change in theoretical and practical thinking. It is necessary to now take this a little further, and lead into a theological consideration which seeks to mine resources from the Christian and biblical tradition. While it is true that the contemporary conception of the human person can call on analogies that were beyond the imagination of past philosophical and theological accounts, a retrieval of the relational implications of Trinitarian and Christological doctrines can assist the present quest for the person. Contemporary worldviews are necessarily influenced by the relational horizon of modern science. It speaks of everything from the interactions of most infinitesimal sub-atomic particles to the complex ecologies of the rain forest, from the wave and particle models of quantum mechanics to the fundamental forces pervading the whole cosmos, in relational terms. With this as a background, key doctrines from the Christian inheritance spring into new life as relational realities expanding the fundamental conceptions of the human person.

There is also an historical background that is ignored only at the peril of becoming hopelessly abstract. The thinking of the 20th Century focused on the value of the human person under threat from violent, totalitarian ideologies. In reaction to the philosophical abstractness of past thinking on human nature, its emphasis lay on the concreteness and irreplaceable uniqueness of each human person, the irreducible value of the "I". Yet, this too, is in danger of vanishing into abstraction unless critical attention is given to the structures that shape human life: social, economic, political, cultural. These might be called the transpersonal "It" of the human world that had proved so adverse to the transcendent value of the individual person. By concentrating on that "It" and following the lead of the social sciences, philosophy and theology were implicitly invited to appreciate that the "I" needed to understand itself in terms of a socially and culturally formed "We". This more relational and inclusive sense of the person led to further questions, as indicated in Chapter Four: with whom are *you* in solidarity? Who do you stand with? Who do you speak for? Clearly, these questions gave rise to the various types of liberation and contextual theologies which seek to give voice to the option for the poor, to solidarity with victims. Now in the context of ecology and cosmology, the relational "We" is invited into greater awareness of its links with the interconnected, multiform life of the planet itself. The human person is an "earthling" in the temporal and spatial reality of the cosmos. This growing

appreciation of the planetary web of life and the cosmic process that has given birth to it, inspires a fresh expansion of the relational "We", the person-in-community, within a world of relationships. This represents a change of paradigm in thinking about persons and is the basic point of this chapter.

After the philosophical perspectives presented in the previous chapter, we now address the theological, under four headings:

1. Biblical Perspectives

2. The Relational Trinity

3. The Mission of Jesus

4. A Christian Relational Worldview

1. Biblical Perspectives

The Judaeo-Christian tradition depicts God from a variety of relational perspectives.[364] In the first instance, there is the primordial relationality of creation as it presented in Genesis accounts (Gn 1:1-3:24). These Creation narratives have their origin in Israel's awareness of election into a covenantal relationship with the God who is Lord of all.[365] The opening chapter of

---

[364] John Randall Sachs, *The Christian Vision of Humanity: Basic Christian Anthropology*, Zacchaeus Studies. Theology (Collegeville, MN: Liturgical Press, 1991).

[365] Hardy, *God's Way with the World*

Genesis presents the human beings as created in God's "image" (Gn 1:26).
Though the meaning of this term is not beyond dispute,[366] commentators
agree that humanity images God by being a community of persons,[367] and by
acting in the world as the agents or ambassadors of God.[368] The *imago dei* is, in
this respect, a profoundly relational concept. Human beings, by participating
in the divine Creation, realise their destiny.[369] Human action derives from the
creative power of God, as human agents live out the fundamental relationship
at the core of their existence.[370]

In its divine origins, humanity takes on a communal form. God creates the
human as male and female. Only through this primal relationship to another
can human beings be complete.[371] Created in this way as relational beings,
humans bear the divine image, so that in and through their relationships, they

---

[366] A range of perspectives can be found in the following sources, J. Alexander Sider, "Image, Likeness, and the Ethics of Memory," *Scottish Journal of Theology* 54, no. 4 (2001)., Colin E. Gunton, *The Triune Creator : A Historical and Systematic Study*, Edinburgh Studies in Constructive Theology (Grand Rapids, Mich.: Wm. B. Eerdmans Pub. Co., 1998)., Ann Elizabeth O'Hara Graff, *In the Embrace of God: Feminist Approaches to Theological Anthropology* (Maryknoll, NY: Orbis Books, 1995)., Nancy L. Eiesland, *The Disabled God: Toward a Liberatory Theology of Disability* (Nashville: Abingdon Press, 1994).

[367] Sachs, *The Christian Vision...*

[368] L. A. Turner, *Genesis*, ed. John Jarick, Readings: A New Biblical Commentary (Sheffield, England: Sheffield Academic Press, 2000).

[369] McFadyen, *The Call to Personhood...*

[370] Walter Brueggemann, *Theology of the Old Testament* (Minneapolis: Fortress Press, 1997).

[371] Sachs, *The Christian Vision...*

reveal something of the Creator,[372] as bearers of the divine image, and are called to act *in loco Dei.*[373]

The second account of Creation (Gn 2:5–3:24), however, is more explicitly relational. Humanity is presented as formed of the very stuff ("clay", "dust") of the world, an intrinsic part of the Creation. The terms for man (*adam*) and earth (*adamah*) suggest the link with the earth.[374] This connection is not related just to the initial forming of the "man", but also to the vocation of humanity to work with the earth (Gn 2:5 and 3:17-19), while in death they return to the earth from which they were made (Gn 3:19). While the human is related to rest of creation, it exists in a special relationship with the Creator.

The Genesis account of the formation of woman (Gn 2:18-25) has been a *crux interpetrum*. For some, it is an irredeemably patriarchal text attesting to the subordinate position of women. For others, it manifests the essential equality between the sexes pre-existing later patriarchal interpretations.[375] The phrase,

---

[372] Swinton and McIntosh, "Persons in Relation: The Care of Persons with Learning Disabilities."

[373] David A. S. Fergusson, *The Cosmos and the Creator: An Introduction to the Theology of Creation* (London: SPCK, 1998). Turner, *Genesis*.

[374] Raymond E. Brown, Joseph A. Fitzmyer, and Roland E. Murphy, eds., *Jerome Biblical Commentary*, 1st ed. (London: Geoffrey Chapman, 1969), 12 Bruce Vawter, *On Genesis* (London: Geoffery Chapman, 1977).

[375] D. J. A. Clines, *What Does Eve Do to Help?*, Journal for the Study of the Old Testament (Sheffield: JSOT Press, 1990). The eponymous essay in this collection gives a detailed account of a full variety of the patriarchal/feminist readings of this passage. Also see, Ronald A. Simkins, "Gender Construction in the Yahwist Creation Myth," in *Genesis: The Feminist*

"a helper like himself" (v. 8) has been proposed as a justification for the subordination of women by placing the focus of the account of the formation of the woman on the *role* that the woman she is expected to fill as "helpmeet". It is argued that such a status means always a secondary and subsidiary role, that is, never to be the leader, the initiator, the protagonist.[376] If the emphasis in this verse is placed not on the *role* of the woman, but on the *presence* of the woman as necessary to fill a void in the man, then a quite different theology can be developed. In this interpretation, the woman is the complement to man without which he is incomplete; she is not, therefore, an appendage.[377] That is, humanity cannot be complete unless in relationship. In that case, the marital relationship becomes a primary example of the kind of quality that should be present in interpersonal relations—similar to the way Macmurray focuses on the mother – child relationship.

Grounding the relationship of human beings to one another, is the transcendent dimension their relationship to the God who has chosen to be in relationship with them. Levinas' emphasis on the primacy of the Other, when applied to God points to the respectful and passive dimension of God's presence to the world: "Here I am" (Ex 3: 4b). This divine offer does not

---

Companion to the Bible (Second Series), ed. Athalya Brenner, (Sheffield: Sheffield Academic Press, 1998), 32-52

[376] Clines, *What Does Eve Do to Help?*

[377] Brown, Fitzmyer, and Murphy, eds., *Jerome Biblical Commentary* , 12

overwhelm the other, but respects the freedom required to accept or reject the offer. But there is also a more active aspect to the divine self-revelation. God reveals the divine name. In Exodus 3:13, Moses calls on God to make known the name that will validate his mission to the Israelites. The response is "I am who I am. This is what you are to say to the Israelites: I am has sent me to you" (Ex 3:14). John Courtney Murray has suggested that the name of God is best translated as, "I shall be there as who I am shall I be there."[378] Such a translation expresses the relational nature of the One who will be present to the Israelites throughout history. This relationship reaches back to the past, for God is the God of Abraham, Isaac and Jacob (Ex 3:14), and makes this same God present to each generation.

The revelation of the name of God and the formation of the community of the People of God takes place over time. In the Old Testament a variety of names or terms for God are used: Elohim, El Shaddai, Shekinah, Yahweh. These conjure images of power and transcendence in the attempt to articulate the ineffable mystery. Over time, the people of Israel began to identify their God, not by reference to what this God has done, but in terms of who this God is for them: "God of my master Abraham" (Gn 24:12), "the God in whose presence my fathers Abraham and Isaac walked" (Gn 48:15). Calling on God to reveal the divine name indicates the desire on the part of humanity to enter

---

[378] John Courtney Murray, *The Problem of God* (New Haven, CT.: Yale University Press, 1964).

more fully into relationship with the transcendent Other, as when Jacob asks, "please tell me your name" (Gn 32:29). Raimon Panikkar, the eminent interfaith scholar, has argued that this transformation is a development from a spirituality focused on a divinely representative object or quality, to a spirituality based on relationships between persons.[379]

This dynamic of call and self-revelation underpins any theology of interpersonal communication. The specifically Christian foundation of such communication necessarily includes confession of the Trinity, arising as it does from the mission of Christ.

2. The Relational Trinity

The doctrine of the Trinity is sometimes considered to be one of the more arcane aspects of Christian theology to the extent that even Karl Rahner, in the 20th century, noted for the Trinitarian framework of his theology, concedes that this doctrine has little practical resonance in the lives of many Christians.[380] The very technical and metaphysical nature of much of the theology of the Trinity would imply that this particular Christian doctrine

---

[379] Raimon Panikkar, *The Trinity and the Religious Experience of Man: Icon - Person - Mystery* (New York: Orbis Books, 1973).

[380] Karl Rahner, *The Trinity*, trans. J. Donceel, Mysterium Salutis (London: Burns & Oates, 1970);F. J. van Beeck, "Trinitarian Theology as Participation," in *The Trinity*, ed. Stephen T. Davis, Daniel Kendall, and Gerald O'Collins, (Oxford: Oxford University Press, 1999), 317

would have little role to play in contemporary health care ethics. I argue, however, that the doctrine of the Trinity is highly relevant to a Christian anthropology, and, as a consequence, to practical theology and the meaning and values of health care. My intention here, therefore, is to present the Trinity as the paradigm of relational personhood.

Admittedly, due to the technical nature of Trinitarian theology, it does not appear to be immediately relevant to applied or moral considerations. Liberation theology, on the other hand, makes extensive reference to the Trinity in order to present ethics from the perspective of the poor.[381] The political theologies of Europe, as evidenced by Jurgen Moltmann[382] and Johannes Metz,[383] are likewise deeply trinitarian. Van Beeck has urged theologians not to complacently accept that the doctrine of the Trinity has limited value in the lives of Christians,[384] but to ground Trinitarian theology explicitly in the celebration of the mystery of God in worship.[385] For his part, John Dixon, drawing on the thought of Mikael Bakhtin, argues that that this

---

[381] Leonardo Boff, *Trinity and Society*, Liberation and Theology Series ; 2 (Tunbridge Wells: Burns & Oates, 1988).

[382] Jürgen Moltmann, *The Trinity and the Kingdom of God: The Doctrine of God* (London: SCM Press, 1981).

[383] Johannes Baptist Metz and Edward Schillebeeckx, *No Heaven without Earth*, Concilium 1991/4 (London: SCM Press, 1991).

[384] van Beeck, "Trinitarian Theology as Participation," 315-319

[385] Such an approach is also supported by J. J. Shuman, *The Body of Compassion* (Boulder, Colorado.: Westview Press, 1999).

central Christian doctrine is, in principle, of universal significance.[386] He links discoveries in contemporary physics to demonstrate that relationality is the primary mode of all being: "both observer and observed are merging and interpenetrating aspects of one whole reality".[387] In other words, the observer and the observed are in relationship with each other, thus suggesting a trinitarian relationality. He goes on to suggest that, as a result of this intrinsic relationality, humanity has developed its distinctive self-consciousness:

> [T]he human mind and its products are a part of the web of relations. The relational structures of human culture are added to the order of nature as a part of it as well as supplementary to it, not over against it as something wholly other.[388]

Culture is the expression of human self-consciousness, he argues, and this is what distinguishes human from animal life. The cultural evolution of our species depends upon interpersonal relationality. These affective inter-subjective exchanges with others are, in turn, built on the essential relationality at the heart of the universe. Dixon points to a paradox: humanity is by nature both intrinsically part of the natural world and, at the same time, set apart from the natural world. Humanity is distinct from nature in its liberty to choose, yet it is organically linked to the finitude of nature.[389] This

---

[386] John W. Dixon, "Toward a Trinitarian Anthropology," *Anglican Theological Review* 80, no. 2 (1998).

[387] Gerald M. Edleman, *Bright Air, Brilliant Fire: On the Matter of the Mind* (New York: Basic Books, 1992). Cited in Dixon, "Toward a Trinitarian Anthropology."

[388] Dixon, "Toward a Trinitarian Anthropology."

[389] Dixon, "Toward a Trinitarian Anthropology."

paradox has parallels in the Genesis accounts of humanity's connection with all of creation in its creaturely being, but always separate from the rest of creation because of its particular God-given role and mission.

A second aspect of this paradox deals with the inter-human or inter-subjective relationship.[390] The human person as individual is insufficient. The Creator recognises that "it is not good that the man should be alone" (Gn 2: 18). The resolution to this problem of singularity is not the creation of other species from the same soil, but the division of the human into male and female. While there is a distinction of one individual from another, the first utterance of the original human being is on his companion, "This at last is bone from my bones, and flesh from my flesh…This is why a man leaves his father and mother and joins himself to this wife, and they become one body" (Gn 2: 23 – 24). The scriptural text highlights the limitations of thinking about human beings simply as discrete individuals: for we are not made to survive as separate individuals. That is not to deny the value or reality of individual uniqueness, or to claim that identity is so merged in a community of others that the person's experience of individual uniqueness is of no account.

The trinitarian principle that Dixon highlights demands the development of philosophical and theological language adequate to the paradoxical situation

---

[390] Dixon, "Toward a Trinitarian Anthropology."

inherent in human existence, namely, that of being part of nature yet distinct from it, and as individually unique yet reliant on a community. Dixon argues that the doctrine of the Trinity is, at one level, an attempt to resolve this human paradox. Trinitarian doctrine recognises the duality of Father and Son, but also a unity between them in the Spirit. This kind of unity does not imply the domination of one over another, nor the absorption of one into the other. Instead, the relation which binds the divine persons into unity is understood to enhance their distinctiveness. While this model can and must be applied to humanity, the "unity of the Holy Spirit" on that finite level is never fully realised in history, but awaits an eschatological fulfilment. Nonetheless, a trinitarian dynamic is at work, for humanity cannot be adequately described in terms of individuality or in terms of a communal whole, but only as individuals-in-relation. Dixon, therefore, sees in the Trinity the basis for Christian anthropology and ecclesiology.[391] Anne Hunt, in a recent work,[392] develops what she terms a "trinitarian nexus" in which all aspects of Christian faith and practice are inter-related. Taking up, at least in part, a similar theme to Dixon, Hunt demonstrates the pivotal relationship that the doctrine of the Trinity has to a range of other Christian doctrines. She highlights not only the relational dimensions of the Trinity but also that this relationality is a methodology for understanding the Trinity.

---

[391] Dixon, "Toward a Trinitarian Anthropology."

[392] Anne Hunt, *Trinity: Nexus of the Mysteries of Christian Faith*, ed. Peter C Phan, Theology in Global Perspective, vol. 1 (Maryknoll, NY: Orbis Books, 2005).

A feature of this renewed interest in Trinitarian relationality as a model and foundation of human interpersonal existence is a growing appreciation of the Eastern Christian tradition, with its strong emphasis on the persons of the Trinity.[393] The Western theological tradition, following on St Augustine's use of the "psychological image", is to some degree in contrast to the Eastern approach, for it emphasises more the one divine nature or consciousness in which the three divine persons are related.[394] The apparent opposition of Eastern and Western approaches should not be exaggerated. It has been argued that Augustine was not only familiar with the Cappodocian contribution, but that he too argued for a relational understanding of the Trinity,[395] while stressing the mutual love between the persons of the Trinity which is yet to be fully appreciated.[396] It is clear, however, that the interaction

---

[393] J. Thompson, *Modern Trinitarian Perspectives* (New York: Oxford University Press., 1994).

[394] John Milbank, *The World Made Strange* (Oxford: Blackwell, 1997)., Sarah Coakley, "'Persons' in the 'Social' Doctrine of the Trinity: A Critique of Current Analytic Discussion," in *The Trinity: An Interdisciplinary Symposium on the Trinity*, ed. Stephen T. Davis, Daniel Kendall, and Gerald O'Collins, (Oxford; New York: Oxford University Press, 1999) And recently, C. C. Pecknold, "How Augustine Used the Trinity: Functionalism and the Development of Doctrine," *Anglican Theological Review* 85, no. 1 (2003).

[395] Pecknold, "How Augustine Used the Trinity: Functionalism and the Development of Doctrine."

[396] S. Studebaker, "Jonathan Edwards's Social *Augustinian* Trinitarianism: An Alternative to a Recent Trend," *Scottish Journal of Theology* 56, no. 3 (2003). See also: Edward Russell, "Reconsidering Relational Anthropology: A Critical Assessment of John Zizioulas's Theological Anthropology," *International Journal of Systematic Theology* 5, no. 2 (2003). and Neil Ormerod, "Faith and Reason: Perspectives from Macintyre and Lonergan," *Heythrop Journal* 46, no. 1 (2005).

of these two approaches has come to be expressed in a more communal or social understanding of God's Trinitarian life. [397]

In the West, the psychological analogy, typical of Augustine – though also found in Gregory of Nyssa in the East – provided the interpretative key: the distinctions between, and the distinctiveness of, the divine persons, and the manner of their relationship in the one divine nature, was based in spiritual activities such as memory, intellect and will. [398] Augustine, in fact, proposed a number of different triads in the development of his Trinitarian theology. [399] These experientially based analogies were later given greater precision by Thomas Aquinas. He reduced them to two in his more metaphysical account of Trinitarian doctrine. The procession of the Word took place by way of knowing, and that of the Spirit by way of love. [400] In this approach, the spiritual activities of human consciousness were the prime type of analogy used to describe the intra-Trinitarian connections. This theological analogy has the advantage of locating the three divine persons in the one divine nature and consciousness. Further, in highlighting the differences between the procession of the Word and the Holy Spirit, the order of its presentation

---

[397] Moltmann, *The Trinity and the Kingdom...*

[398] James Alison, *The Joy of Being Wrong: Original Sin through Easter Eyes* (New York: Crossroad Pub. Co., 1998).

[399] Studebaker, "Jonathan Edwards's Social *Augustinian* Trinitarianism: An Alternative to a Recent Trend."

[400] Hunt, *Trinity...*

tends to emphasise the divine unity rather than the interpersonal relationships of the divine persons in a communion of divine life which has been more evident in the Eastern approach.[401] John Zizioulas captures the strong relational character of the Eastern emphasis on communion in the following passage:

> In God it is possible for the particular to be ontologically ultimate because *relationship is permanent and unbreakable*. Because the Father, the Son and the Spirit are always together, the particular beings are bearers of the totality of nature and thus no contradiction between the "one" and the "many" can arise…

> This means that if we wish to build the particular into ontology we need to introduce *relationship* into substance itself, to make being relational…[402]

In this condensed expression of his approach, Zizioulas is reacting against a theological imagination that would persuade us to think of the Trinity primarily as the one divine substantial reality to which personal relationships are added in some sense; or of the divine persons as already constituted entities which are subsequently brought into reciprocal relationships. In contrast, he is pointing to the inherent and essential relationality which the Trinitarian mystery expresses. As a result, we should think of the divine Being as "Being in communion", rather than an undifferentiated totality. As a result, the most profound account of the revealed one God of Christian faith is

---

[401] Alison, *The Joy of Being Wrong: Original Sin through Easter Eyes*.

[402] Zizioulas, "On Being a Person: Towards an Ontology of Personhood," 41-42 italics in original text

not to be sought in the unitary of essence and substance, but in the dynamic reality of communion and love. He goes on to say,

> This results in a reality of communion in which each particular is affirmed as *unique* and irreplaceable by the others—a uniqueness which is *ontological*, since the whole being in question depends on it, due to the unbreakable character of the relationship. If we define *love* in ontological terms. . . we must speak here of an ontology of love as replacing the ontology of ??s?a ["nature" or "substance"].[403]

Zizioulas argues, from his Eastern perspective, that the trinitarian relationality of the divine persons assumes that, "substance never exists in a 'naked' state, that is, without hypostasis, without a mode of existence."[404] This is taken as a fundamental theological principle, applicable to every aspect of Christian and ecclesial life: the mode of existence for all persons, divine and human, is relational. In their inter-relational existence the persons of the Trinity are revealed and known; and it is through relationships that human persons are constituted as both mirroring and participating in the divine life of trinitarian communion.

My concern is not to debate the relative merits of particular theological approaches to Trinitarian theology, but to ground a relational theology of personhood in the Trinity, as the central mystery of faith. To that degree, in this exercise of practical theology in relation to health care, I take a more

---

[403] Zizioulas, "On Being a Person: Towards an Ontology of Personhood," ibid

[404] Zizioulas, *Being as Communion*.

synthetic approach, hoping thereby to establish a strongly Trinitarian basis for the notion of inter-relational personhood already discussed in the approaches of Macmurray, Levinas and McFadyen. I am in agreement, therefore, with Dixon's conviction, that only a Trinitarian anthropology is adequate to a full account of human existence and its destiny.[405]

Theology, past and present, recognises that the conceptions of personhood at any one time are applicable to the divine persons only in an analogical fashion. This is especially the case with our modern, more psychologically attuned understanding of the person as a distinct centre of self-awareness: it would be anachronistic to read such a conception back into the theology of the patristic era.[406] Note, in this connection, that the "psychological" aspect of the Augustinian-Thomist "pyschological analogy" has little immediate connection to the contemporary sense of "psychology". It appealed to the metaphysical, spiritual notion of the human soul with its faculties of intellect and will.[407] In contrast, in contemporary parlance there is no reference to such faculties but to interior affects relevant to individual self-consciousness.[408] For example, Gerald Gleeson draws a sharp distinction between the

---

[405] Dixon, "Toward a Trinitarian Anthropology."

[406]Coakley, "'Persons' in the 'Social' Doctrine of the Trinity: A Critique of Current Analytic Discussion," The article provides a critique of this kind of thinking through an analysis of the theology of Gregory of Nyssa.

[407] C Schwöbel, "Introduction," in *Persons, Divine and Human*, ed. C Schwobel and Colin Gunton, (Edinburgh: T & T Clark, 1991), 2

[408] Coffey, *Deus Trinitas.*

contemporary psychological sense of consciousness and its use in some theological contexts.[409] I agree, therefore, with Gleeson in maintaining that being a person depends on "a metaphysics of personhood that goes beyond essences and substances, and [on] a relational view of personhood that is grounded in metaphysics, rather than psychology."[410] On the other hand, attempts to relate the understanding of person in relation to the Trinity goes back to patristic times and to the earliest doctrinal formulations.[411]

The enduring problem is that of analogical application of the notion of personhood to trinitarian doctrine of "three divine persons". Simply applying the term "person" to the divine and human cases would risk merging the uniqueness of the two and would be problematic in terms of Christian doctrine. On the other hand, treating the two senses of the use of the term as being in complete disjunction would be equally problematic. The theological problem, consequently, is that of elaborating an analogical manner of reference that attends both to similarities and to differences—while rejecting univocal equivalence and equivocal claims that would allow only for a purely verbal correspondence. In an analogically informed theology, it must be asked: "how does the human experience and conceptualisation and

[409] Gerald P. Gleeson, "Speaking of Persons, Human and Divine," *Sophia* 43, no. 1 (2004).

[410] Gleeson, "Speaking of Persons, Human and Divine."

[411] Zizioulas, *Being as Communion*. A more recent and Catholic exposition of similar material can be found in Coffey, *Deus Trinitas.*

experience of personhood cast theological light on the Trinity as the three divine persons?" Such a question reflects the ordered analysis of systematic theology typical of the Western theological tradition. There is another question: "how does revelation of the Trinity of persons throw anthropological light on human, personal existence?" This may be taken as a indicating more an Eastern theological approach, but, within the present concern of this thesis, to unfold a practical theological exposition of relational personhood, the latter question is more important.

To return to the central point of this chapter, I consider that a theology of the Trinity that highlights the essential inter-relationality of the divine persons should radically affect Christian anthropology of personal existence, and the ethics deriving from it.[412] The practical significance of relational models of the Trinity has been explored by Catherine LaCugna, to give one example. She argues that it is due to the relational nature of personhood that human persons are called into relationship with the divine and with each other. She writes, "becoming persons fully in communion with all; becoming Christ to one another; becoming by the power of the Holy Spirit what God is: love

---

[412] A. J. Kelly has recently pointed out both the need for Trinitarian perspectives in Christian ethics and also the paucity of current applications, Anthony Kelly, "A Trinitarian Moral Theology," *Studia Moralia* XXXIX, no. 1 (2001).

unbounded, glory uncontained."[413]   This theological position links well with

the more philosophical views referred to in the previous chapter.   It also

echoes Zizioulas' theology: "A personal identity is possible for God not on

account of His substance but on account of His trinitarian existence… The life

of God is eternal because it is personal, that is to say, it is realized as an

expression of free communion, as love."[414]   Theological anthropology, with

such a foundation, clearly leads to an other-centred existence and genuinely

dialogical relationships.

Trinitarian theology, while based on biblical narrative, symbolism and

rhetoric, cannot expect to find the Trinitarian doctrines of the 4th Century in

the scriptural text.[415]   Nonetheless, the Trinitarian form of both liturgy and

doctrine is anticipated for instance in Jesus' prayer to the Father and in his

anointing by the Spirit.[416]   The foundation of the unique intimacy of Jesus'

relationship with the Father is later clarified in doctrinal terms. Likewise, he

is possessed, guided by, and communicates the Spirit which is later confessed

as "the third divine person."[417]   The biblical account of the Father revealing

---

[413] Catherine Mowry LaCugna, *God for Us: The Trinity and Christian Life*, 1st ed. (San Francisco: HarperSanFrancisco, 1991).

[414] Zizioulas, *Being as Communion*.

[415] Ralph Del Colle, *Christ and the Spirit: Spirit Christology in Trinitarian Perspective* (New York: Oxford University Press, 1994).

[416] Del Colle, *Christ and the Spirit: Spirit Christology in Trinitarian Perspective*.

[417] David Coffey, "The Holy Spirit as the Mutual Love of the Father and the Son," *Theological Studies* 51, no. 2 (1990).

himself in his only Son and the Holy Spirit eventually raises the question of the eternal foundation of God's self-revelation in history. If there is divine self-giving involved in the Father sending his Son and Spirit, what is the character of the "self" that the divine mystery has to give? In this way, the "economic" Trinity revealed in the history of salvation leads to an eventual recognition and articulation of the "immanent" Trinity of God's eternal being and life in doctrinal terms, and to an exploration of it in Trinitarian theology. In other words, the relationship of the divine three – Father, Son and Spirit – to the world gives rise to the question of how the divine three are inter-related as persons in the life of the One God. There would be no Trinitarian faith or theology unless God had been experienced in the threefold or triadic manner communicated in the personal terms of Father, Son and Holy Spirit.[418] In theological terms, the "missions" of divine persons *ad extra*, that is, as experienced in the world, lead to knowledge of the processions of the divine Word and Spirit *ad intra*, that is, within the eternal life of God. Through the experience of events of salvation and grace, the believer is related to the divine persons. These relationships are expressed in such phases as "becoming children of the Father", "being baptised into Christ", and "becoming temples of the Holy Spirit". In the field of manifold relationships expressive of the threefold character of God's relationship to God and of the

---

[418] Elizabeth T. Groppe, "Catherine Mowry Lacugna's Contribution to Trinitarian Theology," *Theological Studies* 63, no. 4 (2002).

relationship of humans to God, the radical theological question of how the

divine three are related to one another needs to be framed and answered,

within the limits of faith seeking to understand what has been revealed.

The Christian doctrine of the Trinity, then, derives from its historical

experience of the missions of the *Son* and Spirit. In the New Testament, God's

self-involvement with the world transforms the Christian sense of creation

itself. With reference to the divine Word incarnate in Christ, John's prologue

states, "all things were made through him and without him nothing came to

be" (Jn 1: 3). The hymn in Colossians proclaims, "He is the image of the

unseen God, the first born of all Creation, for in him all things were created,

visible and invisible: thrones, rulers, authorities, powers… All was made

through him and for him. His is before all and all things hold together in

him" (Col 1: 15-17).[419] The Christ-centred nature of all creation is thus

revealed.[420] Yet within that creation, the Spirit is at work. As the whole of

creation "groans" in one great act of giving birth, as Christian believers

themselves "groan" in hope for what is to come, the Holy Spirit intercedes for

us, with inexpressible "groanings" (See Rom 8:18-28).[421]

[419] Elaine H. Pagels, "Exegesis of Genesis 1 in the Gospels of Thomas and John," *Journal of Biblical Literature* 118, no. 3 (1999).

[420] Coffey, *Deus Trinitas*.

[421] Brendan Byrne, *Romans*, Sacra Pagina, vol. 6 (Collegeville, Mn.: The Liturgical Press, 1996).

The Gospel of John, particularly in the Last Supper discourse (Jn 13-17) expresses the relational matrix of Christian theology. For example, the prayer of Jesus in John 17 demonstrates the Evangelist's understanding of the communal dimensions of both divine and human personhood and the interrelation of the one to the other. In this section of the Gospel, believers "overhear" as it were, the dialogue between the Father and the Son. To know Jesus Christ is to know his origin, to know him as the one uniquely sent by the Father (Jn 17: 21-26). Hence, the only true God and Jesus Christ are not juxtaposed as two unrelated truths or entities. In the realm of eternal life, they exist in a single reality of perfect communion: "... as you, Father, are in me and I am in you" (Jn 7: 21). The source and form of eternal life is this original communion. Not only are the Father and the Son dwelling in one another; they are united in an affirmative reciprocity — which the Scriptures express as "glorification": "I have glorified you on earth and finished the work that you gave me to do" (17: 4). The Father glorifies the Son, and the Son glorifies the Father: "Father... give glory to your Son, that the Son may give glory to you" (17: 1).

This reciprocal relationship radically subverts the world of human success, identity and "glory". When persons are thought of as independent self-contained entities, the Other is apprehended as a threat to one's own status. But in this divine instance, there is a mutual affirmation, of one for the other.

This other-related kind of communion existing between the Father and the Son opens out to the whole world of believers (Jn 17: 23). It is so original that it precedes "the foundation of the world" (Jn 17: 24c)—even if that world had been imagined in terms of violence, division and self-seeking against the other (cf. 1 John 2: 15-17). But Jesus Christ, sent as the Word made flesh and as existing before the foundation of such a world, opens the world of the flesh to participation in divine communion. As Jesus completes his mission to glorify the Father on earth (Jn 17: 4), he prays that the original union he enjoys with the Father be manifest as the unifying principle of all time, history and creation: "give me in your presence the same glory I had with you before the world began" (Jn 17: 5). Since Jesus was "in the beginning... with God" (Jn 1: 1-2), since "all things were made through him" (Jn1: 3), and since "whatever has come to be, found life in him, life which for man was also light" (Jn 1: 4), the Son can pray that his glory in the presence of the Father will be revealed as the fundamental reality in which the conflict-ridden world can rediscover itself as: "light that shines in the dark: light that darkness could not overcome" (Jn 1: 5). The relationship between Father and Son becomes the eschatological hope for all persons, both in terms of eternal life, but also that it be manifest in biological life: "The goal of salvation is that the personal life which is realized in God should also be realized on the level of human existence."[422]

---

[422] Zizioulas, *Being as Communion*.

The reality of the Father—Son relationship is lived out in time, for the Word made flesh. The Father, the utterly Other, has been made known by him who is closest to the Father's heart (Jn1: 18). The depth of this relationship is historically revealed in the words and deeds of Jesus throughout the whole course of his mission to the world. This revelation is focused on and directed towards, "the hour" when Jesus is "lifted up". In his Passion and Death Jesus reveals the glory of God; and is glorified through the accomplishment of his mission (Jn11: 4; 12: 23, 32-33; 13: 31-33). In the drama and actions comprising the salvific event, the limitless extent of Jesus' love for the Father, as well as for "his own", is apparent (Jn13: 1, 18-20; 14: 30-31; 17: 1-2). As Zizioulas remarks, "The life of God is eternal because it is personal, that is to say, it is realized as an expression of free communion, as love."[423]

In contrast to the rivalistic conflict of the world, the glory Jesus receives from God derives from complete surrender to the will of the Other, the Father who has sent him and to whose cause he is wholly and unreservedly dedicated. The world is thus challenged by an alternative sense of life and relationships which are contrary to the dominant perspective and is, in some ways, incomprehensible to it due to its defensive holding on to what is its own (Jn12: 43). The true form of eternal life cannot be won from God as a personal

---

[423] Zizioulas, *Being as Communion*.

adornment or possession. It is the gift of the Father alone. Such is the glory that Jesus, the original receiver—in resurrection—that is now given to those who follow Jesus, his disciples: "I have given them the Glory you have given…" (Jn 17: 22a).

The ongoing creative activity of the Father is depicted in terms of a continuing exchange of gifts. There is no holding on to what is one's own–neither in the case of the Father, nor of the Son, since the relations of the Trinity are complete self-giving or self-communication. The nature and structure of the self-communication is such that it does not threaten to overwhelm the Other, does not seek to negate or to absorb but is the ultimate invitation to communication. It is both received and reciprocated, that is, it elicits a returning self-communication which is self-emptying or kenotic. The ecstatic and extrinsic nature of the Trinitarian relations is the reason that in Jesus' prayer the communication of Father to Son can be extended to the disciples. However, for them too the conditions are the same—there can be no holding onto what is one's own. The glory of God is revealed; not in one self-assertion against another in a dynamic of murderous violence and exclusion.[424] The communication of the glory of God makes for unity and inspires self-surrender for the sake of the other: "… that they may be one even as we are one, I in them and you in me, that they may become perfectly one…" (Jn 17:

---

[424] See Zizioulas, *Being as Communion*. Levinas, *Totality and Infinity…*

22b-23a). The form of life originating in the self-giving relationships of the Father and the Son now opens out to be the determining principle of a communion including all in its relational field. As Zizioulas puts it, "Christ becomes the 'principle' and 'end' of all things, the One who not only moves history from within its own unfolding, but who also moves existence even from within the multiplicity of created things, towards the true being which is true life and true communion."[425] In other words, reflection on the relational life of the Trinity has implications for our understanding of persons as such.

The indwelling of Jesus in the disciples and the indwelling of the Father in Jesus replace the externality and limitation of traditional sacred places–"... not on this mountain or in Jerusalem" (Jn 4: 21). Though there is a new intimacy and freedom of access to God, the character of this new existence is that of the grain of wheat falling into the earth so as not to remain alone, but to bear abundant fruit. It is a form of existence which inspires the followers of Jesus "to hate their life" in the world of false glory, in order to keep it for eternal life (Jn 12: 24-25). United with Jesus in the glory of self-giving love, the disciples will be honoured by the Father (Jn 12: 26), and share in the paradigmatic oneness of life and communication existing between the Father and the Son: "... perfection in unity" (Jn 17: 23a).

---

[425] Zizioulas, *Being as Communion*.

Nonetheless, this life of communion is not turned inward. It is not an undifferentiated symbiotic fusion, self-sufficient and exclusive, locked in its own symmetry. Rather the Trinitarian relations look outwards seeking, in love, creativity and unity. For Jesus himself communicates to others, those who follow him, what he has received from the Father. This giving, and self-giving, is directed beyond the present instantiation to an expanding circle of communication. It looks to the world coming to know that the Father has sent his Son, and loved his disciples as he has loved Jesus himself (Jn 17: 23b). The "only true God" has sent his Son, Jesus Christ, into the world to be the source and form of eternal life (17: 3). Deriving from this, the disciples of Jesus have a mission to the world to make manifest the gifts which they have received, but which are destined for all. Both the sending of the Son and the Son's sending of the disciples into the world are the outcome of the Father's unreserved love–for Jesus, for the disciples, and for the world itself. The horizon of Christian understanding of the self and the world is thus deeply relational: the relational world of the divine communion opens out to the world of everyone, in which self-giving love is the determining feature. [426]

How then should the Trinity be understood as paradigmatic in terms of personhood? Zizioulas proposes an answer to this question:

---

[426] For the Johannine insights in this section I am indebted to Anthony J. Kelly and Francis F. Maloney, *Experiencing God in the Gospel of John* (New York: Paulist Press, 2003).

> Who am I? This is a basically human question which no animal can raise. It is thus the question *par excellence* that makes us human and shows personhood to be an exclusive quality of the human being in the animal world… In posing this question, however, man usually receives an answer to *what* he is, not to *who* he is… [427]

Zizioulas further clarifies the answer the question, specifying the ontological character of personhood:

> Personhood is not about qualities or capacities of any kind: biological, social, or moral. Personhood is about hypostasis, i. e. the claim to *uniqueness* in the absolute sense of the term…
>
> Absolute uniqueness is indicated only through an affirmation arising freely from a relationship which constitutes by its unbrokenness the ontological ground of being for each person… [428]

His emphasis on the relational constitution of both divine and human persons is reiterated:

> [I]n the case of God and of man the identity of a person is recognized and posited clearly and unequivocally, but this is only so in and through a *relationship*… [429]

Given the dialogical character of personhood suggested above, it can be argued that persons, whether divine or human, are never capable of full definition. While both faith and philosophy, in their respective ways, can affirm the objectively ontological status of the person, there is the dialogical and relational aspect intrinsic to personal existence that can never be summed

---

[427] Zizioulas, "On Being a Person: Towards an Ontology of Personhood," 44-46

[428] Zizioulas, "On Being a Person: Towards an Ontology of Personhood," 44-46

[429] Zizioulas, "On Being a Person: Towards an Ontology of Personhood," ibid

up.[430] As Walter Kasper notes, "The revelation given in the history of salvation does not therefore explain the mystery of God to us but rather leads us deeper into this mystery; in this history, the mystery of God is revealed to us as mystery."[431] It is clear that, analogically, the situation is the same when dealing with the mystery of the human person.

In the relational perspective of Christian anthropology, just as the Trinity is a communion of distinct Persons so too, analogously, human persons image God in dynamic inter-relationships.[432] When this is recognised, it fundamentally alters the way that personhood is to be understood. The ineffable reality of God as Unity and as Trinity analogically reflects the essential mystery of the human person.[433] The interpersonal and transcendent relationships of the persons of the Trinity suggest a relationship with the world itself, and the character of the relationships intended for the world of persons.[434]

The self-communication of the Father takes on a particular significance in terms of Christology. This chapter now moves its focus from the inter-

---

[430] Dixon, "Toward a Trinitarian Anthropology."

[431]Walter Kasper, *The God of Jesus Christ*, trans. M. J. O'Connell (New York: Crossroad, 1989).

[432] McFadyen, *The Call to Personhood...*

[433] Kasper, *The God of Jesus Christ*.

[434] Kelly and Maloney, *Experiencing God*

relational Trinitarian perspective to the person of Jesus Christ, specifically his mission.

3. The Mission of Jesus

The Christian belief that Jesus is the unique self-revelation, *the* self-communication of God distinguishes Christianity from the other monotheistic religions of Judaism and Islam. As Larry Hurtado demonstrates in his extensive study, *Lord Jesus Christ, Devotion to Jesus in Earliest Christianity*, this sense of the uniqueness of Christ was present from the earliest periods of the Christian faith.[435] This perception gradually achieved doctrinal precision, especially in the Councils of Nicaea (325 CE), Ephesus (431 CE) and Chalcedon (451 CE). Christ as the Son of God is confessed as "one in being" (*homoousios*) with the Father, and, with Chalcedon, truly divine and truly human, both the divine and the human nature hypostatically united in the one person, Jesus Christ.[436] The incarnation of God in the world not only involved a sense of divine descent but also the ascent of humanity into the realm of the divine. These two movements – descent and ascent – are inscribed into the one mystery of Christ—with each allowing for its own Christological emphases, but within a single intrinsic soteriological dynamic.

---

[435] Larry Hurtado, *Lord Jesus Christ, Devotion to Jesus in Earliest Christianity* (Grand Rapids, Mi.: W. B. Eerdmans, 2003).

[436] Monika Hellwig, "Christology," in *A New Handbook of Christian Theology*, ed. D. W. Musser and J. L. Price, (Cambridge: The Lutterworth Press, 1992), 85

In other words, the usual description of ascending and descending Christologies are, ultimately, a single dynamic event designed to achieve the salvation of humanity. The Kingdom proclaimed by Jesus promises salvation for all, but it operates within cultures and social structures, and is oriented toward fulfilment in God.

Fundamentally, Jesus' mission is one of liberation. The concepts of liberation and salvation are not abstract but very concrete. They concern the least and the most vulnerable in society, scripturally described as the *anawim*. This term literally means "the poor", but in the language of the prophets Zephaniah (Zeph 2: 3; 3: 12), Jeremiah (Jer 15: 10 – 21) and Isaiah (Isa 51: 21 – 23), it developed an explicit theological sense referring to those who are humble before the Lord and who have no one else to turn to than God.[437] Their situation of poverty, oppression and need means that they are open to the promptings of the Spirit to reach out to fellow-sufferers.[438]

In the Gospel, Jesus identifies with the poor and the vulnerable, as in the instances of the woman caught in adultery (Jn 8: 1 – 10), Zaccheus (Lk 19: 1-10), and the woman who anoints him for his death (Mk 14: 3 – 9). In these

---

[437] Brown, Fitzmyer, and Murphy, eds., *Jerome Biblical Commentary*, see 18:10 and 22:48. As an aside, it is clear that this heritage has informed Levinas' thinking about the role of the stranger, the other and the vulnerable Levinas, *Totality and Infinity…* Levinas, *Of God Who…*

[438] Alfonso L Trujillo, "Liberation, a Permanent Value," in *Liberation Theology: A Documentary History*, ed. Alfred T. Hennelly, (Maryknoll, NY: Orbis Books, 1990), 167-168

encounters, the vulnerable other is touched and transformed. Despite the scandal that this occasions, Jesus declares that his mission is to "to seek and to save the lost" (Lk 19: 10).

The Gospel accounts usually present Jesus in a one-to-one encounter with the other. A dialogue takes place, and the outcome of this exchange is a call to radical conversion.[439] Along with the examples given above, other instances are the call of Matthew (Mt 9: 9 - 12) and the Rich Young Man (Mt 19: 16 - 30), the post-Resurrection appearances to Mary Magdalene (Jn 20: 10 - 16) and to Peter (Jn 21: 15 - 19). Such examples are of paradigmatic significance for Christian life in its concreteness and drama.[440]

The focus of Christian faith is Jesus Christ, in his person and mission. In the life, death and resurrection of Jesus, his followers are called to be united with him, in his relation to the Father and beyond to all to whom the saving will of God extends. Jesus is risen, as the form and source of new existence, characterised by his self-giving solidarity with all humanity. This is expressed in phrases such as "for the many" (Mk 14:24); "for everyone" (Hb 2:9); "for all" (Rom 8:32; 2 Cor 5:14ff; 1 Tim 2:6); "for the people" (Jn 11:50;

---

[439] M. Jamie Ferreira, ""Total Altruism" In Levinas's "Ethics of the Welcome"," *Journal of Religious Ethics* 29, no. 3 (2001).

[440] William C Spohn, "Notes on Moral Theology - Parable and Narrative in Christian Ethics," *Theological Studies* 49, no. 1 (1990).

18:14); "for us sinners" (Rom 5:8), "for me" (Gal 2:20); "for you" (Lk 22:19f; 1 Cor 11:24); "for the Church" (Eph 5:25); "for the sheep" (Jn 10:11-15).[441] Indeed, so expansive is his relational existence that it extends to the whole of creation, as I observed above in regard to the Prologue of John's Gospel and the great Christological hymns of Ephesians and Colossians: everything stands in him who is the first born of all creation (Col 1:16), the first born from the dead (Col 1:18): "All things were made through him and without him nothing came to be" (Jn 1:3).

John Macmurray has noted that the Gospels present a perspective which is grounded in human experience, yet is antithetical to ethico-legal prescription and focused on restoring broken relationships.[442] Jesus' consistent response in the Gospel encounters is to offer reconciliation. Likewise, in a more Levinasian sense, Jesus' commitment to the Other is not formless. It reaches out to the most vulnerable in the community, to serve them in their need.[443] Within each encounter of Jesus with the other there is an offer of a different way of life. It calls to a relationship which, if taken up, can bring about

---

[441] See, H. von Balthasar, *The Glory of the Lord, Volume 7: Theology and the New Covenant*, trans. Brian McNeil (Edinburgh: T & T Clark, 1989).

[442] Macmurray, "Prolegomena..." 192-193

[443] Ronald A. Carson, "Focusing on the Human Scene: Thoughts on Problematic Theology," in *Notes from a Narrow Ridge: Religion and Bioethics*, ed. D. S. Davis and L. Zoloth, (Hagerstown, Maryland: University Publishing Group, 1999), 54

freedom and hope. The individual instances referred to above are of universal significance.

Take, for instance, the following examples of the inclusive significance of Jesus' activity. Chapter four of the Gospel of Luke records Jesus' return to Nazareth after initiating his mission in other parts of Galilee. In the context of synagogue worship, he takes up the scroll of the prophet Isaiah and reads:

> The Spirit of the Lord is upon me. He has anointed me to bring good news to the poor, to proclaim liberty to captives and to give new sight to the blind; to free the oppressed and announce the Lord's year of mercy. (Lk 4: 18 – 19)

Following the reading, he comments: "Today these prophetic words come true even as you listen" (Lk 4, 21). Here he explains his mission in the light of the prophecy in Isaiah, in concrete terms of hope for the poor, the liberation of captives, sight for the blind, and freedom for the for the oppressed. Immediately after this proclamation of his mission, representatives of these marginalised groups receive forgiveness and healing: demoniacs (Lk 4: 33-36, 41), the sick (Lk 4: 38-39, 40), lepers (Lk 5: 12-14), the paralytic (Lk 5: 17-24). The Word proclaimed is enacted in tangible form among those most in need.

The account of the anointing at Bethany in the Gospel of Mark (Mk 14: 3 – 9) indicates a measure of excess in serving Christ as his members. The woman who anoints Jesus is praised for her love. The precious ointment she uses is

not used cautiously; the jar is broken; none can be salvaged. She is criticised

by those gathered for the meal since the cost of the ointment could be used to

alleviate the suffering of the poor. At that point in the narrative, Jesus speaks,

defending the woman and praising her action. Love involves the gift of self

and demands extravagance, with nothing withheld. This kind of service to

others is even more strongly endorsed in the account of the washing of the

feet in John 13: 2-17. Jesus gives the example of practical, even menial,

service: this is the criterion for kinship with him and the hallmark of his

followers.

In Matthew's Gospel, there is parable of the Last Judgement (Mt 25: 31 - 46).

Salvation is ensured through care for those who are most vulnerable: the

hungry, thirsty, homeless, naked, sick, and imprisoned. While faith is a

relationship with Jesus, it is to be expressed through service of the poor and

the least with whom he identifies (Mt 25: 40, 46). Moltmann notes that this

Parable of the Last Judgement is not calling for Christians to become

professional carers, social workers, health care providers and so forth, but is a

summons to the followers of Christ to make the needs of others central to

their relationship with him.[444] Gustavo Gutiérrez sees this parable as stressing

the priority of praxis over knowing in the encounter with the God of Jesus

---

[444] Jurgen Moltmann, *Experiences in Theology*, trans. Margaret Kohl (London: SCM Press, 2000).

Christic.[445]   This parable is of paradigmatic significance in that faith in Christ

must be worked out on an interpersonal level, in the one-to-one relationships

in which the suffering other is the determining factor.[446]   Judgment turns on

how this particular and suffering other is being helped or ignored.

Shuman, with the context of health care in mind, writes,

> when Christians find themselves in the presence of the sick and dying
> and charged with their care... they take it upon themselves to *make
> space* in their lives for those persons as if they were making a space for
> Christ himself... Because God cares for and intervenes on behalf of the
> sick in a wide variety of ways, Christians must care and intervene as
> well.[447]

Through Jesus, God is unambiguously identified with the most vulnerable—

the victims who are constantly the losers in social interactions.[448]   Hence, care

for the vulnerable becomes the criterion for an authentic relationship with

God. As the First Letter of John and the Letter of James make clear, it is not

possible to have a relationship with an unseen God without a relationship

with those God's own, the all-too visible brother or sister in need (1 Jn 4: 20;

James 2: 1-5 and 5:1-5).

---

[445] Gustavo Gutiérrez, *A Theology of Liberation* (London: SCM Press, 1973).

[446] Jürgen Moltmann, *The Church in the Power of the Spirit* (London: SCM Press, 1993).

[447] Shuman, *The Body of Compassion*.

[448] N. H. Gregersen, "Risk and Religion: Toward a Theology of Risk Taking," *Zygon* 38, no. 2 (2003).

Behind each individual parable Jesus delivers is the basic parable of his life and mission. He embodies, in his life, death and resurrection, the Reign of God that he proclaimed. It is important to note here the relevance of the two key Christological doctrines, namely, the Incarnation and the Resurrection in the Trinitarian context elaborated in the previous section of this chapter. The Incarnation is not a single event, but looks to its fullest realisation in the Resurrection. But through the Resurrection the universal significance of Christ is disclosed,[449] and empowers Christian witness to the saving activity of God so that God will be "all in all" (1 Cor 15: 27). In the light of the Resurrection, the full dimensions of the Incarnation as the self-revelation of God are made known. For the "Word made flesh" reshapes our notions of God and what it means to be human, for all that is human has been assumed and transformed in Christ.[450] Nothing of humanity is lost in being joined to the divine.[451] Through the Incarnation, God has entered the world and been subjected to its risks and limitations.[452] Yet, through the Resurrection, God glorifies Jesus who gave himself for the life of the world—in such a way that he becomes the source and exemplar of self-giving love for all who follow

---

[449] Christopher B. Kaiser, "The Incarnation and the Trinity: Two Doctrines Rooted in the Offices of Christ," *Greek Orthodox Theological Review* 43, no. 1 - 4 (1998).

[450] Sider, "Image, Likeness, and the Ethics of Memory."

[451] John of Damascus, *On the Divine Images: Three Apologies against Those Who Attack the Divine Images*, trans. David Anderson (Crestwood, NY: St Vladimir's Seminary Press, 1980).

[452] Gregersen, "Risk and Religion.."

him. Such love is the form of true life, divinely vindicated in the resurrection of the Crucified. [453]

The post-Resurrection appearances of Jesus to his disciples[454] and the accounts of the empty tomb,[455] express the experience of the risen Christ in the early communities. James Alison draws attention to the significance, in the post-Resurrection narratives, of Jesus' "death-marked" body (Lk 24: 37 - 40; Jn 20: 20, 27).[456] He is the same person who died, but is now alive. Jesus has not only returned to the Father, but is for all the form and source of life beyond the powers of violence and death. He is the first born from the dead (Acts 26: 23; 1Cor 15: 20; Col 1: 18), to become the source and anticipation of an eschatological transformation of humanity. In the Incarnation, God assumes human nature; in the Resurrection, there is the transformation of that human nature before God. [457]

In the Resurrection, the work of Creation is brought to fulfilment. This must be taken as the starting point for Christian anthropology. For in the light of the Resurrection, our understanding of what it is to be persons is altered: each

---

[453] Zizioulas, *Being as Communion*.

[454] Mt 28: 9, 16 -20; Mk 16: 9 - 20; Lk 24: 13 - 53; Jn 20: 10 - 21, 25.

[455] Jn 20: 1 - 9; also Mt 28: 1 - 9; Mk 16: 1 - 7; Lk 24: 1 – 8.

[456] Alison, *The Joy of Being Wrong: Original Sin through Easter Eyes*.

[457] Walter Kasper, *Jesus the Christ*, trans. V. Green (Tundbridge Wells, Kent: Burns & Oates, 1976).

one is destined to participate in the divine communion of love and eternal life, within a transformed creation. In his earthly ministry, Jesus had gathered a community about him to share in his life and mission of healing and proclaiming the Kingdom (see Lk 9: 1-6 and 10: 1-16; Mt 10: 5-14; Mk 6: 7-13). Following his Resurrection, this community of followers is commanded to make disciples of all nations, baptising them into the communal life of God, in the name of the Father, the Son and the Holy Spirit (Mt 28: 19-20).

The Incarnation and Resurrection are therefore expansively relational in their signficance. In the Incarnation, God's salvific will is revealed in Jesus as the "Word made flesh" dwelling amongst us, and offering eternal life to all. The Resurrection anticipates the fulfilment of creation, when God will be "all in all" (1 Cor 15:28).

4. A Christian Relational Worldview

Christian Anthropology is an interpretation of humanity in the light of God's self-revelation in Jesus Christ. Christian life does not primarily consist in a set of doctrines or beliefs, but in following Jesus.[458] Action has priority over reflection, and ethical behaviour has precedence over doctrinal orthodoxy. Christian theological ethics, especially Catholic moral theology, has been

---

[458] M. J. Scanlon, "Christian Anthropology and Ethics," in *Ethical Viewpoints in the Catholic Tradition*, ed. Judith A. Dwyer, (Washington, DC: Georgetown University Press, 1999), 27

articulated in the past by an understanding of the world, society and persons in philosophical terms deriving from a metaphysics of substance and the ontological and moral order of the universe deriving from natural law. [459] The nature of the human person was taken as the norm for the moral goodness or badness of particular action intending an end or means in accord with, or contrary to, the laws of nature and reason. [460] A relational theology of personhood broadens the context, especially by explicating the communitarian dimensions of Christian life and conduct.

It must be emphasised that the concept of communion is larger than an ensemble of individual relationships; it also includes the quality of the communication that is occurring in the field of interpersonal relationality in question. For communion recognises and affirms the persons involved, as each unique Other affects the self-identity of all. [461] In this, a *telos* or ultimate goal is envisaged, deriving from the divine intention to draw all into unity through a common participation in the life of the Trinity.

---

[459] August Lehmkuhl, "Moral Theology," in *The Historical Development of Fundamental Moral Theology in the United States*, ed. Charles E. Curran and R. A. McCormick, Readings in Moral Theology, 11, (New York: Paulist Press, 1999)

[460] Kevin T. Kelly, *New Directions in Moral Theology: The Challenge of Being Human*, Geoffrey Chapman Pastoral Studies Series (New York, N.Y: G. Chapman, 1992).

[461] Zizioulas, "On Being a Person: Towards an Ontology of Personhood," 45

In addition, the concept of communion goes beyond that of society and the interactions that make it up. For being in communion transcends the social situation of rivalry, violence and fear, to find its expression in active and loving relations between the persons.[462] Macmurray's metaphor of mother-child relations, discussed earlier,[463] is not reducible to a biological relationship. I agree with him in seeing this relation as a primary metaphor for all interpersonal relations. It is a relation characterised by personal mutuality, linking the self and the Other in the nurture of a shared life.[464] The mutual transformation enacted in the relation is more fully expressed in the relationship between lovers. In such an encounter, there is a notable intensity which moves the self to embrace the Other, in a communication that transforms both parties.[465] The self is newly experienced as being both for, and from, the beloved Other.[466] Communion, understood in this way, does not imply the loss of self, nor absorption in the other, but the realisation of the true self through the affirmation of the unique other.[467] In this, both the self and the Other are subjects of communication.[468] What is at stake is not some

---

[462] Macmurray, *Persons in Relation*.

[463] Macmurray, *Persons in Relation*.

[464] Frank G. Kirkpatrick, *The Ethics of Community*, Blackwell Religious Ethics (Malden, Mass.: Blackwell, 2001).

[465] Charles Marsh, "In Defense of a Self: The Theological Search for a Postmodern Identity," *Scottish Journal of Theology* 55, no. 3 (2002).

[466] Zizioulas, *Being as Communion*.

[467] Zizioulas, "On Being a Person: Towards an Ontology of Personhood," 40-41

[468] L. Zagzebski, "The Uniqueness of Persons," *Journal of Religious Ethics* 29, no. 3 (2001).

base level of contingent relationality,[469] but the progressive realisation of a goal. In this regard, this kind of experience of mutuality and communion suggests analogies, not only for communication within the Christian community as it celebrates the Eucharist, for example, but for an understanding of the forms of community that derive from the Trinitarian community itself.[470]

In short, this emphasis on community and relationship does not undermine the unique reality of the persons involved. It is not a matter of promoting an amorphous collective, but of recognising both the ontological basis of personhood and the experiential importance of relationships in the psychological constitution of persons. Entering into a relationship with the other neither dissolves nor constitutes the unique reality of the "someone" who the person is. On other hand, the field of communion, interaction and interpersonal relationships affirms and enhances the living identity of the persons involved.   Hence, I argue that an exclusively metaphysical understanding of persons is restrictive, by accenting an ontological minimum, irrespective of any stage of development. Likewise, functionalist views of personhood are inadequate in that they limit themselves to empirically demonstrated abilities/capacities, e.g., reason, and so fail to account for

---

[469] Russell, "Reconsidering Relational Anthropology: A Critical Assessment of John Zizioulas's Theological Anthropology."

[470] Zizioulas, *Being as Communion*.

continuity of existence at every stage of personal development. The notion of relational personhood I have articulated represents a third and more comprehensive way of thinking about personhood. By combining the ontological and the psychological, it overcomes the limitations of metaphysical individualism and empirical functionalism. By stressing the relationality inherent in personhood, it is possible to understand the importance of community and social relations for the development of personal existence.[471] The person is "someone", yet the potential to realise this uniqueness lies in actuating an endless field of relationships. Modern paediatrics has demonstrated the way that even very early embryos respond to the world around them and develop in particular ways in response to changes in their environment.[472] Likewise, Jean Vanier's work with the profoundly disabled is based on the centrality of a relational framework in his remarkable ministry.[473]

The person is always indefinable.[474] The path to personhood is never finished. This is crucial when considering the situations of children, the infirm, the

---

[471] Ralph Del Colle, "Person and Being in John Zizioulas' Trinitarian Theology: Conversations with Thomas Torrance and Thomas Aquinas," *Scottish Journal of Theology* 54, no. 1 (2001).

[472] T. B. Brazelton, *Touchpoints* (Sydney: Doubleday, 1993). In the opening chapter Brazelton makes mention of examples relating to sound and light stimulation and the responses of embryos.

[473] Jean Vanier, *Becoming Human* (London: Darton, Longman and Todd, 1999). A feature of Vanier's work which is left implicit is that there is a transformation that occurs in those who take up his ministry and work with the disabled that is in no way less remarkable or less dramatic. Both depend on the relational encounter.

[474] Zagzebski, "The Uniqueness of Persons."

disabled and the unborn. If "personhood" is constructed as an ideal of some kind, say, a fully functioning rational adult, then all who fall short of the ideal must have diminished moral status. If, on the other hand, there is recognition that persons are beings in the process of becoming, then those who do not meet the usual ideal are not simply excluded or thought to have less moral status. Theologically speaking, I have argued that those who do not meet the social ideal have a special role in interpersonal relations, since they are among the most vulnerable. In them, we meet Christ, but also through them all are called forth into a deeper understanding of how we belong together in a personal world, subject to limitations, yet with the capacity for self-transcendence. [475]

In terms of health care, conceptualising persons as relational beings has a dramatic impact on the context of health care. The emphasis is placed, not on a pathological case, but on the person. Admittedly, this entails risks and its own kind of stress, once health care professionals recognise themselves and the suffering other in an interpersonal, relational mode. When persons so interact, a transformation of all parties can occur, even if, medically speaking, a cure ceases to be possible.

---

[475] H. Tristram Engelhardt, "Whose Religion? Which Moral Theology? Reconsidering the Possibility of a Christian Bioethics in Order to Gauge the Place of Religious Studies in Bioethics," in *Notes from a Narrow Ridge: Religion and Bioethics*, ed. D. S. Davis and L. Zoloth, (Hagerstown, Maryland: University Publishing Group, 1999), 126

5. Conclusion

First, a word of summary: at the beginning of this chapter, I noted once more the paradigmatic significance of relationality in our contemporary sense of reality, in, say, the sphere of atomic physics, ecology or social solidarity. From there turned to address the explicitly theological questions that are the concern of this chapter. This meant referring to the relational dimensions implied in the biblical accounts of creation and God's progressive self-revelation to Israel. After emphasising some of the main points the Old Testament account, I proceeded to explicitly New Testament and the doctrinal expressions resulting from it, above all, the Trinity and the mystery and mission of Christ. In reference to Zizioulas and others, I sought to explicitate the relational character of the Trinity as a communion of persons, and its effect on our understanding of personal existence on the human level. By moving on to a consideration of Christ, we sought to bring out the relational character of his identity and mission, and how, by being called into union with him—in his unique relationship to the Father, and to all in his redemptive mission, such relationality formed Christian self-awareness. The communion that God is was at the foundation of the formation of the Christian community in its life and Christ-derived mission. The chapter concluded with a brief remark on the Christian world view, further clarifying

the meaning of communion and the field of relationships implied in it leads to a profound appreciation of the human being as a "relational person".

Secondly, for this exercise of practical theology in the domain of health care, conclusions follow. In the first place, the field of interactions which constitute health care is of necessity a field of inter-relating persons on the most intimate and vulnerable level. In this regard, it provokes an exploration of ultimate significance of such a praxis of inter-relational persons in which the limit-situations of suffering and death, powerlessness and diminishment meet with the responsibilities of care, the possibilities of healing, the meaning of life and the form and destiny of our common humanity. By appealing to biblical accounts of the image of God, and the reality of God revealed as a trinitarian communion, and in the life and mission of Christ in his concern for the poor, the suffering and the defenceless, I, in effect, open an ultimately gracious space in which the practice of health care is both inspired and challenged. There is a depth-dimension to the patient-carer interactions that calls all involved to the profound significance of what is taking place, in oneself, in the other, and in the relationship between the two. Philosophical considerations of persons-in-relation are fittingly illuminated by what faith perceives of divine persons-in-relation and the relational existence and mission of Jesus himself.

In the second place, there is a double movement to be noted. The obvious first movement lies in the task of practical theology to bring down to practice the great doctrinal and mystical expressions of theology, in this case within the area of health care. To this degree, it means arguing, with due critical respect, that the ultimate vision of Christian faith makes, or should make, a difference in how we treat one another, and care for each other in a shared responsibility—especially when, on the one side the other is suffering, and on the other side, I may be in a special position of expertise, possessing the power that this implies. With this in mind, I have frequently insisted that the suffering other demands to be regarded as more than a pathological case, but as person constituted as the centre of relationships—with God, and with others, be they carers, physicians, the "system" itself, or the wider community of family, friends and colleagues. For, in an ultimately theological light, each one is related to all, all are responsible for each one, and in the fate of each one, the existential vulnerability of everyone is disclosed. In this sense, health care is lifted beyond a professional or functional context, and revealed in its most profound relational significance.

But there is a second movement involved in the task of practical theology. For it is not only a matter of making theology practical in a given area, but of showing how a given praxis is theological. The first movement necessarily implies a certain criticism of a given form of human conduct, by relating it

back to a theological perspective, and exposing any shortcomings in this regard. But the second movement consists in registering a challenge to theology itself. For a given practice, in this case, that of health care, is not only a subject of theological criticism, but a source of illumination for the more generalised and theoretical reflections of theology. In other words, the witness of carer and cared, in their self-giving and often compassionate service on the one hand, or, on the other, in the courage and hope of the sufferer, despite human limitations, "embarrass" theology into taking the experience of health care more seriously. In it is to be found a testimony what theology is ever attempting to formulate, namely, hope at the limits of life, and the imperative, on the individual and systemic level, of realising a compassionate involvement with this suffering other in the name of God, even if in this case, God may be without a name. This is to say, the concern of practical theology is to assist in making the praxis of health care more open to its ultimate and theological dimensions—but also to make theology more "healthy", in its appreciation of the witness involved in the experience of the suffering and those who care for them. In its recognition of this double movement, a practical theology of health care extends the possibility of a genuinely interdisciplinary or multidisciplinary approach in which theology, medical science, nursing, and chaplaincy play their respective roles in the care of the suffering other.

Given the urgent imperatives of health care, theological considerations can appear too abstract and mystical. For that reason, in the following chapter I return to a considerations of the specific cases I have already referred to, and approach them in the light of the theological and philosophical considerations presented in this and the previous chapter.

CHAPTER SIX: THE PRAXIS OF HEALTH CARE:

RELATIONAL PERSONHOOD AND CRITICAL CASES

This chapter addresses two kinds of questions in the light of the philosophical and theological model of relational personhood outlined in previous two chapters. It accomplishes this through analysis of concrete scenarios in health care. Some of these cases have been controversial, others are barely known; they come from different countries and arise in different circumstances. What unifies them, for my purposes, is that they demonstrate the need for relational personhood to be at the heart of health care.

The first type of questions is critical in intent, and deconstructive in style. In its most general formulation, this kind of critique asks how philosophical and theological conceptions of relational personhood expose the shortcomings of current health care practice in the cases under consideration. It is specified in the following:

1. How, for instance, is a diminished or isolated sense of self in both the patients and in those professionally caring for them disclosed in this or that particular case?

2. How are some values being overlooked so that the systemic practice of health care is diminished in its authentic motivation, and narrowed or skewed as a field of persons-in-relation?

3. How is the very concept of health being compromised in the kind of care active in a particular case?

The second kind of questions has a more positive and constructive goal, in the hope that the theory and practice of health care might derive a more complete vision and a deeper kind of inspiration by aligning itself more fully with the philosophical and theological anthropology expressed in the relational understanding of persons I have been commending. It can be framed by asking the following:

1. How, for instance, does a relational understanding of personhood make a difference in the patient's sense of self, especially to those who are more powerless?

2. How does it affect the carer's responsibility for the patient?

3. How does it affect the system of health care itself, the values that motivate it, and the understanding of the whole interactive field in which health care operates?

4. How does all this suggest a more comprehensive or holistic approach to health and the healing related to it?

Through an examination of a number of particular cases I propose to address

the force of these questions. However, since the cases have similarities and a

number of differences I have not artificially structured the chapter around

these questions as though they formed a grid to be imposed on each

particular case. They suggest, nonetheless, a hermeneutical perspective in the

analysis of these cases can be utilized, in the light of what has already been

outlined in the previous chapters. Consequently, in this chapter I aim to

underscore the necessity of the philosophical and theological positions that I

have elaborated in this exercise in practical theology. Accordingly, I present

the content of this chapter under the following five headings:

1. Critical Issues in Health Care

2. A Philosophy of Relational Personhood

3. Theological Implications

4. A Practical Theology of Health Care

5. Relational Personhood and Controversial Cases

1. Critical Issues in Health Care

As noted earlier, George Khushf, addressing the problem of evil, illness and

the structures of healing, argues that illness is deeply revelatory. It discloses

our radical dependency on the Other. He tellingly remarks:

> Through illness individuals become aware of their insufficiency and
> they turn to others for help. However, most people do not appreciate

the full revelatory function of illness – that it discloses a deep brokenness that is there already, and not brought about for the first time by the sickness. Instead, people think of the dis-integration of self and the alienation from community and God as a consequence of sickness, rather than as something unveiled in and by sickness. [476]

The cases examined in this chapter are examples of Khushf's point. Gracie and Rosie, Nancy Crick and the other cases presented in the course of this chapter reveal humanity's intrinsic vulnerability and the need for a relational perspective to add a dimension to health care practice.

A starting point for relational perspectives in health care is simply to take account of patients' life-orientation and the mythic conception of life's meaning and purpose. Joel Shuman argues that where no account of this is taken the medical outcomes are adversely affected. [477] His reference to his own grandfather's experience is instructive. The old man, after being diagnosed with a terminal condition, was removed from the isolated rural community where he had spent his entire life. He was taken several hundred miles away to a major medical institution for palliative treatment, with unfortunate results. Shuman argues that the moral harm done to his grandfather resulted, not from any deliberate intent or medical incompetence, but from a generalised failure of the health care system—what he describes as

---

[476] Khushf, "Illness, the Problem of Evil..." 34

[477] Shuman, *The Body of Compassion*.

a "fundamental inability to know and to care for its patients."[478] The patient

in this case had been encouraged to believe that the "world of the physicians",

that is, the clinical setting, was worthy of trust in terms of his care and

treatment; this trust was then betrayed:

> That trust had no real basis in a commonly held, deliberatively arrived
> at vision of what it might have meant for my grandfather to live well
> for the remainder of his life…[479]

Those caring for Shuman's grandfather focused on what they could do for
their patient, instead of what their patient needed:

> …for though my grandfather's physicians knew as much as there was
> to know about his disease, they seem to have been totally oblivious–
> and in their minds, perhaps not unjustifiably–to the things that really
> made him the person he was – a simple man of remarkable character,
> with deep attachments to work and land and family, who had lived an
> exceptional life and who deserved a death consistent with that life.[480]

The irrationality of this kind of case is borne out by the continued treatment

of the man's condition even after it was realised that the treatment could not

effect a cure. Here, health care exhibits its own kind of pathology when it is

blind to the "mythic" orientation of the person's life.

The revelatory power that Khushf describes is not limited in focus to patients,

it also casts light on the underlying assumptions of health professionals and

flaws in health systems. Another case illustrates this: Armando Dimas, a

---

[478] Shuman, *The Body of Compassion*.

[479] Shuman, *The Body of Compassion*.

[480] Shuman, *The Body of Compassion*.

young Hispanic male was shot during an attempted robbery. He was admitted to a major private hospital because of his poor prognosis and the expectation of his being a desirable organ donor. But Dimas survived against the odds, despite becoming a severe quadriplegic as a result of the gun-shot injury. Staff at the hospital proposed removing life-support since what they understood as a desirable quality of life was incompatible with such a dependent state. Yet neither Dimas, nor his family, supported this course of action. Dimas eventually managed to communicate, through eye-blink answers to questions, that in many ways his life following the injury was more secure and an improvement on the situation prior to the injury. Being cared for around the clock without needing to work, and with access to television, were for him significant improvements. With frequent visits from family, Dimas was largely content with his new situation.[481]

The hospital staff caring—in a medically exemplary fashion—for Armando simply considered his physical prognosis and the limits this would impose in their own circumstances. They did not recognise the relative security which his new—diminished—health status offered in the context of Armando's life. The case also reveals the systemic objectification that can occur in health care. Armando Dimas was given excellent care following his injury only because he was viewed as a commodity—a fertile site for organ harvesting. While he can

---

[481] Lisa Belkin, *First, Do No Harm* (London: Hodder and Stoughton, 1993).

be grateful that this was a crucial decision made at the time, it provokes significant questions about the motivation for treatment in some cases, in some systems. Only when patients are pathologised and objectified can this happen. An alternative, which places health and well-being at the centre of the clinical encounter, is to recognise the patient as person.

Such systemic failures are commonly described with reference to neonatal medicine. As is indicated in the case of premature neonates Jake and Taylor Poarch, which is also instructive in terms of the importance of the symbols, beliefs and narratives which shape our lives.[482] The Poarch twins were born after twenty-five weeks gestation: Taylor, the girl, weighed 680 grams and her brother Jake 878 grams. Jake died several hours after birth, but Taylor lived on for over two months. During the course of Taylor's treatment, the conflicting agendas and beliefs of the attending physicians and her parents were teased out. Many of the health care professionals charged with Taylor's care were totally focused on ensuring that she lived for as long as possible—the initial concern of her parents as well. The attending obstetrician had asked the parents (Carey and Fran), what should be done in the event that one or both twins were born alive: "Do everything", Carey said, and Fran

---

[482] Belkin, *First, Do No Harm.*

nodded her agreement. "Do everything possible to save my kids. Do more than what's possible".[483]

Over the ensuing two months Taylor's parents became convinced that the procedures being used to sustain her life were not ultimately beneficial, for she would inevitably die, and that treatment was burdensome to her. This view was supported by some health care professionals and strenuously resisted by others. The attending neonatologist commented at the Institutional Ethics Committee meeting considering the case, "I don't like giving up."[484]

The parents' decision to request discontinuance of life-support for their daughter was inspired by their faith. They reported asking themselves, "Did God mean for her to live this way?"[485] Their religious idiom in this instance did not come from a fatalistic view of the world. They had talked their views through with a number of health care professionals, including a social worker. The social worker's notes indicate that their request was not the outcome of either a swift or easy decision, but based on a carefully considered prognosis of the quantity and quality of their daughter's life. Moreover, the decision was supported by the parents' families, in the belief that Taylor

---

[483] Belkin, *First, Do No Harm.*

[484] Belkin, *First, Do No Harm.*

[485] Belkin, *First, Do No Harm.*

would join her brother in heaven.[486] With their decision made, Fran Poarch

went home to get her child's baptismal gown and some of the other clothes

Taylor had never worn.[487] Far from being a morally insensitive abandonment

of a child deemed not worth saving, this was a deeply moral choice for what

the parents' believed was the best for their child. This case is a practical

demonstration both of the relevance of a faith-perspective on the whole of life

and its destiny, and of the role of theological language in interpreting the

basic symbols and mythic orientation directing moral decisions, particularly

at critical junctures in human experience and responsibility.

A second neonatal case that of Baby Andrew Stinson who was born four

months prematurely, reinforces the difficulties experienced by Carey and

Fran Poarch. Baby Andrew's complications included osteopenia (severe

fragility of the bones) due to prematurity. One of Andrew's radiologists

commented in case notes that the only time he had seen more fractures in a

person was someone who had been in an airplane crash. In Andrew's case,

he had never left intensive care.[488] Peggy, Andrew's mother, describes the

experience of premature birth and neonatal intensive care as though "the

baby had come out of my body onto a conveyor belt which moved slowly but

---

[486] Belkin, *First, Do No Harm.*

[487] Belkin, *First, Do No Harm.*

[488] R. Stinson and P. Stinson, *The Long Dying of Baby Andrew* (Boston: Little, Brown, 1983).

inexorably through an unlighted tunnel with no apparent end."[489]   In this case, however, the family's sense of the situation was of little consequence for the medical authorities involved.   Peggy Stinson, on challenging her son's treatment, was rebuffed: "Mrs Stinson, I wouldn't presume to tell my auto-mechanic how to fix my car."[490]   The Stinsons recognised that they and the neonatal team were operating in different worlds, with different sets of expectations, hopes and dreams.   Where they were focused on the needs of their child in the context of their own sense of meaning and the values structuring their lives, the neonatologists worked on the assumption that a "baby must be saved at all costs: anything less is illegal and immoral."[491]   At a deeper level there is also the role of the neonatal team as frontier scientists working to push back the boundaries of human limitation, to develop new skills to save more lives and enhance the health of those saved.   It may be that this was a powerful motivation for the team at the Manchester Hospital caring for the Attard twins since they had not previously performed a separation of conjoined twins.   Circumstances such as these point to the need for a philosophical framework within which to situate the scenarios and which establishes the parameters for reasoning which will be applied.

---

[489] Stinson and Stinson, *The Long Dying...*

[490] Stinson and Stinson, *The Long Dying...*

[491] T. J. Connolly, "Should This Baby Live?," in *Living the Gospel Today*, ed. Margaret M. Press and Neil Brown, Faith and Culture, 13, (Manly, NSW: Catholic Institute of Sydney, 1987), 77-78

2. Philosophy of Relational Personhood

Levinas' ethics give no easy solution to the case of the Attard twins, or Baby Andrew and the Poarch twins for that matter. But in his privileging of the Other, his style of thought, as I would apply it, would question the symmetries implicit in an "I – Thou" relationship. It suggests giving much greater weight to the needs of Rosie which were entirely discounted by the judges and the physicians involved, once it was deemed that she could have no independent life. It would ask a more communal and relationally focused set of questions in relation to Armando Dimas, the Poarch twins and Andrew Stinson. In other words, the priority of an "I" or the ego was assumed over the needs of the vulnerable Other, who is, in effect, banished to the margins, as a "non-person".[492] The conjoined Attard twins give a particular poignancy to Levinas' call to attend to the face of the other. Gracie could not but be elementally aware of the essential relatedness to the Other, in this case, Rosie—whose very survival was at risk. In a Levinasian perspective, this is an acute example of the situation that all persons are in--we are radically dependent on the Other whose needs are always greater than my own. Likewise, McFadyen would question who—among the health care professionals—was caring for Rosie? Similar questions can be asked about Armando Dimas. No doubt several people awaiting organ donations could have been in a measurably better position if he had succumbed to his injuries—but who was caring for Armando? His care was predicated on

---

[492] For a thorough and disturbing analysis of the relevance of Levinas to health care ethics see, Clifton-Soderstrom, "Levinas and the Patient..."

keeping his organs in the best possible condition, rather than ensuring his optimal health.

Macmurray's approach, again in terms of an application in practical theology, would have given more weight to the parents' perspective in each of the neonatal cases. For the Attards to take the option which the hospital and physicians wanted was not only choosing death for one of their children, but also making a choice which would profoundly alter their sense of self. No doubt the outcome (either way) did alter the parents' sense of self, but it is likely that greater damage would have resulted from making such a choice as distinct from now having to live with the consequences of the choices of others. Likewise, for Macmurray, only the quality of our relationships substantiates a claim of personhood:

> We are not individuals in our own right; and in ourselves we have no value at all, since we are meaningless. Our human being *is* our relations to other human beings and our value lies in the quality of these relations. [493]

Here, Macmurray is not denying the intrinsic value or dignity of the human being. But he does argue identity and meaning can derive only from our relationships. His approach would not alter the need for moral decision-making in the case of Gracie and Rosie, but it does alter the perceptions of who should make the decisions and what the resultant outcomes might be. Similarly in the cases of the Poarchs and the Stinsons, the health care team's

---

[493] John Macmurray, *Search for Reality in Religion* (London: Quaker Home Service and the John Macmurray Society, 1995).

focus on maintaining the life of the threatened infant to the exclusion of all other considerations was an implicit denial of the relational bonds between parents and their children.

Alistair McFadyen's interest in personhood began in his experience of nursing psychiatric patients. His intention in formulating his communicative model of personhood is to find a way of thinking about persons which is applicable to the mentally ill, the intellectually disabled and those with dementia. He suggests that as we diminish the personhood of particular patients it becomes increasingly possible to reduce our level of care for them and the quality of our treatment of their conditions.[494] Consistent with this, calling into question Rosie's personhood, as some physicians did,[495] or by according her lower personal status, as the courts did,[496] certainly assisted the decision-making which lead inexorably to a course of action that caused her death. McFadyen notes that in the case of health care there exists an asymmetry that is a necessary part of the communication. In his view while the power rests with the more powerful figure in the communication—the health care professional—proper structuring of the relationship requires that the communication of this professional "be directed towards the genuine health needs of the patient (whether implicitly or explicitly communicated)."[497] The application of this in the cases of the Attard and Poarch twins and of Andrew

---

[494] McFadyen, *The Call to Personhood...*
[495] Riddell, "Pity Us, but Pity Jodie More,"
[496] "Case of the Siamese Twins,"
[497] McFadyen, *The Call to Personhood...*

Stinson is questionable. In conjunction with the Attard case, the evidence tendered in the Court of Appeal indicated that physicians at Manchester clearly believed that they were acting in accord with best medical practice for Gracie and some even argued that they were acting in the interests of Rosie.[498] Neither the Poarchs nor the Stinsons questioned the integrity of the medical motivation applied for their children. What all questioned was whether or not the planned and enacted medical procedures were, in fact, in the best interests of their children and who was in a better position to determine what was "best" for their particular child.

Nancy Crick might have conceived of her world differently in the light of the philosophical perspectives so far presented. Her web diary is an eloquent testimony to her loneliness, isolation and suffering. Those who assisted her in coming to the decision to end her life and supported her in that decision reinforced those feelings. Despite the "community" which gathered around her to witness her death, she saw herself as an isolated individual who could no longer sustain a sense of self sufficient to continue in life. Understanding herself to be a person-in-relation may have altered the outcome. Those who promoted her cause failed to express her vulnerability in this regard. For purposes of their own, they championed the cause of the individual fundamentally separated from all other persons, and for whom any decision

---

[498] "Conjoined Twins V Central Manchester Health Area," In direct evidence and under questioning from the Lord Justices, two physicians indicated that they believed that separation and inevitable death were in Mary's best interests.

has no impact on the lives and being of others. The argument offered by those supporting Crick's choice to end her life moved from the narrow case of voluntary euthanasia to the acceptability of a personal choice to end one's life at anytime, for any reason. This makes a certain degree of sense if persons are simply individuals who happen to exist within a social context; it is not meaningful, however, if the relational aspect of personhood is included. Nancy Crick's web-diary,[499] the video tape she made in order to present her own views,[500] and some of the commentaries on her choices,[501] all reinforce the view that she understood her life and her personhood in purely functional terms.

Crick wrote in the web-diary that when she postponed her death from 10 April, 2002 she received a number of hostile messages from some who previously supported her, indicating that she was failing the Voluntary Euthanasia cause. She notes that her supporters have become critics precisely because she was not doing exactly what they wanted her to do. Her justification for postponing her euthanasia was that she needed to explore palliative options in order to meet the objections of those who oppose

---

[499] Crick, *The Diary of Nancy Crick* (accessed)

[500] Nancy Crick, "Transcript of the Nancy Crick Video," *The Sydney Morning Herald*, 24th May 2002

[501] Syme, *Nancy Crick* (accessed), Rodney Syme, "Response to the Nancy Crick Case," *Monash Bioethics Review* 21, no. 4 (2002). and, Eric Gargett, "Beyond Nancy Crick," *Monash Bioethics Review* 21, no. 4 (2002).

euthanasia.[502] Throughout the process the diary increasingly reflects her view that her death serves the cause:

> I am honoured to be called a torch-bearer for Voluntary Euthanasia[503]

> I appeal to visitors to my site if you have personal experience or have knowledge of a relative, a friend, or acquaintance in a similar situation to mine please provide details in either my guest book or send me an e-mail. I want to collect as much evidence as I can to put under the noses of our politicians, and ask them this question…"HOW MUCH LONGER WILL YOUR CONSCIENCES ALLOW YOU TO IGNORE THE PAIN AND SUFFERING OF A GROWING NUMBER OF THE CITIZENS YOU CLAIM TO REPRESENT."[504] (Emphasis in text)

> I made a promise to myself not to suffer another winter & shortly I will keep that promise. It is my life – my choice.[505]

The dominant message of the web-diary is that it is her function to be an advocate for medically assisted suicide and legal sanction of euthanasia. It is ironic that Crick proposed a change in Queensland law to permit medically assisted suicide or voluntary euthanasia based on independent diagnosis of terminal illness, when the person concerned was mentally stable and rational.[506] Sources close to Crick acknowledged after her death that she was not suffering from a terminal illness in the usual sense of the term and claimed that she knew this about her health status.[507] Van Gend cites Nancy's

---

[502] Crick, *The Diary of Nancy Crick* (accessed) 27 April, 2002.

[503] Crick, *The Diary of Nancy Crick* (accessed) 28 February, 2002.

[504] Crick, *The Diary of Nancy Crick* (accessed) 10 March, 2002.

[505] Crick, *The Diary of Nancy Crick* (accessed) 25 March, 2002.

[506] Crick, *The Diary of Nancy Crick* (accessed) See entry for March 3, 2002.

[507] Syme, *Nancy Crick* (accessed), van Gend, "Nancy Crick's Death Not in Vain."

physician and confidant, Philip Nitschke, maintaining that Crick's medical condition was irrelevant to the decision to end her life.[508] Syme presents evidence that Crick's decision was made with no interference from her family or friends in support of his view that her decision was autonomous.[509] Recently, Graham Downie has reflected that:

> In dying with dignity, as her supporters put it, she demonstrated the need for very sound medical and personal counsel for anyone concerned about a terminal illness.[510]

While Crick agreed to delay her suicide until after her son's birthday and granddaughter's wedding,[511] there is little evidence from her comments on these events that she was relationally engaged with the people or events. This stands in stark contrast to her eager anticipation of the euthanasia rally held on March 25, 2002 – the day after her granddaughter's wedding.[512]

An approach to Crick's situation as, say, in McFadyen's sense of relational personhood, would appreciate the limitations to relationality already sedimented in her life. Previous choices and relationships, ingrained patterns in physical, psychological and sociological development, all have their effect. But these need not close off the opportunity for further development. Some relationships are inherently asymmetrical, as between parent and child,

---

[508] van Gend, "Nancy Crick's Death Not in Vain."

[509] Syme, *Nancy Crick* (accessed)

[510] Graham Downie, "No Need to Legislate for Euthanasia," *Canberra Sunday Times*, 9 July 2006, 16

[511] Crick, *The Diary of Nancy Crick* (accessed)

[512] Crick, *The Diary of Nancy Crick* (accessed) See entry for March 17, 2002.

doctor and patient, teacher and student, employer and employee. Problems
arise not from this inherent asymmetry but when the weaker partner is so
objectified as to not be a subject of communication. Even in the asymmetrical
relations just mentioned, the one-sidedness is not intended to be permanent.
Rather, this comparatively powerless other transcends the categorical
relationship as a worthy subject of communication.[513] Even those whose
capacity for dialogue is severely handicapped are still to be regarded as
persons in the communication, with the result that a transformation on both
sides can occur.[514]

I would suggest, then, that those who became significant to Nancy Crick in
her last year were not genuine dialogue partners, but rather echoed back to
her the judgment of the worthlessness of her life. The point of contention in
her decision was not ultimately euthanasia or medically assisted suicide, but
her medical condition of not being terminally ill and probably able to be
cured; hence, not a candidate for either option as presently proposed. Crick's
plea was for someone to provide her with a relatively certain means to end
her life (sodium pentobarbital-Nembutal-being her preference), and to have
people with her when she died.[515] Those publicly supporting her decision
made it clear that what they supported was the autonomous decision to end
life whenever a person chose to do so, regardless of their state of health and

---

[513] McFadyen, *The Call to Personhood...*
[514] Vanier, *Becoming Human*.
[515] Crick, *The Diary of Nancy Crick* (accessed)

possibilities of cure.[516] Crick herself recorded in her diary that postponing her announced date of death led to a number of pro-euthanasia advocates criticising her personally, while the euthanasia advocate handling the media for her was more concerned with protecting euthanasia organisations than with Crick.[517] By her own account, she felt that she was the object of a monological communication in her last year. Her relations with physicians trying to introduce a range of options for her were rejected—in favour of those who endorsed the position that she had arrived at: her major contribution to the world would be to challenge existing laws by ending her life.

Any serious issues in health care and the philosophical frameworks which are applied in them will have relevance for theological reasoning. I now turn to consideration of the theological implications which arise in such cases in health care.

3. Theological Implications

A theologically relation-based analysis may not offer a ready solution to all moral dilemmas, but it does broaden and humanise the context, as in the following instances.

---

[516] Philip Nitschke, *Voluntary Euthanasia - a New Radicalism* [web site] (Online Opinion, 2002, accessed 17 December 2003); available from http://www.onlineopinion.com.au/2002/May02/Nitschke.htm, Miranda Devine, "The Death Knell for Euthanasia," *The Sydney Morning Herald,* 30 May 2002

[517] Crick, *The Diary of Nancy Crick* (accessed)

Concerning euthanasia, the traditional moral-theological approach argues that such an act is morally wrong due to the deliberate intention of terminating the life of an innocent person (even if carried out at their own request). Such an approach is helpful when it is possible to clearly delineate between life and death, ordinary means of health care and extraordinary means, terminal conditions and temporary lapses in health. In an era of advanced medical technology, it is no longer clear how this moral norm operates. Are all acts deriving from an intention to end life to be considered euthanasia? Opinion on this varies, with some thinkers arguing that all acts which result in death where the activity undertaken directly causes death are equivalent to euthanasia. This perspective would hold that disconnection of life-support equipment, the cessation of nutrition and hydration, or even some forms of pain relief are all morally equivalent to euthanasia. Others argue that the distinction between intending to kill and taking a course of action which results in death is of moral significance.

Peter Singer, for example, has argued that appeals to the principle of "double effect",[518] and distinguishing between ordinary and extraordinary means[519] obfuscate the genuine moral issues. The principle of double effect was the central defining principle of Catholic medical ethics prior to the Second

---

[518] Peter Singer and Helga Kuhse, "Allocating Health Care Resources and the Problem of the Value of Life," in *Unsanctifying Human Life*, ed. Helga Kuhse, (Oxford: Blackwell Publishers, 2002), 269

[519] Singer, *Rethinking Life & Death: The Collapse of Our Traditional Ethics*.

Vatican Council.[520] It is specifically designed to deal with a range of health care procedures where there are both good and bad effects flowing from a proposed action, for example, where physicians administer high doses of analgesia where the intention is pain relief, even when it is known that the dosage will hasten the patient's death.

The distinction between ordinary and extraordinary means of health care refers to situations in which patients, their families and carers can make a decision to forego treatments which will prolong life but where the treatment is no longer beneficial to the patient in any meaningful sense.[521] In contemporary health care practice, this distinction has lead to the cessation of nutrition and hydration of terminally ill patients. Singer argues that the choices made in such situations are tacitly, if not openly, choices designed to bring about the death of the patient; and that most people believe that the death of the patient in such circumstances is the correct outcome.[522] He suggests that it would be more honest and practical to simply acknowledge that the root intention is to ease suffering by bringing about death.[523]

In defence of these principles—double effect and the distinction between ordinary and extraordinary means—Luke Gormally points to an important

---

[520] Kelly, *Contemporary Catholic Health...*

[521] Kelly, *Contemporary Catholic Health...*

[522] Peter Singer, "Is the Sanctity of Life Ethic Terminally Ill?," in *Unsanctifying Human Life*, ed. Helga Kuhse, (Oxford: Blackwell Publishers, 2002)

[523] Singer, *Rethinking Life & Death: The Collapse of Our Traditional Ethics*.

distinction between "intention" and "foreseen causation of death".[524] Intentionally causing the death of a person, that is, choosing a course of action designed to bring about death, is always wrong; it is incompatible with human dignity. But this does not rule out all medical decisions which could lead to death. The foreseen causation of death can be compatible with human dignity; nor does it shape the fundamental moral disposition of the agent as the intention to kill must. Acting intentionally to cause the death of another is, as Levinas would argue, an instance of the ultimate negation of the other. To engage in an act which will hasten death can be based on the relationship between the persons. This is the situation in relation to the cases of Tony Bland and Nancy Cruzan. Interestingly, it is more contested in the case of Terri Schiavo where her husband and parents disagreed about the appropriate course of action.

This is not to suggest that the distinction between direct killing and choosing a course of action resulting in death is a simple matter of examining the levels of relationship or of health professionals passing hard decisions to relatives. Take the case of Tony Bland, a victim of the Hillsborough [Soccer] Stadium disaster. Bland was crushed and remained in a persistent vegetative state from April 1989 until 1993 when the British Law Lords ruled that it was permissible to withdraw medical means of nutrition and hydration.[525] Singer

---

[524] L. Gormally, "Against Voluntary Euthanasia," in *Principles of Health Care Ethics*, ed. Raanan Gillon and Anne Lloyd, (Chichester, England: John Wiley and Sons, 1994)

[525] Singer, *Rethinking Life & Death: The Collapse of Our Traditional Ethics*.

cites the Bland case as one where the advice to doctors was that any act which resulted in Bland's death could be construed as criminal.[526] The legal dispute was initiated by Bland's family and physicians. They argued that Bland was meaningfully dead, but his body was being indefinitely sustained by futile treatment. The families of Bland and of Cruzan (cf. Chapter Three) were clear that the course of action they sought would result in the ending of biological life. In other words, the course of action they *intended* was to bring about the biological death of the patient.   Singer argues that this indicates that the principle of the sanctity of life is flawed and no longer broadly applicable.[527] If this is the case then the distinction between killing and letting die is also called into question. Tobin, in contrast, suggests that to gauge the validity of the principle, the underlying attitude is one of valuing human life.   What seems clear from the decisions of both the Bland and Cruzan families and the relevant health care professionals is that human life was valued; however, a judgement was made that meaningful human life had *already* ceased.   In neither case did the families of the patient accept that the person was still alive. It might be possible to demonstrate that they were in error about this, but their stance was that biological existence needed to be brought into conjunction with the "actual" existence of the person they loved.   In other words, based on their relationship with the person, a number of people arrived at a similar determination. It should be recognised that in neither case was the decision precipitate. It took some time for the respective families to

---

[526] Singer, *Rethinking Life & Death: The Collapse of Our Traditional Ethics*.

[527] Singer, "Is the Sanctity of Life Ethic Terminally Ill?,"

come to terms with the circumstances and situation in which they and their loved ones found themselves. The families believed that their relationship with the injured person demanded a response appropriate to the relationship. The fact that both families were prepared to expend their time, energies and resources in these situations reflects the level of care and commitment to their loved one, who they perceived to be dead but requiring finality.

These cases contrast with that of Terri Schiavo. Schiavo was a Florida woman who collapsed in 1990 due to a suspected potassium imbalance which caused a heart attack and temporarily cut-off the supply of oxygen to her brain. She was subsequently diagnosed with hypoxic encephalopathy. Following initial treatment Schiavo was able to breathe unassisted but did require artificial means of nutrition and hydration. From 2000 her husband began attempts to cease nutrition and hydration; the various legal battles finally concluded in 2005 ruling that her husband could request the hospital to cease artifical nutrition and hydration.[528] Terri Schiavo died on March 31, 2005.

This case is quite different to either Bland or Cruzan. Physicians argued that Schiavo exhibited eyes open permanent unconsciousness with physiological sleep/wake cycles. Her parents, in contrast, held that she was conscious, though with some form of brain damage which had obvious physical effects. The precise extent of her neurological damage was never completely

---

[528] Associated Press, "Terri Schiavo Right-to-Die Case," *The Age*, March 21 2005

ascertained while she was alive. A second major difference in this case is that the primary relationships of which Terri Schiavo was part, her marital relationship with husband Michael and her relationships with her biological family, parents and siblings, were not in agreement about the decision. That is, her biological family wanted nutrition and hydration to continue, it was her husband who conducted the legal battle and made the decision to withdraw treatment, with court orders to enforce his determination. It should be noted that while definitive diagnosis of the extent of brain damage was limited, there was medical consensus that given the severity of the damage and the length of time which had elapsed, Schiavo had little chance of recovery, in the sense of a return to her previous life or even substantial improvement. An autopsy confirmed this diagnosis and also that many of the claims of her parents about "eye-tracking" (following movement) and some spontaneous eating when offered food, were highly unlikely to be accurate.[529]

The scenario then is this: a severely compromised and damaged patient who requires artificial means of nutrition and hydration to maintain biological life, but who is not terminally ill, nor likely to die from anything other than dehydration or starvation. Her husband believes that her quality of life is insufficient to warrant ongoing care; her parents and siblings dispute this claim. The courts consistently determine that her husband has the legal power to make decisions about her ongoing care. There are many

---

[529] J. R. Thogmartin, *Report of Autopsy: Schiavo, Theresa* (Largo, Florida: Medical Examiner, Sixth District, 2005), Autopsy Report

controversies in this case concerning alleged physical abuse by the husband, money from a malpractice suit and the validity of conflicting medical opinions. Two aspects of this case are instructive for this thesis. Firstly, the legal determination that adult relationships which are chosen and have legal standing--marriage, for instance--should take priority over biological relationships. Secondly, that the law is not a particularly sound arbiter of the reality of relationships.

In relation to the first matter, the courts recognised that being in relationship to the patient brings a responsibility, even duty, to make decisions on behalf of the vulnerable incapacitated patient. Clearly this is a stance which I argue should be supported in a *prima facie* sense and it is, at one level, the battle that the families of Bland and Cruzan had to fight. Interpersonal relationships do bring such responsibility and when the relationship is chosen and serious, and of long standing, like marriage, it should take a certain priority over other relationships, even familial relations. This is should not be an unlimited priority, however. I believe that the courts made a formal determination in this case based on a legal reality which was predicated on a fictional relationship.

At the time of her original collapse and injury, Schiavo and her husband were married and there is no serious evidence to suggest that it was not a genuine relationship in that Terri Schiavo was, at the time, undergoing treatment to

achieve pregnancy. However, by the time of the final court decisions in this case, the husband Michael was in a *de facto* relationship of long standing—about eight years—with two children from that relationship.[530] Whether, as has been alleged, he wanted to cease treatment in order to preserve the monetary award for malpractice given for Terri's ongoing care for his own use is irrelevant to my argument. The point is that he had made decisions which repudiated the level and kind of relationship which the courts were maintaining still existed due to the fact the couple had never divorced. There might be a number of reasons why Michael Schiavo decided not to divorce Terri Schiavo. It is reasonable, however, to assume that had she returned to consciousness, Terri may have viewed her husband's adultery and two children from this relationship as grounds for her to divorce him!

The differences between this case and those of Bland and Cruzan are not only due to the different apparent differences physiological presentation, or even the different perspectives on Schiavo's condition held by her parents and her physicians, but also due to the very different relational circumstances. In Bland and Cruzan the most significant relational networks of the two patients were united in their beliefs about the appropriate course of action and their beliefs about what was in the best interests of the person. In the Schiavo case, the courts made an identical legal determination but it was based on a very different set of relational realities. In the Schiavo case the people in the two

---

[530] Ron Word, "Appeals Court to Consider Schiavo Request," *ABCNews*, March 30 2005

major relationships of her life, her parents and her husband, fundamentally disagreed over the value of the medical prognosis, what it meant for Terri to be maintained in her current health state and over who should make such decisions. While the marriage continued legally, no reasonable observer would believe that Michael Schiavo's primary relationship was with his legal wife and not with his *de facto* wife and children.

A relational perspective would have taken this real set of relationships into account, and pointed out that the husband's claims of duty and responsibility for his wife were, at least, compromised. The overriding value of the sanctity of life cannot absolutely depend on whether or not a supposedly legal marriage must take precedence over other relationships. This is similar to the legal decision in the Attard case in that the consistent legal ruling failed to take into account the real state of the relationships involved. Instead of looking to who had the patient's best interests in mind, the legal decision turned on very narrow legal definitions.

A practical theology of health care based on relationality contests decisions about life based on rigid and abstract determinations of either a legal or biological character. The moral discernment it envisages presupposes an unfolding search for meaning within an ultimate and theological conviction of human destiny as sharing in the very life of God. While such a conviction does not offer a ready solution to all moral dilemmas, it does highlight the

value of the relationality in which all persons exist. This relational context is preferable to an exclusive focus on the morality of a particular isolated act. It also provides a basis for refuting Peter Singer's claim that people have given up on the sanctity of life in all but name. Only a relational context can provide a sufficient basis to uphold moral ideals and make sense of concrete decision-making in such cases. In the four end-of-life cases examined in this chapter a relation-based analysis highlights a much stronger and clearer sense of who should be responsible for decision-making. In situations where a number of different relational perspectives can achieve consensus in support of a particular well-founded medical position, a more ethical outcome is likely. In situations of significant dispute between the parties it is unlikely that the outcome will be ethical, even if warranted legally and medically.

It is important at this stage to recall a point I have repeated throughout the thesis: using a model of relational personhood in health care may not alter the outcomes of decision-making but it does shape the reasoning process and the analysis of the situation. The four cases just considered demonstrate the validity of this point. When investigated from the perspective of relational personhood, these cases take on different analyses: in the case of Cruzan and Bland it becomes clear that the initiative and stance taken by the families is actually a stance which affirms life and the quality of relationship that they enjoyed with the respective patients. Applying a relational matrix to the decision-making would not have altered the outcome, but the public view,

perhaps especially that of religious commentators would have been quite different. In the Schiavo case, however, the different reasoning process would have highlighted a number of flaws in using the legal system to arrive at moral decisions. In this case the courts upheld a decision based on the legal marriage of Terri and Michael Schiavo even though the relationship, as marriage, had been effectively repudiated and for a number of years. While Terri Schiavo was in care for fifteen years, it is clear that her legal husband was, in fact, in another marriage for at least half that time. An analysis of the case based on relational personhood would have taken into account other relationships as well as the marital relationship equally, coming to a conclusion that weighed their competing claims more validly based on actual relationship rather than just a legal definition of relationship. For Nancy Crick, a relational analysis would have suggested that her sense of isolation and refusal to accept most medical advice might have more in common than has been highlighted in public discussion of the case.

These cases demand continuing reflection on the nature of relational personhood in ways that respect all the values involved and the various kinds of relationships that are in play. Recall that Macmurray placed special emphasis on the mother-child relationship.[531] Though the initial responses of "mother" and "child" are spontaneous and instinctive, this is not the full story

---

[531] Macmurray, *Persons in Relation*. and David S. Cunningham, *These Three Are One: The Practice of Trinitarian Theology*, Challenges in Contemporary Theology (Malden, Mass.: Blackwell Publishers, 1998).

of the relationship. Prior to birth, or perhaps beforehand, the woman (and in some instances, her partner) have been creating a "space" for the child in her life/their lives. The couple, ideally, have been structuring their relationship, their lives, and even their bodies, to make room for this new, life-giving and life-changing relationship. Even if the pregnancy is unplanned, continuing it entails a choice to accept this "other", especially when abortion is a socially established option. But following the choice for the child, multiple new identities come into being within the community involved, even if the number of those concerned is initially small. Within that nurturing space, a new person comes into being and develops in a network of relationships.

The option for abortion is paradigmatic of all types of rejection of the personhood of the other, as in the case of slaves, the disabled, the marginalized and the exploited. For these categories of people, their claim to personhood has been rejected on the part of those who regard the other only in accord with their subjective criteria, as is instanced in the history of slavery, genocide, and present government policies to endorse the termination of pregnancies in which a disabled child is likely to be born.

There is an objective aspect as well. Just because I choose to reject the Other does not mean that there is no relationship at all. In genocide, the Other is not just acknowledged, but also must be viewed as a threat. It is the ultimate rejection of relationship, of one individual in regard to another, and of others

classified as non-persons. An already given relationship is terminated. In the paradigm case of the mother-child relationships, a relationship is recognised even if a decision is made to terminate it. By the time the woman is aware she is pregnant, the relationship has commenced on a physical level. The conceptus has become an embryo and has established a symbiotic relationship with its mother, even if she comes to regard it as parasitic. The embryo has an identity already existing in relation to the mother.

Such a physical description of relationships savours of a clinical detachment foreign to the language of relationship. Yet, as Alisdair McFadyen has argued, this objectification and sterilization of the language of relation makes possible the rejection of the other in a radical manner.[532] Here, there are two levels to be considered. On the objective level, the relationship can be considered in a purely physical fashion, with its various biological and clinical components. On the subjective level, the relationship implies recognition of the other in a more personal manner, as this other is given, inviting in its otherness to enter unreservedly into the relationship which already exists, through further choices and continuing commitment. A moral space is opened up in which new identities are formed and flourish within an inter-subjective community. This kind of space, identity and interdisciplinary approaches to community are properly the focus of practical theology.

---

[532] McFadyen, *Bound to Sin...*

4. A Practical Theology of Health Care

As persons develop they become increasingly conscious of their inter-relationships, the webs of implicit and explicit commitments which bind them to others and others to them.[533] The deepest theological foundation for this inter-relational existence derives from the Trinity itself and the mission of Jesus, as I presented such themes in the previous chapter. This theological conception of personal relationships affects both the conduct of the moral life and theoretical and practical exposition of Christian ethics.

Advances in medical technology bring new challenges. The case of the conjoined twins, Gracie and Rosie, is a clear example. Even though the surgery was "successful" in that the twin intended to survive did so, it is far from the case that such surgery will routinely be successful. The *possibility* of success, in a technical sense, created the option of separation. The actuality, in this case, of a "successful" outcome encourages further intervention in similar cases. As little as twenty-five years ago, the Attards would have been told that their daughters would inevitably both die; as it was, they were given the option of sacrificing one child so that the other would have a possibility of life. It is clear that, according to the traditional model of ethics, the parents made the correct choice (to refuse consent for surgery), since to act in such a way as to directly oppose a fundamental good—in this case, the life of Rosie—would be morally wrong. However, for those who must make such

---

[533] Neil Brown, *The Worth of Persons*, Faith and Culture, vol. 7 (Manly, Sydney: Catholic Institute of Sydney, 1983).

decisions, the matter is not so clear-cut. The outcome envisaged depends on the vantage point from which the situation is viewed. From the point of view of the twin who was viable, it is possible to argue that the choice to do nothing would amount to a direct attack on her life and may also be contrary to what might be termed "practical reasonableness". To some medical practitioners it would seem absurd that, when faced with a possibility to save one of the twins, both should be allowed both to die. This course of action would appear to violate principles of medical practice.

Admittedly, a practical theology of person in relationship does not make such decisions demonstrably clearer. What it does do is to highlight the complexities of human existence and the multivalent perspectives on the values inherent in the decisions. It recognises that the relationships involved bring a different dimension to the decision, sometimes leading to easier or clearer decisions and in other contexts, such as the situation with the Attards, it leads to an impasse. Frequently, especially in the media, the Attard parents were characterised as simple-minded victims of a primitive society infected with superstition (i.e., Catholic Christianity), who were refusing their child a chance at life for obscure and eccentric reasons.[534] In contrast, the health care professionals involved were presented as the champions of reason, science and civilization.[535] However, a number of relevant reports throw light on the moral dilemmas involved. The judge in the initial court case, Justice Johnson,

---

[534] Riddell, "Pity Us, but Pity Jodie More,"

[535] Kevin Toolis, "Hate That Dare Not Speak Its Name," *The Guardian*, September 15 2000

noted that the written submission by Gracie and Rosie's parents was testament to their agony. A report commenting on his judgement is illuminating:

> There was (as [the judge] did not say) a subtext. The statement began with a rehearsal of their belief, as Catholics, that they could not kill one child to save the other. It moved quickly on to argue a very different case. "In addition, we cannot see how we can possibly cope either financially or personally with a child who will have the serious disabilities that Jodie will have". Their daughter, they had decided with great sorrow, would therefore fare better in England, being "looked after by other people", if the courts decided she must survive. They did not know whether she could be fostered or whether she would have to be adopted and they would have no contact with her at all. Although honestly presented as the best deal for Jodie if she should be kept alive against their wishes, this outline of a bleak and uncertain future also implies a secondary argument for letting her die.[536]

As this excerpt and other commentaries make apparent,[537] interpersonal issues were very powerful features of this case. The identity of Rosie was denied in any genuine sense in order that the identity of Gracie could be asserted. This reflects a common view of human relationships—that the only way in which I can be recognised and succeed is if someone else is un-recognised and fails. What was missing in the perspective of the health care professionals and the courts was any recognition that part of Gracie's identity was derived from her relationship with Rosie. More broadly, that the identity

---

[536] Riddell, "Pity Us, but Pity Jodie More,"

[537] Steven Morris, "Jodie and Mary: The Point Where the Law, Ethics, Religion and Humanity Are Baffled," *The Guardian*, September 9 2000 Pete Tobias, "Twin Dilemmas of God and Man," *The Guardian*, September 16 2000

of each individual derives in large measure from the networks of relationships of which they are part.

All solutions in the Attard case were fraught with difficulties even when the importance of the relational field affecting this case was most important. Parents were being asked to choose between their children; a "successful" separation would mean that they would bury the child they had chosen to kill; the child who survived would, in effect, be separated from them, perhaps permanently, due to their recognition that the level of disabilities anticipated in the separation procedure was beyond their capacity to adequately treat or manage. An analysis of the relationships involved would have led directly to questions pertaining to the responsibilities of parents for their children. What parent should be able to make a life and death decision between their children? In this situation it is not a spur of the moment decision to rescue one but being unable to save the other, nor is it the same scenario as depicted in *Sophie's Choice* where a decision to save one leads to mortal danger for the other—but where the dangerous outcome for the other child is the responsibility of someone else. A decision to act to save Gracie is to choose an action which inevitably ends Rosie's life. In most circumstances if a parent could easily make such a decision the value of their parenthood would be questioned by many. While choosing to save the life of one child is a priority, how is such a choice compatible with allowing the termination of the other? Further, how should parents choose when faced with the severe disability of a

child? The medical prognosis was that Gracie would live but would require substantial assistance and ongoing surgical intervention to manage the resultant disabilities—which would have been beyond the parents' means to provide.

A second question which practical theology generates relates to the interactions between the Attards and various health care professionals. On being told, in Malta, that they were pregnant with conjoined twins and being offered the opportunity to go to Manchester for a better quality of care in managing the pregnancy and for the twins, what kind of relationship was being initiated? Were the Attards told that St Mary's at Manchester had no experience managing or separating conjoined twins? Would this have influenced their decision? What would the Attards have believed that "better care" meant? Associated with these kinds of questions are those associated with a legal system which assumes jurisdiction because of geography and which turns down a request from the Attards to allow them to take their children home.

A relational worldview would have provided further morally relevant data for the decision-making process. Such data would examine all the relationships involved, especially between the parents and their children, and even between the children themselves. This would have been a more humane basis for decision-making. It would have respected the personhood of all

those involved, not simply the expertise and authority of the health care professionals within a distinctly rational scientific and legal framework.

Applied in the context of health care, relational anthropology demands recognition of the fact that patients are not pathologies or disabilities or conditions, they are persons-in-relation. This recognition, in turn, demands a paradigm shift in health care away from a pathological focus to one focused on human health as a means to achieve the optimal flourishing of persons. Within such an altered paradigm someone like Nancy Crick would be supported in her health condition and challenged to accept that a return to health or at least an optimal level of health for her age and medical history was possible. Those who joined with Crick to advocate her death would be challenged about their own anthropologies and agendas. This new paradigm would also offer more to the Attards. The process of decision-making about the conjoined twins would have respected the various levels of relationship; it would not have countered the parents' concerns about being able to afford/supply ongoing health care for their child/children by suggesting severing all contact (adoption); it would not have argued that perspectives which cherished Rosie were ignorant or superstitious.

A theology of relational personhood generates a very different model of health care and a very different health care ethic. Conceptualising persons relationally shifts the primary task of health care from pathology to the care of

persons. This transformation involves risks for health care professionals because relationality demands that the person who is a health care professional invite relationship with patients and be open to relational encounters. Necessarily, this will cause them to be more open to the pain and the suffering of the Other. This is the consequence of moving beyond the comfortable boundaries of a functional repair model of medicine to a model of health care which is genuinely able to effect transformation in the lives of those involved in health care. The need for such openness to transformative possibilities is demanded both by the nature of persons and by the nature of health care. The latter has a focus on human flourishing not just cure of illness; this cannot happen unless the transformation of persons is encouraged. Such transformation is invited and demanded by the face of the Other in the clinical encounter. These cases demonstrate again the importance of relational anthropologies in offering models for thinking and a means of discernment of how to proceed.

5. Relational Personhood and Controversial Cases

Relational personhood provides a quite different grounding for analysis of concrete cases in health care ethics. Instead of attempting to start from an objective calculus or ethical principles approach, whereby a set of pre-determined standards are applied to a given case, regardless of context, utilizing a relational perspective requires that the analysis occurs from the

viewpoint of the subject. In this context the subject is not primarily an individual but a *person-in-relation* and, therefore, their relationships are a vital part of the analysis. Such a focus means that physicians and ethicists involved in a case such as Nancy Crick's for example, do not have to endorse and/or carry out her request to die simply on the basis of an emphasis on autonomy constructed as the rational request of an individual. Rather, a relational health care ethic adopts a broader set of criteria.

The relationships which became significant to Nancy Crick in the last year of her life were those that endorsed her desire to end her life. They championed the idea that an individual should be able to request medical intervention to end their life in the case of terminal illness and an unwillingness to continue treatment. No relationship which argued a contrary position was accepted as meaningful. This seems decidedly odd. A group of people who are virtual strangers or who have only been known for a brief period of time are taken on as "dialogue" partners but close members of her family are not. From the description of her life in the diary, a reasonable person might conclude that Crick's family neglected her, perhaps prompting a turn to strangers and an articulation of a desire to die. Her acquaintances who supported a bid to end life on the basis of a single choice are embraced; but those who argue for life, choices and options are rejected. The value of empirical evidence was denied, while erroneous assumptions about Crick's health status were uncritically accepted. These circumstances would suggest that the claim of rationality in

the case of Nancy Crick is misplaced. The conception of the autonomous rational person relies on an understanding of reason as meeting objective criteria and being subject to public scrutiny. While it might be plausible that Crick's desire to forego burdensome and futile treatment is understood and endorsed widely as a rational desire, it is unlikely that the same endorsement can be made in the light of the medical evidence: Crick was not terminally ill, she was presented with a range of treatment options which were all standard for her situation – she rejected all views which did not coincide with her own.

Attention to her relational circumstances would have yielded a different analysis: it would have highlighted that meaningful primary relationships were lacking in her life, leaving her vulnerable to expedient relationships – ones where her personhood was neither affirmed nor promoted. Crick was vulnerable and instead of her needs being met by those with whom she was in relationship, her vulnerability was being exploited by people who viewed her as a means to an end.

This analysis demonstrates why the notion of relational personhood represents a necessary ingredient in health care: not only is the analysis of particular cases different, but in order for the health outcomes to change it is necessary to alter the structures within health care delivery to enable relational analyses to be acted on. Nancy Crick's distorted perspective about her health condition could not ultimately be challenged by health

professionals due to the dominance of the concept of patient autonomy and wariness about the dangers of medical paternalism. The focus on patient autonomy in cases concerning euthanasia and assisted suicide is counter-productive since any analysis is too tightly constrained by pre-determined criteria and unable to take sufficient account of subject-specific issues.[538]

While it is difficult, even in well publicised cases such as this, for one to propose a precise course of action, one feature of the case does offer scope to suggest a more relational approach. Based on Crick's web diary, the writings of health care professionals and commentators at the time of her death, it appears that no medical consultations were held with a wider group of people than Crick herself. As noted above, she appears to have had a distant or tenuous relationship with her children. Had her children, and even grandchildren, been included in discussions about her health status and prognosis Crick may have received a different range of support and/or advice. Had Crick's treating physicians been able to take into account the nature of women's relationships with their families and associated features of depression, poverty, vulnerability and poor social support,[539] then they may have had a wider range of options open to them and Crick may well have found other solutions to her situation.

---

[538] Jennifer A. Parks, "Why Gender Matters to the Euthanasia Debate: On Decisional Capacity and the Rejection of the Woman's Death Request," *Hastings Center Report* 30, no. 1 (2000).

[539] Susan M. Wolf, "Gender, Feminism, and Death: Physician-Assisted Suicide and Euthanasia," in *Feminism and Bioethics: Beyond Reproduction*, ed. Susan M. Wolf, (New York: Oxford University Press, 1996), 284f

Had her supporters in the voluntary euthanasia movement been aware that her health condition did not meet the criteria for terminal illness, it may be that they would have proposed a different course of action, since it was reasonably predictable that the public sympathy which is often aroused in cases where the terminally ill want to die would not be forthcoming in a situation where a person refused all advice, treatment and assistance. In reaction to the announcement that Nancy Crick had not been terminally ill, the Australian community significantly reduced support for voluntary euthanasia, even if only on a temporary basis.[540] At the very least, as David van Gend argues, any discussion of euthanasia and/or assisted suicide needs to take account of "the grim nature of some family relationships." He goes on to cite a House of Lords decision to reject assisted suicide/euthanasia on the grounds that "[W]e are concerned that vulnerable people – the elderly, lonely, sick or distressed – would feel pressure, whether real or imagined, to seek early death."[541]

Relational analysis of the conjoined twins' case challenges the actual outcome in a far more controversial manner. Had the familial relationships been taken more seriously and given greater priority, it is likely that both twins would have died. This is a difficult position to advocate since Gracie Attard is now a

---

[540] Otlowski, "Discussion: The Nancy Crick Case."

[541] van Gend, "Nancy Crick's Death Not in Vain."

relatively healthy child.[542] Without doubt the Attards are grateful to have one of their children, though this should not be taken as an automatic endorsement of the position that the physicians and the hospital took in seeking to overturn the Attard's decision to forgo surgery, allowing both twins to die.

This highlights that relational personhood is not a panacea for all moral dilemmas in health care ethics. What I have argued throughout this thesis is that it is both a more authentic way of understanding persons and a better basis for discourse in contemporary theology. My objections to the decisions in the conjoined twins' dilemma are not based on the outcomes for Gracie but on the lack of attention paid to the needs of the vulnerable Rosie and on the lack of appreciation of the parents' quandary. A relational analysis, instead of the utilitarian/legal perspective which dominated the decisions, would have taken seriously their plight – being asked to make a decision to kill one of their children and the prospect of giving up their children through adoption in order to gain access to medical treatment for the survivor (if Gracie survived). This case is controversial, especially given the very positive outcomes for the surviving Attards, yet it illustrates the manner in which the vulnerable in health care are consistently discounted, ignored and how perspectives which argue for their priority are dismissed.

---

[542] Nick London and Suzanne Rock, "Amazing Gracie," (United Kingdom: Grenada Television, 2001)

The concentration on a happy outcome for one of the twins and the joy shared by her parents and family is not the sole feature of this case that is relevant for moral discourse. For those who seek to determine the ethics of health care based on health outcomes alone this case appears to be a success. Again, this is not an unambiguous situation. While the death of Rosie was expected and occurred and, likewise, Gracie was expected to survive and did so, this outcome is by no means certain. In cases concerning conjoined twins there will usually be some doubt about the outcomes since the conjoining often involves the sharing of major organ or neural systems.

The 2003 case of Bijani twins, Ladan and Laleh, Iranians who were joined at the brain, indicates the difficulties involved. The twins' request for separation had been considered by German surgeons in 1996 but the chances of success were rated as being so low that surgeons refused to engage in the procedure. In 2003 a surgical team in Singapore determined that separation was feasible. In this case pre-surgery diagnostic tests indicated that the sisters had distinct brains. During surgery it became clear that their brains, while distinct had fused together and also that their circulatory systems were more integrated than had previously been recognised.[543] The Bijani twins were law school graduates and had expressed a desire to be separated and lead individual lives. Physicians cited this desire as a motivating factor in attempting the

---

[543] BBC News Online, *Iranian Twins Die in Surgery* [Website] (British Broadcasting Corporation, July 8, 2003 (GMT 18:18) 2003, accessed March 8 2006); available from http://news.bbc.co.uk/2/hi/asia-pacific/3053638.stm

highly risky surgery. Subsequent to the surgery it was suggested by the editor of *Bulletin of Medical Ethics* that the medical imaging technology on which the plan for surgery had been based is not yet sophisticated enough to serve as the basis for such complex surgery.[544] The twins died during surgery as a result of a number of complications.

There is little doubt that the Bijani twins genuinely sought this surgery as a means to live independent lives. In this they were supported implicitly by a social paradigm which holds that personal existence is the existence of an autonomous individual. That is, the perspective that persons need to live lives which are conducted without reference to another person. A paradigm which assumes this autonomous individuality will prioritise the potentially fatal risks involved over the value of a conjoined existence. If relational personhood shaped the dominant paradigm of health care then it is more likely that conjoined existence would be viewed more positively, not only by society at large and health care professionals, but also by the twins themselves. It is difficult for any person to accept his/her own value when society operates in such a manner as to fundamentally question the present mode of one's existence.

---

[544] Richard Warry, *Conjoined Twin Surgery Highly Risky*(British Broadcasting Corporation, 8 July, 2003 GMT 10:47 2003, accessed 21 March 2006); available from http://news.bbc.co.uk/2/hi/health/3053862.stm

The case of the Attard twins differs from that of Nancy Crick in that while Crick was certainly vulnerable due to her lack of meaningful relationships, her case does not call attention to innate human vulnerability in the same way that the case of Gracie and Rosie does. In the situation of the conjoined twins, particularly as newborn babies, it is not possible to ignore their vulnerability or their co-dependence. The circumstance of the twins' existence is emblematic of all human existence: we are all joined each to the other and we are all dependent on each other.

6. Conclusion

The late twentieth century and early twenty-first century have witnessed a turn to relationality as a conceptual framework in a number of fields of enquiry. This continues to have an impact in theological and philosophical reasoning, especially in terms of refocusing attention on the connections between anthropology and ethics. It is my contention that health care requires an anthropology that sustains the moral status of those at the margins of human society and human existence, the poor, infants and children, the disabled and the sick, for example. A practical theology of relational personhood can contribute this because of the centrality it accords to the vulnerable. It is the vulnerable who are the priority of God and they should be the priority of health care.

The call to care for the vulnerable is not uni-directional—theology as well as health care must make the vulnerable central. Participation in the mission of Jesus demands that the Christian community champion those who are most vulnerable. In terms of a relational analysis this means highlighting that when the value of one person is diminished then the value of all is diminished. To argue that the vulnerable have a lesser moral status is unacceptable within the Christian worldview; it is also antithetical to the goals of health care. More insidious however, is that such an argument is rarely advanced openly. Peter Singer stands out as being among the few who make such an argument publicly. More commonly, particular categories of persons are simply accorded lesser moral status precisely due to their acutely compromised situation, as I argued earlier in the thesis. Children, the elderly, the impaired and disabled are all examples of those who are, in fact, if not in theory, accorded a lower moral status and hence are more likely to be subject to adverse outcomes in terms of their life and health. The Parable of the Last Judgement reminds us that it is among these that the demand to recognise Jesus and to act with compassion will be made.

The challenge for Christians is to shape our faith convictions, analyses and moral decisions around our fundamental beliefs. Only in this way can the criticisms of Alasdair MacIntyre that theological ethics must clearly articulate the difference that particular faith perspectives make in ethics; that a theological critique of society must be undertaken; and how theology can

contribute to particular cases in health care ethics be answered.[545]   Only by making central faith beliefs part of the Christian contribution to health care can the dominant secular stance be countered.

The connections between Christian beliefs, moral thinking and health care are best made through a relational anthropology. Within this framework for understanding personhood, it becomes possible to re-conceive health care and the ethics of health care in terms which assist health care to achieve its goals, particularly that of human flourishing. Utilizing a theology of relational personhood in health care ethics prioritises the needs of the vulnerable and demands that attention is paid to the relationships between persons in health care. It demonstrates that the only way for persons to achieve their potential is through active participation in interpersonal relationships which call us forth into new and transformed possibilities. This transformation includes a re-conceptualisation of "vulnerability" such that it is not defined as weakness but as the key to understanding personhood.   A human person is always vulnerable because they are always in relationships where there is a risk of rejection. Only through embracing this reality is there hope for resurrection and unity. This is the message which is conveyed through the person of Jesus Christ and it is the message which Christian theology has recognised in the doctrine of the Trinity.

---

[545] MacIntyre, "Theology, Ethics, and the Ethics of Medicine and Health Care."

In the next chapter I propose a systematic answer to the questions posed in Chapter Two: theology can offer a great deal to health care and the ethics of health care through a practical theology of relational personhood.

CHAPTER SEVEN: THE THEOLOGICAL CONTRIBUTION TO HEALTH CARE.

As remarked in the introduction to this thesis, theology works within a given cultural matrix. It aims to articulate the role and significance of religious faith in regard to the meanings and values that inform that cultural way of life.[546] Within the particular culture of contemporary health care, a whole complex of meanings and values informs the institutions and practices of the public health systems of society.

I further observed, that as theology works to mediate the role and significance of religious faith to this social and cultural sector, theology can be expected to make its distinctive contribution in three ways: (a) It works as a critique of reductive or mono-dimensional views of health care, especially when these lose sight of personal dignity and the inter-relational field of personal existence; (b) Theology contributes further by supporting and deepening the basic meanings and values that religious faith shares with activities of health care—for example, scientific and professional expertise, compassion, and the transcendent value of personal dignity; (c) in performing these two tasks, a genuinely theological method can suggest opportunities for a productive

---

[546] Lonergan, *Method in Theology.*

interdisciplinary approach focused on the patient and on health in its integral meaning.

In the previous chapter, I referred to a number of health care cases which suggest that a purely scientific perspective is inadequate to the task required of health care. In order to achieve its own goals related to human wholeness and well-being, health care is required to draw on the insights of other disciplines. Theology has a particular role to play in this context since both religion and health care are concerned with testing the "understanding of the very meaning and importance of human life…both are concerned with the existential centre of the human person."[547] However, for a constructive contribution in any field of theory or practice, three conditions must be fulfilled: firstly, the avoidance of a defensive attitude of self-regulation, with any particular professional context: a cultural and social perspective larger than the routine outlook and conduct of the discipline concerned must be recognised. This gives rise to a broader vision and a more healthy inclusiveness—especially in a pluralist society. Other voices must be heard when matters as elemental as health care treatment are involved. Certainly, no voices should be excluded.

---

[547] Kelly, *Contemporary Catholic Health…*

Secondly, a certain fusion and sympathy of perspectives is ideal: the standpoint of criticism must have a positive view of the competence and goals of the field that is being criticised—otherwise the criticism will itself be arbitrary and reductive. Theology may offer a broader horizon of meaning and values, but it does not have inspired answers to all the problems health care professionals must face.

Thirdly, since theologies derive from particular religious narratives and communal experiences, their efforts to be a ministry of meaning and ultimate values must respect the given plurality of cultures present in the wider society.

With regard to the first condition, theology is an academic discipline distinct from health care in terms of methodology and the data it explores. This is particularly the case with Judaeo-Christian theology. And yet, and this refers to the second condition, it shares many goals similar to health care, and evidently shares many of its values. As Gregory Pence points out, "whether or not the metaphysical beliefs of the Islamic-Judeo-Christian tradition are correct, modern medicine has undeniably been humanized by values associated with this tradition: respect for human life, family integrity,

unselfishness, humility, equal moral worth, and compassion."[548] With regard to the third condition, in this era of inter-faith dialogue and the challenge of a non-religious secular world, theology has a valuable, if often painful, experience of both the fundamental differences and possibilities of fundamental agreement in many areas represented in today's pluralist world.

What, then, is the kind of critical contribution that theology can offer? It will consist mainly in challenging practitioners and those who shape the practice of health care to recover values originally quite fundamental to the care of the sick and the suffering—namely, to alleviate suffering, to cure the sick and to care for the vulnerable. While there is no simple prescription for the manner in which this can be done, theology can question the "narrative" that tends to dominate modern health care, with its insensitivity to the transcendent meanings and values inherent in personal experience and its concentration on vital values alone. In this, it can act as an advocate of the patient, the suffering other or the stranger in our midst.

I will now develop these points under the following headings:

1. A Theological Perspective on Personal Wholeness

2. A Theological Sense of the Patient as "Other"

3. Compassion as a Theological Value

---

[548] Pence, *Classic Cases in Medical Ethics*.

4. A Theological Recognition of Human Limits

5. A Theological Approach to Human Dignity

1. A Theological Perspective on Personal Wholeness

As noted above, part of contemporary experience of medicine, particularly of acute health care, is the sense of being "squeezed", as Karen Lebacqz described it, by technology, the pace of change, the range of options, and by the very language which is employed.[549] In some cases it is the physical surroundings of health care facilities which lead to a sense of dislocation on the part of patients, their visitors and, at times, even their carers. Many people, patients and health care professionals, ethicists and academics from other fields, have observed that an underlying problem in contemporary health care is the impersonal objectivization of medicine. The patient is more a pathology than a person.[550] This is a first area of the theological critique of heath care system and its style of conduct.

---

[549] Lebacqz, "Religious Studies In..."

[550] This tendency has been observed by many writers. The following are simply a sample: Belkin, *First, Do No Harm*; C. S. Campbell and B. A Lustig, eds., *Duties to Others*, ed. E. E. Shelp, Theology and Medicine, vol. 4 (Dordrecht, NL: Kluwer Academic Publishers, 1994); Davis and Zoloth, eds., *Notes from a Narrow Ridge: Religion and Bioethics*, especially Chapters Three, Seven, Eleven and Fourteen Lammers and Verhey, *On Moral Medicine: Theological Perspectives in Medical Ethics*. Parts I and II; Küng, *Eternal Life*. Tubbs, *Christian Theology and Medical Ethics, Four Contemporary Approaches*. G Whittier, "The Ethics of Metaphor and the Infant Body in Pain," *Literature and Medicine* 18, no. 2 (1999).

Laurie Zoloth points out that contemporary Western medicine is largely a product of the Enlightenment project that held that reason and science could achieve unlimited progress in human endeavour. David F. Kelly, writing from a Catholic perspective makes the same argument as Zoloth.[551] For health care, this influence has undoubtedly given rise to medical "miracles" on many fronts and given the medical practitioner cultic status in society. But Zoloth questions the illusory nature of the Enlightenment and of the mechanistic model of health care derived from it. She contends that the Holocaust stands as an enduring indictment of the Enlightenment view of medicine.[552] For Hans Küng, too, the Holocaust is the Achilles' heel of medical practice. Following the extensive and systematic abuse of various groups in German society during the period of Nazi government, it is not feasible for medicine to claim to be the panacea for human ills. It was not simply the experiments conducted by the Nazi doctors, but their attempts to justify them during the Nuremberg trials that signalled the fundamental limitations of modern medicine. The Nazi doctors considered that their experiments were based on reason and good science.[553]

---

[551] Kelly, *Contemporary Catholic Health...*

[552] L. Zoloth, "Faith and Reasoning(S): Bioethics, Religion, and Prophetic Necessity," in *Notes from a Narrow Ridge: Religion and Bioethics*, ed. D. S. Davis and L. Zoloth, (Hagerstown, Maryland: University Publishing Group, 1999), 255-256

[553] Küng, *Eternal Life*.

Critiques based on the behaviour of Nazi doctors in the concentration camps are dramatic in the extreme, however such horrors must be kept in our historical memory. The Nazi experiments are nonetheless a piercing example of the tendency of any scientific enterprise or professional field to be so arrogantly self-regulating that broader humanitarian considerations are dismissed as of no relevance. An exclusively scientific model of health, disease, disability and injury to the human person is paradoxically cut off from the sense of human well-being it originally meant to serve. Some would see the current debates on therapeutic cloning in order to harvest stem cells as pursuing a model of reasoning and of health care that is dangerously close to that which inspired the Nazi doctors. While this is a serious allegation, the use of human tissue and, at least to some, human persons in deliberately destructive ways is likewise very serious.

A fuller appreciation of health care begins with understanding it both as an art and a science. Many doctors willingly admit that some treatments work better on some patients than others, and that the reason for this is unknown. In this regard, the skill and experience of the physician is more like an art-form than a strictly scientific enterprise. The healing "art", be it expressed in word, gesture, touch or presence, has its own mysteries. What is beyond doubt, is that the goal, achieved through whatever mixture of science,

experience, intuition or other gifts, is the healing, in body and mind, of the sufferer.

Any exclusive focus on health care as science begins to open itself to questioning when "the art of healing" begins to be recognised amongst its practitioners. That is the first step to a broader multi-disciplinary method which will allow for collaboration with theology and religious and spiritual perspectives. The Buddhist tale of the blind people asked to describe an elephant is instructive. Depending on what part of the animal they touch, answers vary: to touch the head leads to the description of it as a pot, while the one who finds the ear concludes it is like it is like a winnowing fan, while the tusk suggests a ploughshare, and the foot, a pillar. And so it goes on. Each description is limited; the whole remains unrecognised. In the matter of health care, science, art, sociology, economics, politics, philosophy and theology operate from perspectives limited to the discipline involved. It can be the task of theology to call attention to these limits, even while admitting its own limitations and the need to collaborate with other kinds of exploration and expertise. A multidisciplinary collaboration thus respects the contribution of each discipline along with the limitations of each, in order to care for the whole reality of the person which extends beyond the boundaries of the physical. Theology, therefore, cannot but take issue with obviously limited types of reason that manifest totalitarian pretensions, as in the case of

Nazi doctors in the concentration camps. Theology seeks to promote a kind of health care that respects, not only scientific expertise, but the broader and deeper aspirations of human beings, whether these are found in patients or doctors and other professionals.

A number of Christian moral theologians have drawn attention to the value of worship and liturgical acts in the care of the sick and suffering.[554] Illness, suffering, disease, incapacity and death are seen as intrinsic to human existence when viewed in the perspective of Christian worship. Liturgical celebrations serve to lift these experiences of suffering and physical evil into a larger world of healing, mercy and grace. Suffering is not eliminated nor anaesthetised, but celebrated as a participation in the redemptive suffering of the Crucified and as promising union with Jesus in the Resurrection.

While medical practice has dramatically improved its capacity to fight disease, to cure illness and to prolong life, it remains, of itself, unable to contribute to a larger sense of purpose—to live and die well as human beings.[555] Health care, however, is intent not only on combating disease or curing illness, but also on providing opportunities for healing in its every

---

[554] See, for example, Gustafson, *Theology and Ethics*. Hauerwas, *Suffering Presence*. James F. Keenan, *The Works of Mercy: The Heart of Catholicism*, ed. Karen Sue Smith, The Church Book Series (Lanham, Maryland: Rowman and Littlefield Publishers, 2005).

[555] Shuman, *The Body of Compassion*.

dimension. This can be expressed as the restoration and maintenance of wholeness,[556] even if, on occasion, the wholeness entails the recognition of insurmountable limits, as when biological life is ending. Included, necessarily and always, is the responsibility for, and to, the suffering and vulnerable other.[557] Along with the requirement of technical and scientific skill, also necessary is an appreciation of the complexity of the human person and the relationships of which they are part.[558]

The wholeness which is the goal of health care cannot be described fully except in teleological terms: the wholeness that is the goal of health care thus serves the goal or *telos* of human life. Understood in this teleological perspective, theology can draw on its particular understandings of "the last things", or our "last end" from the eschatological intentionality of faith and hope.[559] The theologically understood *telos* of humanity looks to a world-transcending destiny, beyond the confines of the present stage of existence.

---

[556] See, L. R. Kass, "Regarding the End of Medicine and the Pursuit of Health," in *Concepts of Health and Disease*, ed. A. L. Caplan, H. Tristram Engelhardt, and J. J. McCartney, (Reading, Massachusetts: Addison-Wesley Publishing Group, 1981), 10-18 L. Nordenfelt, *On the Nature of Health* (Dordrecht, Holland: D. Reidel Publishing Company, 1987). H. Tristram Engelhardt, "The Concepts of Disease and Health," in *Concepts of Health and Disease*, ed. A. L. Caplan, H. Tristram Engelhardt, and J. J. McCartney, (Reading, Massachusetts: Addison-Wesley Publishing Group, 1981), especially 32 and 43 T. Parsons, *Definitions of Health and Illness in the Light of American Values and Social Structure* (Reading, Massachusetts: Addison-Wesley Publishing Group, 1981).

[557] Hauerwas, *Suffering Presence*. and, C. S. Campbell and B. A Lustig, "A Call to Respond: Duties to Others," in *Duties to Others*, ed. C. S. Campbell and B. A Lustig, Theology and Medicine, 4, (Dordrecht, NL: Kluwer Academic Publishers, 1994)

[558] Zaner, "Encountering the Other,"

[559] See Anthony Kelly, *Eschatology and Hope*, ed. Peter C Phan, Theology in Global Perspectives (Maryknoll, NY: Orbis, 2006).

The eschatological orientation of theology does not mean that the value of the present is simply displaced by anticipations of a future state. Though the teleological orientation and eschatological dimension obviously entail some hope for the fullness of life beyond its present form, such perspectives generate a critique of present structures, especially when the transcendent value of human beings is being demeaned, for whatever cultural, economic, political or social reason. What is at stake is the very understanding of God, and the creative and salvific will at every stage of human existence. Gordon Kaufman, for instance, in *An Essay on Theological Method*, argues that the term, "God", stands for the ultimate point of reference or the goal toward which all human activity is directed.[560] Theologically this generalised notion of the divine as the goal of human self-transcendence is subject to the specifications given it by the vocabulary of religious tradition, with its use of such images and concepts as Creator, Father, Redeemer, Saviour, Trinity, Judge and Lord of all. Different notions of God—as the ultimate concern or goal of life—arise from and illuminate human existence, and its limit-experiences of joy, thanksgiving, and hope, along with the negativities of guilt, suffering, despair and oppression. The sense of God held by individuals and communities affects the way we see ourselves, now and in the future, and how we relate to others in a universe of divine creation, for good or ill. Consequently, theology, as a discourse centred on God, must consider the whole field of

---

[560] Kaufman, *An Essay on Theological Method*.

human existence, in its personal, social and cultural forms.[561] The more the divine is appreciated in relational and communal terms, the more our relationship to God and one another will exhibit and demand a relational understanding of person and community.

2. A Theological Sense of the Patient as "Other"

Under this heading, I consider less the reaction of the health care professional, and more the presence of the patient as a suffering "other". In the terms of the Scriptures that inform Christian theology, the patient is the neighbour who demands our care, and the stranger who must be made at home in an alienating situation. A relational theology recognises the patient as one who suffers and who is "other" in a manner that transcends the projections or field of competence of the professional carer. This is to say that the patient is a person—with the totality of relationships and values involved in such a status; therefore, not just a pathological object.

At one level, it is impossible not to recognise that another person is *other*. Yet this commanding alterity is muted by the effort to classify people into manageable groupings—such as nationality, ethnic origin, complexion, financial resources, type of illness, disability or trauma. Such classifications

---

[561] Kaufman, *An Essay on Theological Method.*

are clearly a pragmatic necessity. But these kinds of categorisations are not designed to appreciate the individuality of each case and uniqueness of each person. Taken to an extreme, as noted above, classifications based on pathology or ethnic origin have resulted in horrendous atrocities: to be negatively "classified" has meant being dehumanised or even demonised, with all semblance of personhood excluded. Levinas' approach to the other as calling the ego into moral responsibility, expressed in the biblical command, "Thou shalt not kill", is especially poignant in the health care context.

While theology is rightly focused on the reciprocity of relationships between the divine and the human, it just as rightly maintains that there is no simple symmetry between the human way of relating to God, and God's way of relating to the human. God is always the infinitely Other, never a projection of human need nor an object of human manipulation. Person(s) in the divine sense are never reducible to the human concept of self. This transcendent sense of otherness or alterity is analogically applicable to the love and care existing between human subjects: the ultimate otherness of the human person is found in its origin and destiny in God. If such personal alterity is not respected—in health care and in social relationships and services—a distortion enters into relationships concerned: the "other"—in its inexpressible uniqueness and transcendent destiny—is reduced to the

"same", as, say, a projection of "my" needs or concern or as even as an object of "my" care: the unique "you" becomes merely an extension of "me". In this way the other is permitted their distinction not in genuine recognition of uniqueness but in order to service my own sense of self. Any conversation generated in such interactions cannot be genuine. Not an implicit monologue, but genuine dialogue is at issue, in the philosophical and theological contexts already outlined. By recognising the otherness of an individual, particularly in a situation of suffering, we are faced with the appealing vulnerability of the other, and the inescapable fact of our own vulnerability as well. This leads to our consideration of compassion.

3. Compassion as a Theological Value

Philosophy, theology, Old Testament and New, share in recognising the demands of compassion, with the medical tradition summed up in the Hippocratic Oath.[562] With its emphasis on the dignity of the human person and the reality of the Incarnation, a theological perspective would insist that the personal reality, context and capacities of the patient be engaged. The basic relationships inherent in health care do not stop at information or gaining consent: a meeting between persons is involved. Indeed, Ian

---

[562] Ludwig Edelstein, "The Hippocratic Oath," in *On Moral Medicine: Theological Perspectives in Medical Ethics*, ed. Stephen E. Lammers and A. Verhey, (Grand Rapids, Mi.: W. B. Eerdmans, 1998), 107

McFarland has argued that personhood itself is reliant on an act of compassion. McFarland suggests that the challenge to Jesus by the lawyer in Luke 10 and the subsequent Parable of the Good Samaritan is a dialogue about anthropology in which the lawyer's question, "And who is my neighbour?" (Lk 10: 29) is analogous to the contemporary question at the heart of this thesis: "what is a person?"[563] His exegesis of the narrative proposes that to be a neighbour/person, one must first be shown compassion:

> [O]ur life as persons requires a prior act of compassion in which another person treats us as persons. [564]

While such a perspective appears to call into question the objective status of persons, leaving it in the hands of another, McFarland also grounds his exegesis in an understanding of the Trinity. Deriving human personhood from Trinitarian personhood establishes the ontological ground for personhood. As McFarland argues,

> If we adhere to a trinitarian framework in our use of the term "person", then only the divine persons are capable of showing us this kind of compassion. And since only one of those persons has become flesh and dwelt among us, no human being but Jesus can assume the role of the Samaritan for us. The compassion he shows to us by claiming us as sisters and brothers constitutes us as persons sharing his communion with the Father and the Spirit. [565]

---

[563] Ian McFarland, "Who Is My Neighbor?: The Good Samaritan as a Source for Theological Anthropology," *Modern Theology* 17, no. 1 (2001).

[564] McFarland, "Who Is My Neighbor?..."

[565] McFarland, "Who Is My Neighbor?..."

McFarland demonstrates the wider applicability of this argument by noting that since all human beings are putatively persons due to the act of compassion by Jesus, then I am likewise called to treat them as persons. He also grounds his example of this broad call to personhood in health care. He indicates that any treatment options considered for a vulnerable person who cannot act for themselves, depend not so much on any objective reading of their personhood, but on the particular relationship which I have with them:

> In other words, the crucial ethical judgement in my behavior toward those I meet on the road is not primarily the general category under which they fall (however necessary some such judgement may be), but rather the way in which I define my relationship to them in their particularity.[566]

A theological perspective on the understanding of personhood in the Trinity and its analogous application to humanity opens into a wider network of relationships. The human person is not judged according to criteria of biological perfection. Death and suffering must be given their place in human existence, and too, recognition of the vulnerable and the marginalized in human society has an essential place. While theology may inspire a positive view of suffering as salvific, this is not to be confused with a glorification of pain as a pathway to sanctity. Rather, it points to an acceptance of suffering as a dimension of human existence which demands a style of communication founded in compassion. That is, to offer assistance, to address the other in

---

[566] McFarland, "Who Is My Neighbor?..."

need, requires an affective self-identification with this suffering other, and the constant effort to enter into his/ her hopes and fears, and to share the horizon of feeling and questioning in which the patient concerned is experiencing the world. In the setting of health care, the inter-relationships concerned are by their nature asymmetrical, as mentioned above. The health care professional, for example, has a clearly defined role and sense of identity within it. This is not the case for the patient whose structures of meaning have been inevitably disrupted by the onset of a health crisis. Not only are patients literally no longer "at home" in the hospital ward—with its different hours of functioning in terms of meals and so forth—they are cut off from their sustaining communities and, of course, addressed, or referred to, in an unfamiliar technical language.[567]   Their situation demands an appreciation that only genuine compassion can supply.

The attitude of compassionate involvement is nourished by rich scriptural sources. In the Old Testament, solidarity with the suffering other, particularly the widow, the orphan and the stranger is commanded by the Law (see, Ex 22: 22–24; Lev 25: 35–38; Dt 10: 18, 24: 17–22, for instance). In the New Testament, two scriptural examples stand out: the Parable of the Good Samaritan (Lk 10: 25 – 37), which has been briefly referred to above, and the Parable of the Last Judgement (Mt 25: 31 – 46). In both parables, the

---

[567] Epperly, "Prayer, Process, and the Future of Medicine."

compassionate are contrasted with those who lack it. Compassion always presupposes action—what is done to and for the other who is deserving of care. This value has been embodied in the mission of numerous religious orders (Little Company of Mary, Sisters of Charity, Sisters of Mercy, Brothers of St John of God, and so forth), and in various institutes such as the St Vincent de Paul Society. It is vital to the Christian identity, even if everyone must acknowledge their omissions and failures in this respect.

Furthermore, it has variously been argued that compassion and empathy are basic values in any system of health care,[568] and required in the physicians' duty of care to all patients.[569] To stand with others in their suffering and need has also been considered as a social virtue fundamental to the fabric of society. Martha Nussbaum has argued that "compassion" is essential to the functioning of society.[570] Compassion has three elements corresponding to the cognitive, affective and volitional domains: "an appreciation of the suffering under which another labours;…a sympathetic reaction of distress on the part of the agent—the one who feels pity or compassion;…the agent's

---

[568] James Duffy, "Rediscovering the Meaning in Medicine: Lessons from the Dying on the Ethics of Experience," *Palliative and Supportive Care* 2, no. 2 (2004).

[569] T. K. Kushner and D. C. Thomasma, eds., *Ward Ethics: Dilemmas for Medical Students and Doctors in Training* (Cambridge: Cambridge University Press, 2001), 106ff

[570] See, Martha Craven Nussbaum, "Compassion: The Basic Social Emotion," *Social Philosophy and Policy* 13, no. 1 (1996). The reasoning in this article has been contested by Brian Carr, but not the conclusion that Nussbaum reaches that compassion is essential for social cohesion. See, Brian Carr, "Pity and Compassion as Social Virtues," *Philosophy* 74, no. 3 (1999).

being moved if possible to help to alleviate that suffering."[571] Compassion is essential to the functioning of society and brings about social cohesion precisely because it draws us out of ourselves and into the situation, the need of another. Through compassion persons are engaged in an activity where their minds and hearts must meet in the dialogue. Brian Carr agrees with Nussbaum about compassion being an essential social value, but sees a point of difference in their reasoning due to Nussbaum following Aristotle's equivalence of pity and compassion. Carr argues that while they are similar, pity does not demand, as compassion does, for one to "stand with" the other in their suffering. He notes that the prerequisite for such "standing with" is the capacity for "reaching out of ourselves into the misfortunes of others who are importantly unlike ourselves."[572] This seems to me to be right. The compassion that one feels for another prioritises the suffering of the other and moves me outside myself and my own concerns. While it is necessary to empathy for me to have some idea of the suffering of the other, it is not necessary for me to have exactly the same value system, experiences and decision-making processes.

This "suffering with the other" is both a theological imperative,[573] and surely, part of the medical tradition. But this value has become subject to criticism in

---

[571] Carr, "Pity and Compassion..."

[572] Carr, "Pity and Compassion..."

[573] J. Nelson-Pallmeyer, *The Politics of Compassion* (Maryknoll, New York: Orbis Books, 1986).

the highly professionalised and scientific modern heath care contexts. Texts

dealing with medical professionalism and medical ethics draw attention to

the limits that must be placed on the compassion of health care

practitioners.[574] Junior professionals are advised by their seniors to keep a

detached distance from their patients.[575] Among the cases cited by Thomasine

Kushner and David Thomasma are two which illustrate this point. In the first

a third year medical student with a facility in Chinese language visited a

recently discharged elderly Chinese patient in the patient's home. During the

discharge process the patient had been given a number of medications and

detailed instructions on when, how and why they were to be administered.

The medical student was concerned that the patient did not understand the

instructions or their rationale and took the view that having this explained in

Chinese and in the patient's own home would increase the likelihood of a

successful outcome for the patient. The medical student concludes the

description of the case in the following words:

> When my supervisors heard of my personal concern for this patient
> they said my actions were unwarranted and inappropriate"[576]

There are a number of possible reasons for supervisors to be concerned about

this scenario: that, if universalised in the student's behaviour, it could lead to

greater fatigue and burn-out; that it raises issues associated with duty of care

---

[574] Kushner and Thomasma, eds., *Ward Ethics...* Chapter Eleven Also, Beauchamp and Childress, *Principles of Biomedical...*

[575] Kushner and Thomasma, eds., *Ward Ethics...* 113-114

[576] Kushner and Thomasma, eds., *Ward Ethics...* 113

and public liability; that the care shown by this student was outside the bounds of usual medical expertise. A second case cited by Kushner and Thomasma is worth considering. It concerns a resident in paediatrics who describes the process of working with a neonate with a number of abnormalities requiring repeated surgeries with a very limited prognosis in any event. The resident indicates that the child's mother never left her daughter's bedside, continually searched for options. It is also reported that the resident spent a considerable amount of time talking with the mother. The resident states at the end of the case:

> When all attempts failed and the child finally died, I cried along with the mother. I didn't try to hide my feelings from her. My supervisor admonished me later and said that I would have to learn better control because, 'You don't help your patients by crying with them.' [577]

Again, the potential for burn-out could be an issue here; additionally, it is possible that the supervisor has taken the view that health care professionals have a responsibility to convey to patients confidence and strength, not to share their emotions.

What the supervisors in both cases missed, however, is that to avoid the *potential* flaws, they created an *actual* one, by removing all traces of humanity from the clinical encounters. In both these cases it is clear that the response of the junior person is quite individual. Neither scenario is likely to be a routine

---

[577] Kushner and Thomasma, eds., *Ward Ethics...* 114

experience. In the first, the Chinese speaking student will not encounter elderly Chinese patients on a frequent basis – this situation is the use of a skill separate from medicine but which can enhance the medical encounter for some patients. In the second case, while neonatal care can generate high levels of emotion routinely, the circumstances here are fairly unusual. Not only is the child's illness involved but the lengthy conversations with the mother over a considerable period of time and the resident's awareness of the mother's hope at every turn. Cases like these cannot be the everyday task of health care professionals, but compassion is an essential element in good patient care.

The supervisors did not recognise that a deeper issue is at stake. A professional practice that precludes the demands of compassion prevents medicine from achieving a primary goal: the care and treatment of the whole person. Two problems arise in contemporary highly technological medicine: how does the training of professionals, particularly clinicians and specialists, include education in psychological, emotional and human development? Secondly, how is a team-approach calling on a wide variety of skills and types of care to be implemented? The former problem can be addressed; but space needs to be created within the curriculum for it instead of it being regarded as

"fluff."[578]   The latter is a present possibility; but it means that people who possess genuine capacity for compassion can also be welcomed as part of the health team.   Unfortunately, often such people are often recognised by patients as being of lesser status, and excluded from the critical decision-making process affecting the patients concerned.

It remains, however, that compassion is a value formally shared by both Christian theology and health care. As such, it is a point of contact between the two disciplines, when concern for the patient is uppermost.   Theology accepts what, on occasion, health care is reluctant to recognise—that, in the end, compassion may mean "standing helpless with the patient whose life [is] being ravaged by pain."[579] In making this remark, I am not claiming that the medical profession as a whole, or even a significant proportion of its members, lack compassion. But what I am noting is that, despite compassion being recognised as fundamental to the activity of health care, because it lacks a deeper reflective grasp of its significance—be it in theological or humanist terms—it is in a danger of being reduced to an inappropriate sentiment, with

---

[578] M. B Mahowald, "Commentary," in *Ward Ethics: Dilemmas for Medical Students and Doctors in Training*, ed. T. K. Kushner and D. C. Thomasma, (Cambridge: Cambridge University Press, 2001), 121

[579] G. Micco, "Commentary," in *Ward Ethics: Dilemmas for Medical Students and Doctors in Training*, ed. T. K. Kushner and D. C. Thomasma, (Cambridge: Cambridge University Press, 2001), 119

no place in repertoire of health professionals. [580] It is here that theology has much to offer to health care practice by critically presenting the deep religious and philosophical sources of compassion and its necessity in all human interactions.

4. A Theological Recognition of Human Limits

Palliative care, as a branch of medicine, is dedicated to assisting patients, and those in relationship with them, to come to terms with a terminal diagnosis and to aid the patient in dying well. The degree to which this impressive specialisation animates the ethos of health care is an unsettling question for the whole system. Acknowledging the limitations of medical interventions and the inevitability of death presents a fundamental challenge to health care's healing dimension. In this palliative area, the patient's religious beliefs and spirituality are taken seriously. [581] The meaning of the individual's existence and society's capacity to support it at its terminal phase cannot bypass such considerations. [582] Facing death and dying well draw on rich religious traditions expressed in a variety of rituals designed to console and offer hope to the sufferer at the end of life, along with celebrating, commemorating and mourning the passing of a member of the community. I

---

[580] Micco, "Commentary,"

[581] Tan, Braunack-Mayer, and Beilby, "The Impact Of..."

[582] Koenig, "Religion, Spirituality, and Medicine: Research..."

am certainly not suggesting that religious faith or spiritual standpoints are concerned only with death and dying as though the sacraments, in the Catholic tradition, were exhausted in the anointing of the sick and the giving of Viaticum. These are celebrations of life and communal existence—as with the sacraments baptism, confirmation, marriage and eucharist. The sense of the wholeness of life's journey and its communal setting is imperilled when, in the hospital setting, for instance, the seriously ill suffer a forced separation from their communities and the structures that express meaning and identity—as in previously mentioned examples. But, at such junctures, a practical, interdisciplinary theology can offer a helpful critique.

Illness, disease, suffering and death are part of the biological dimension of what it means to be human. The human person, whether patient or carer, is, ultimately, faced with a fundamental alternative: either to accept such limits of life and learn to deal with them; or reject them, and seek a form of spurious immortality. A fatalistic acceptance of sickness and death is not a theological position, for it would deny the graciousness of God that works through the many ways that give, maintain, heal and enhance human life. On the other hand, prolonging life at all costs without an acceptance of its limits is neither good theology nor good health care. In focusing on the practical dimensions of Christianity's support for the sanctity of life, it is sometimes implied that the tradition is vitalist in its approach—this is certainly not the case.

The tendency to deny death and to reject the limitations of life and ageing is often termed "vitalism". It represents a search for absolute control over human life and resists limitations as they inevitably appear. Even death is to be brought under human control as in the voluntary euthanasia movement. The disproportionate clinging to life or to control over it is further expressed in the demand for surgical interventions of a purely cosmetic nature. In both these situations to live in a manner subject to the individual's capacity to choose is the leading value. If the search for a cosmetically beautiful, independent and pain-free life is compromised, then painless and immediate death is preferable to engaging with limitations of suffering and dying in the normal course of events.

Radical autonomy thus becomes the key issue. In this framework the value of an individual's life is founded on the capacity to choose when, where, and how to live that life. Or, as Ronald Dworkin puts it, "[f]reedom is the cardinal, absolute requirement of self-respect: no-one treats his life as having any intrinsic, objective importance unless he insists on leading that life himself, not being ushered along by others, no matter how much he loves, respects or fears them."[583] The individual's self-determination is the criterion

---

[583] Ronald W Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* (New York: Alfred A. Knopf, 1993).

by which all else is to be measured—with the presupposition that the self-understanding of the individual in question is that of an autonomous and independent subject, sufficient to itself in terms of the meaning, values and the structures informing its existence. But how realistic is such a conception of the individual and autonomous self? The experienced reality for the great majority of people is that to a greater or lesser extent their lives are "ushered along by others" whom they love, respect and even fear. The stages of childhood and old age are times of often acute dependence and limited freedom. The kind of freedom that Dworkin insists on is hardly possible—or even desirable. Does this mean dependent human beings are necessarily lesser beings compared to the ideally autonomous individual, with the wealth and power to so assert themselves? A realistic vision of the human world is at stake.

A theological perspective presupposes a more relationally-structured world in which human freedom and dignity are differently construed, compared to Dworkin's principles—as I have argued throughout this thesis. However, for the moment, it is worth considering the practical implications of the Dworkin's view. Intrinsic to such an outlook is the assumption that that the free choices of individuals, once made, must be acted on by others, for example, in regard to cosmetic surgery, or a life-prolonging course of treatment. In other words, the choice of the individual fundamentally

determines the choices of others involved, and the priorities of society itself.

In a situation when medical opinion sees minimal likelihood of success or the

risk involved, or the sheer cost of the procedure in terms of time and

resources, the alternative can often lead to euthanasia—either as a demand or

an imposition. Dworkin supports the autonomous decision of a patient in

either regard and, in the case of a severely demented patient, their previous

autonomous choices. He claims that,

> "[m]aking someone die in a way that others approve, but he believes a
> horrifying contradiction of his life, is a devastating, odious form of
> tyranny."[584]

The difficulty with this stance is that it assumes that, as noted above, patients

have a full capacity to know everything about their health condition in an

objective manner, that their judgements about these things are always

accurate and that there is never any conflict between their choices and the

health system, a physician's integrity or anything else. In other words, if

Dworkin's view were to be acted upon, the health system would need to

deliver anything a patient requested, health care professionals would need to

carry out whatever was demanded by a patient. In a more disturbing section

of his book he suggests limits to this free choice approach to health care,

> the state should not impose some uniform, general view by way of
> sovereign law but should encourage people to make provision for their
> future care themselves, as best they can…[585]

---

[584] Dworkin, *Life's Dominion...*

[585] Dworkin, *Life's Dominion...*

So, there would be no limit to what a patient can choose in terms of medical treatment and life-sustaining or ending treatments so long as the patient can "make provision" for themselves. The corollary of this approach to autonomy is that people are free to have no health care if they cannot provide it for themselves. In such a system it is little wonder that many would hold that a severely limited life in terms of vitalistic criteria is judged to lack any innate dignity or objective value. I am not suggesting that Dworkin would take his view that far but it is a logical conclusion to reach, particularly in the light of his perspective on the innate value of human existence:

> Value cannot be poured into a life from the outside; it must be generated by the person whose life it is…[586]

Clearly, this judgment will be contested when larger theological perspectives come into consideration. Instead of a radical autonomy, I have argued for a relational understanding of the person where the meaning and value of a life is not just self-generated but is the result of the various relational encounters within a person's life. Freedom is intrinsic to human persons, but it is a freedom lived within the constraints of reality and the webs of commitment that they have entered into. For example, a mother with small children has a number of her potential choices closed off or, at least, deferred due to the commitments that her relationships with her children have placed on her. Theological arguments necessarily accept the "situated" character of human

---

[586] Dworkin, *Life's Dominion...*

autonomy; it can never escape or avoid limitation on many fronts, let alone the terminal limit of mortality itself. To be alive means to be limited as well as free; to die as well as live; to be patient in suffering as well as to enjoy the blessings of good health. Persons have the capacity positively to appropriate these many seasons of life and the natural limitations inherent in every life-journey, so to incorporate them into a personal sense of meaning and identity.

To the extent health care encourages such vitalistic views, it will receive theological critique, especially from a Christian perspective fundamentally formed by the revelation communicated in the life, death and resurrection of Jesus. Health care is directed to curing illness and disease, to alleviating injury and suffering. But this cannot be the whole story. It must also include the passages of human existence marked by risk and suffering, with all events and experiences eventually leading to decline and death. It is precisely in this regard that theology can assist health care to understand its own goals more fully, to be ever alert to unique value of each person and the breadth of considerations implied in such a recognition.

Here, as in other situations, theological perspectives overlap with the aims of health care, even if a transcendent element reaching beyond the primary psycho-biological focus of health care is involved. The closeness of the two fields, both concerned with human well-being, provides a point of dialogue,

while differing human perspectives make possible a fruitful and mutual critique. A fundamental point of dialogue is the dignity of the human person—and indeed, the dignity of all persons involved in the health care setting.

5. A Theological Approach to Human Dignity

The dignity of the human person is a central value for both theology and health care. But what that dignity consists in has been a subject of debate. One conception of dignity is based on the concept of autonomy. As indicated above in reference to Ronald Dworkin, such an understanding of dignity is exclusively based on a radical autonomy and the capacity to bring an individual's choices to fruition. If this argument holds sway, then anyone whose autonomy is seriously impaired lacks the dignity in question or possesses it only in a diminished form. But the essential value of the person consists in autonomy to lead one's own life—and, as a final manifestation of this self-determination, to decide on the manner of one's death. Respect for such a person's dignity would mean accepting the imperative to implement what such a one has decided, even it entails a choice for self-destruction.

In this framework, respect for the dignity of the person ultimately consists in control over one's life, in particular in being able to determine the time, place

and manner of one's death. Respect, in this conception, cannot simply be a negative form of acceptance – that *I* would not interfere with *your* choice to end *your* life. Rather, respect for dignity when it derives simply from autonomy, must mean that *I* am prepared to accept *your* decision to the point of assisting you with carrying it out. A refusal to do so would be an offence against the other's dignity. In other words, recognition of human dignity, when it is so closely associated with autonomy, cannot mean simply an acceptance of a given person's choice to end their life; it must mean that society accepts, endorses and supports such a choice to the point of rendering assistance with the decision to end that life. Anything less is an assault on the dignity person concerned. In this light, society can gradually move from the implicit acceptance of voluntary euthanasia—as the choice of the once healthy members of the community who have expressed their will in this regard—to a point where euthanasia would be compulsory for those who can no longer exercise self-determination, or for those for whom self-determination will never be a possibility, as in the case of an infant with severe intellectual disability: for such a state is an offence to human dignity, and justifies termination or infanticide as the result of an offence against the dignity of others or due to the compromised life interests of the infant.

Such a conception of independence and autonomy contains an implicit anthropology. It assumes that the individual has no intrinsic connection with

others and must be protected from their interference in the autonomous choices that have been made. Relationships derive from choice alone and bring no other unchosen commitments or bonds to another. An individual can be said to lead a "dignified existence worthy of moral respect because (and only insofar as) he is self-legislating, overcoming natural necessity and willing his own actions".[587] Positive support for the autonomous choices, even if they contradict the beliefs and values of others, is entailed.

Contrary to this conception of human dignity based on radical autonomy is one based on an ontology of the individual person. To be a member of the human species is a biological classification. But to be a human person is an affirmation of the objective ontology—the underlying real and permanent status of the person, whatever the "accidents" of a particular condition or state. This conception is not a matter of empirically understood functionality or capacity inherent in the individual, but on the philosophically affirmed permanent "substance" of the person, as possessing human nature, whatever the circumstances of history and social relationships.

The basic dignity associated with this conception of the person has a universal application, indicative of the moral worth of all human beings, whatever their

---

[587] R. E Goodin, "The Political Theories of Choice and Dignity," *American Philosophical Quarterly* 18, no. 2 (1981). Cited in, Pullman, "Universalism, Particularism..."

capacities.[588]   The United Nation's *Universal Declaration of Human Rights* speaks of human dignity in this sense.   It is the basis for the ascription of rights, for rights derive from this basic and intrinsic dignity; they are not given from an external source.

If the former psychologically "autonomous" model is highly individualistic, this model tends to considerations of individual psychological conditions or capacities.   The dignity of the person is ontological, a metaphysical given, irrespective of circumstances, preferences or choices.   Hence, the treatment and care of such persons is moral or immoral, in view of the recognition, or non-recognition, of their basic dignity.   The universal value of human dignity is thus the criterion for justice and the human rights that support it.

Paradoxically, this ontological view of human dignity which seeks to attend to individual worth ends up being, psychologically speaking, to some degree impersonal because of its universal applications, and the ethical prescriptions that follow.   For example, the *Universal Declaration of Human Rights* (UDHR) indicates standards of nutrition, housing, health care and education to which all human beings should be able to rely regardless of economic, social or cultural circumstances.   Likewise, it proscribes activities like torture, unwanted medical intervention without consent, or forced removal from

---

[588] Pullman, "Universalism, Particularism..."

lands and nations, because all these are contrary to the dignity of the person. While the UDHR is of historic significance, a philosophical or juridical affirmation of human dignity is always anthropologically incomplete: for by remaining on the abstract philosophical level, the affirmation of the rights of persons does not express the duties of others in response to this basic value. The intentional relationality and moral interaction of persons among themselves do not come into consideration.

I have in this thesis, therefore, been commending a third model, that of relational personhood. Deriving in different forms from both philosophy and theology, it provides a better account of human dignity in the health care context. Whereas the model of psychological autonomy prizes radical individuality and the ontological model is determined by an abstract universal notion of human nature, a relational conception of humanity has the advantage of bringing together the psychological and philosophical aspects of the other two models, in a manner that allows for the whole field of relationships constitutive of the human person. This relational model extends in a flexible way to the transcendent and the immanent dimensions of the person, the eschatological and the historical, the psychological and the ontological, the individual and the communal—all of which are inherent in human existence and constitute the concrete dignity of the human person. As a consequence, the theme of human dignity is played out in a field of

relationships in a way that goes beyond functional or ontological or even doctrinally religious considerations.

More particularly, this relational model counters a style of health care that "assumes a sociology of strangers who share little in the way of common values and ends."[589] Personal existence is always lived out in communities and communal experiences. This will inevitably include encounters with strangers; but the experience of belonging and mutual responsibility is derived from meaningful relationships through which we are bound to others through implicit and explicit ties and covenants.[590] It is through participation in such "common sense" humanity that moral responsibilities in a field of mutuality and shared responsibility become clear. To refer to George Khushf's observations once more, sickness reveals our essential incompleteness as individuals and our intrinsic need for other persons:

> "through illness individuals become aware of their insufficiency and they turn to others for help. However, most people do not appreciate the full revelatory function of illness—that it discloses a deep brokenness that is there already, and not brought about for the first time by the sickness".[591]

The appropriate response in the face of such intrinsic need and co-dependency is personal communication rather than medical treatment. Even

---

[589] Campbell, "Religion and Moral Meaning in Bioethics."
[590] Brown, *The Worth of Persons...*
[591] Khushf, "Illness, the Problem of Evil..." 34

when it is evident that the sick person requires medical treatment—bed-rest, medication or more serious intervention—this already assumes that the psycho-social need for care is being met. In other words, as Moltmann indicated in reference to the Parable of the Last Judgement, the need of the person does not fundamentally require professional service but that their needs as Other become the central concern. [592]

Care assumes a relationship in which the other is not a stranger, but a neighbour, a fellow human being, to whom one is bound. [593] The other is recognised as vulnerable, calling forth a response worthy of the dignity of the needy patient and of those who offer care. While an ethic of care in medicine has been criticised for encouraging paternalism,[594] it is nonetheless the only appropriate response to illness, disease and injury when there is no possibility of cure. [595] In both cases, the kind of relationships latent in medicine and health care can be examined. Courtney Campbell and W. F. May, among others, have argued that the operational paradigm for relationships in health

---

[592] Moltmann, *Experiences in Theology*.

[593] C. S. Campbell, "Gifts and Caring Duties in Medicine," in *Duties to Others*, ed. C. S. Campbell and B. A Lustig, 4, (Dordrecht: Kluwer Academic Publishers, 1994)

[594] Campbell, "Gifts and Caring," 181 Beauchamp and Childress, *Principles of Biomedical...*

[595] Stephen E. Lammers, "The Medical Futility Discussion: Some Theological Suggestions," in *Secular Bioethics in Theological Perspective*, ed. E. E. Shelp, (Dordrecht, NL: Kluwer Academic Publishers, 1996), 119f

care is that of a contract.[596] But the concept of care understood more deeply

and interpersonally both critiques the contract-model, and offers an

alternative based more on the notion of covenantal relationships. A covenant

is more than an episodic contract; for it connotes a specific historical exchange

between persons in which those involved are transformed through the

interaction. The concept of covenant, with its long history in religious

expressions of the relationships existing between God and Israel and the

Church (e.g., the Mosaic covenant, the New Covenant), is a fitting descriptor

of the communal ties that bind persons to one another. With a specific

medical application, it suggests, in Paul Ramsay's phrase, "canons of

loyalty".[597] Ramsay goes on to explain this in the following terms:

> The conscious acceptance of covenant responsibilities is the inner meaning of even the "natural" or systemic relations into which we are born and of the institutional relations or roles we enter by choice, while this fabric provides the external framework for human fulfilment in explicit covenants.[598]

The implication of such an approach is that the covenant is a kind of

metaphorical basis for all the interactions based on mutual trust, care and

interdependence. For this reason, it is a richer and more evocative notion

than that of a contract between two independent parties in an otherwise

[596] Campbell, "Gifts and Caring," and William F. May, "Code and Covenant or Philanthropy and Contract?," in *On Moral Medicine: Theological Perspectives in Medical Ethics*, ed. Stephen E. Lammers and Allen Verhey, (Grand Rapids, Michigan: William B. Eerdmans, 1998)

[597] Paul Ramsey, *The Patient as Person* (New Haven: Yale University Press, 1970).

[598] Ramsey, *The Patient as Person*.

neutral frame of reference. Covenant expresses the depth of a mutual commitment and communal responsibility, while a contract evokes individuals in isolation negotiating at a more superficial level on a specific point of interest.[599] The covenantal relationship contains an assumption that those in a position of privilege are duty-bound to assist the less well off, and that the powerful have responsibilities to the weak. In this sense of relationship, it is not a question of previously equal parties negotiating something of common interest, but more a matter of living out the original meaning of the covenant and promoting the status of all involved in it. It brings the value of the self and the other into clearer light in an interaction based on reciprocal recognition, in an ultimate horizon of meaning.

The identities of the parties in such covenants are both determined and transcended through engagement in the relationship.[600] In the field of meaning and value within which it works, each becomes more fully a person in and through an intersubjective exchange of call and response. Thus, each participant in the relationship enhances the status of the other, and is in turn enriched by the other. Many such transforming relationships are implicit in society, for a formal objectification of a covenant is not necessarily required, since certain kinds of activities and interactions are evidence of covenant

---

[599] Hauerwas, *Suffering Presence*.

[600] May, "Code and Covenant or Philanthropy and Contract?," 127

relationships already at work. In the case of medicine, a covenant relationship is most apt. As has been argued by several authors, the willingness of members of the community to participate in the training of health care professionals—right to the point of cadaveric donations— implicitly enmeshes all parties in a community of covenantal inter-relationships. [601]

6. Conclusion

The relationships structuring the patient's clinical setting must include the following interacting components. No one of them can be taken in isolation from the rest, and each of them must allow for the others, but within an overall beneficent patient-centred setting:

- Scientific expertise appropriate to the best medical practice;

- An economic structure within the resources of the society concerned;

- Clear contractual arrangements between patient and the health care institutions and staff;

- Bureaucratic management designed to facilitate both care and the availability of resources;

- A milieu or field of interpersonal communication in which all dimensions of the "relationality" of the persons concerned is

---

[601] Edmund D. Pellegrino, "Ethics in Aids Treatment Decisions," *Origins* 19, no. 33 (1990).

maintained and promoted according to the covenantal notion described above in which fundamental meanings and values are at stake.

This list of ideal components in any health care arrangement allows us to itemise the problems that occur when any one of them becomes exaggerated or isolated from the whole. However desirable the best medical science, if the patient is objectified so as to become a mere instance of pathology or trauma, the personal status of both patient and professional is compromised. Clearly, too, if economic calculations enjoy priority, an impersonal system of supply and demand, and the exchange of goods and services for maximum profit, takes over. Likewise, viewing the relationship as a contractual one falls short of the necessary standard. Parties to a contract must have the freedom to go elsewhere or not to enter the contract at all. But in the case of illness or injury this is hardly realisable in the circumstances, even if a contractual structure of some kind has been previously presumed or agreed on, e.g., private hospital care, public hospital access, emergency services, etc.[602] Just as obvious are the harmful effects on the persons involved of an aggressively bureaucratic system. There are forms to be filled out, authorisations to be given, and all

---

[602] It is interesting to note here that this may differ across communities. It seems apparent that Australians are willing to consider that health care relationships are evident and important even when well, given the attachment that the community has to Medicare. Yet, in the US, there does not seem to be the same recognition.

the preliminaries of the appointment, the waiting room, contacting the receptionist, not to mention proving one's ability to pay and clarifying the extent of health-cover. In such a context, the actual need or state of the patient is not the commanding consideration. Such a stance assumes that the two parties enjoy the same degree of autonomy, and they are respectively free to arrange matters as they see fit. Needless to say the religious or spiritual, personal approach to sickness and health would be seriously frustrated and lose all credibility if it attempted to ignore the other requirements of a scientific, economic, contractual and managerial character. If theology is "faith seeking understanding" in a health care context, it is clearly obliged to acknowledge the contribution of other areas of understanding, both theoretical and practical, if it is to make a worthwhile contribution.

A properly developed theology of health care must respect all the values involved, even as it contests the kinds of narrowness I have hitherto mentioned. Theology, reflecting on religion and with its wide familiarity with philosophical consideration of the human person, expresses horizons of meaning and appropriate rituals which not only assist patients in their critical limit-experiences, but also assists health care practitioners to deal with the pain, suffering and loss inherent in their professional and moral

commitments. [603]   The contribution of theology is on the level of an integrating

and ultimate understanding of the human condition and its destiny.   In this

way, it evokes a sense of direction in the journey through life by articulating

the ultimate meanings and values of life, both individual and social.

Theology must contest the "sociology of strangers" implicit in health care

systems at the various scientific, economic, contractual and managerial levels.

What it promotes is more a "sociology of neighbours" or the reality of

community, for human beings, especially because all share in the gift of

creation and are called to a divine destiny, belong to one another, and are

beholden to an ethics of mutual assistance and compassion.   A theological

vision of health care consequently has an important role in the lives of

patients, just as it is fruitful in enlarging the horizons of health care systems.

Finally, it is possible to summarise the conclusions of this chapter on the

contribution of theology to health care by referring to what was stated at the

beginning. Theology mediates the significance of religious faith to the culture

and practice of health care. This implies three tasks, namely, a critique of the

reductive views that are common in health care; support and deepening of the

fundamental meanings and values of persons in health care and of health care

itself; and the refinement of interdisciplinary collaboration.

---

[603] Hauerwas, *Suffering Presence*.

Ultimately, what is at stake for health care is to enhance its capacity to adequately care for persons in terms of all their biological, psychological and spiritual needs or to increasingly leave people with the experience of being "squeezed". Should the latter be the case, then health care will fall short of the attainment of its own goals. The well-being of the human person is not enhanced if it is constructed in narrow biological dimensions, without reference to the transcendent aspects. What is at stake for theology is to involve itself in the concrete life experiences of believers and other persons or to risk irrelevance brought about through a narrow attention to doctrinal concerns alone. The well-being of the human person is not enhanced if their concrete biological needs are ignored or spiritualised in an attempt to justify needless suffering through some spurious reference to eschatological piety. Through interdisciplinary dialogue both health care and theology may be better placed to carry out their goals and to assist the flourishing of human persons. As argued in this chapter, such flourishing can only genuinely occur if relational personhood is at the heart of both disciplines.

This penultimate chapter has returned to one of the initial questions of the thesis—what contribution can theology make to health care. The answer developed throughout the thesis has been that a model of the human person conceived in relational terms is essential to modern understandings of both disciplines. The argument here has been that a practical theology offers a

point of engagement between Christian doctrine, philosophical insights about personhood and the realities of human existence in the field of health care. The next chapter is the conclusion to the thesis. Here I place the answer of this chapter into the wider context of the thesis and I make concluding remarks about the central aspects of the thesis. Paramount in this is the need to clarify the nature, orientation and meaning of relational personhood.

CHAPTER EIGHT: CONCLUSION: A PRACTICAL

THEOLOGY OF RELATIONAL PERSONHOOD

Through this investigation, the focus has shifted from the narrower considerations of health care ethics in particular cases, and away from a code of professional ethics designed to list the prerogatives and obligations of the health care professionals. My concern has been directed by a broader sense of human relationships, to include all persons involved, at the point of their root obligations and responsibility to the Other. This has implications for patients, for all concerned to assist them, and, as a result this alteration, health care will be more likely to achieve its goal. This change of focus will encourage both society, generally, and the actual participants in health care to move from a concentration on pathology to a more holistic focus on health.

One of the consequences of this shift is to question any construction of normality that implicitly marginalises the disabled and the powerless, and so makes it difficult to appreciate personhood in the diversity of its many realisations. The narrow concern with decisions facing health care professionals in the precise areas of their expertise must be broadened so as to appreciate the responsibility of the whole community for the health of all its members. The relational perspective for which I have been arguing is a

necessary frame of reference, but it must go further to the recognition of the
vulnerable other in assigning its priorities. That is, relationality is core to my
thinking but it is a particular kind of relationality — one which recognises
and includes the vulnerable other. In this relational and compassionate
context, the personhood of all is enhanced: professional carers are brought in
touch with their own vulnerability; and the vulnerable other is affirmed in his
or her personal dignity through a genuinely interpersonal style of
communication.

John Swinton has argued that our understandings of impairment, injury,
sickness and death are socially constructed, and that taking relationality
seriously would dramatically alter those constructions.[604] He draws on an
observation made by Stanley Hauerwas in *Suffering Presence*:[605]

> He suggests that within a society that had a different moral system that
> was not dependent on competitiveness, individuality and productivity,
> the concept of "learning disability" simply would not exist.[606]

Linking this insight with those of Macmurray, Swinton argues that our very
moral, social and economic systems construct disability in such a way as to
marginalise those with disabilities and to reduce their social and moral status.
The emphasis on individuality and productivity within modern societies
demand that those who cannot meet a particular level of success must be

---

[604] Swinton, "Constructing Persons..." 239-247
[605] Hauerwas, *Suffering Presence*.
[606] Swinton, "Constructing Persons..." 243

excluded. From the perspective highlighted by Hauerwas and developed by Swinton, it is not the particular physical or mental circumstance of the individual person that causes disability. Instead it is the systems of valuation, the social structures and barriers imposed by society which bring about disability. As Swinton notes, this is not an attempt to "downgrade the important reality of the disablement brought about by individual impairment." [607] The impairment is real, the disability is constructed. This is the case in health care more broadly. Illness, disease, impairment and death are real dimensions of all human lives and experience. In a society based on the concept of relationality rather than individuality, however, while the impairment, suffering and death remain, the disability and exclusion involved are not necessary.

Health care ethics has generally been very good at determining what advice or guidance to provide to health care professionals about various contentious issues in health care. Where this approach has failed is that it has not asked a more subtle and broader question: instead of asking "what do we do?", a more appropriate question is "how do we behave?" [608]

---

[607] Swinton, "Constructing Persons..." 244

[608] William F. May, *The Patient's Ordeal* (Bloomington, Indiana: Indiana University Press, 1991).

This type of question implicitly assumes a more holistic view of persons and persons-in-relation. Within this perspective the focus is not on the success or failures of individuals in specific aspects of their lives, not on discrete capacities or incapacities, not on pathologies. It is on the communal responsibilities of all persons. There are two dimensions to this, that value is ascribed to those with whom we are in relationship through being loved, respected, being regarded as special to us; and the need and vulnerability of the Other make demands upon me which cannot be ignored and must be resolved through embrace—meeting their need as best I can—or through rejection—marginalising them. The challenge in health care is two-fold: to embrace those in need and to construct a system of health care which is worthy of persons, not merely a commodity to be traded.

I present a number of concluding remarks under the following headings:

1. Care for the Vulnerable

2. Patient-centred, Person-centred: an Anthropological Approach

3. An Exemplary Instance: *Deus Caritas Est*

4. Orientation to Liberation

5. The Meaning of Relational Personhood: Dimensions and Carriers

6. Summary

7. Conclusion

1. Care for the Vulnerable

I previously argued, influenced by the philosophies of Macmurray and Levinas and by the praxis of Jesus in the Gospels that, all human relationships commence with a one-to-one interaction. These initial bilateral relationships unfold in the context of other, multiple kinds of relationships, to form the complex relational structures in which people exist and communicate. In this particular instance of the classical philosophical problem of the "one and the many", the one precedes the many, and the many condition the one. To encounter another person is not to meet an isolated individual fundamentally disconnected from anyone else, but to meet a person formed by a history of relationships. For each person embodies a legacy of their previous relational encounters. The intimate language of love expressed in the phrase, this other, this particular person—spouse, child, friend, for example—"means the world" to us. In the language of care necessary to this relational perspective, each other person means, if not *the* world, at least a world embodied in her or his relational existence. That particular world of the individual may in fact be distorted and confused. If previous relational encounters have occurred predominantly, say, in a mood of fear, apprehension or rejection, in contrast to the assurance of love and acceptance, this will have its influence on all subsequent relationships. In the language of McFadyen, the capacity for communication is impeded or enabled due to the impact of previous

relational communications. After all, as Levinas has pointed out, every relational encounter is open to possibility of rejection. Hence, relating to the other with the expectation of rejection rather than acceptance, the possibilities of a continuing negative communication regarding one's identity and society as a whole are intensified. All people are vulnerable because all can be rejected.

Relationships that are more intimate and more personal, run a proportionately higher risk of devastating rejection, with disastrous results in any given personal history. In health care this is especially so. On one level, the interactions that occur in health care can be described in ways very similar to those of a commercial exchange. I need a service of some kind; I seek out expert practitioners/providers of the service; I enter into an implicit or explicit contract about the service. Those involved in providing the service are relative strangers. In a routine commercial exchange, as in buying goods over the counter, the relational encounter need have no deep personal significance, even though a good salesman—or even a good "shopper"—might attempt to make it so as part of the technique of selling or buying—"closing with a smile". But in health care, the difference in the quality and degree of self-investment is notable. In this situation the relationship necessarily entails a very high degree of personal disclosure and intimacy, far beyond the kind of economic transaction just described. The intrusion into one's personal life

and space by relative strangers brings with it a high degree of vulnerability even for the most confident and self-possessed of persons. Once more we refer to George Khusf's observation that the vulnerability and dependence inherent in being a person is revealed through illness and disease far more than the medical need in question.[609]

Vulnerability, in this perspective, is integral to the nature of personhood, and capable of affecting the person, either negatively or positively. Rather than interpreting such vulnerability as weakness and loss of individual integrity, it must be recognised as an inherently personal quality and a feature of all interpersonal exchanges. Relationships reveal the vulnerability of persons; there is always the risk of rejection — even if this is not total or permanent. McFadyen describes this in terms of the extent to which any person, at a particular point in time and with respect to a particular relationship, is open or closed to the communication being offered.[610] Yet personal growth and development depend on entering into relationships with others. Only by risking rejection and hurt, is the self truly open to potential love and intimacy.[611] In Slocum's words, "Our personal knowing requires the relatedness of interpersonal love for the vulnerability and receptivity of

---

[609] Khushf, "Illness, the Problem of Evil..." 30-41

[610] McFadyen, *The Call to Personhood...*

[611] Levinas, "The Face of a Stranger."

authentic self-revelation."[612]   In learning to see what Matthew's Gospel describes as the hunger, thirst, nakedness and isolation of those around us, it is necessary to learn to recognise our own need to be sustained in and through relationships.[613]   In interpersonal relationships, the other is not simply abstract and known only in factual terms, such as one might glean from reading a *curriculum vitae.* It is only through personal interaction that we really come to know another in his or her genuine otherness; and, in so knowing this other, we become more self-aware, and so discover latent depths in our own personal being. As Macmurray put it, adapting the words of Paul addressing the Areopagus about the God of Jesus Christ (Ac 17:28), "we live and move and have our being not in ourselves but in one another."[614] The recognition of another can "only be comprehended as obligation and hence as responsibility."[615] This is what makes health care such a special case in human relationships; for these are not relationships into which a person would ordinarily choose to enter.   We seek health care due to a need that cannot be ignored; and this need entails a significant level of inter-personal relationship, whether we choose it or not.

---

[612] R. B. Slocum, "Kingdom Come: Preliminaries for a Relational Theology of Hope," *Anglican Theological Review* 82, no. 3 (2000).

[613] John Macmurray, *Ye Are My Friends* (London: Quaker Home Service, 1979).

[614] Macmurray, *Persons in Relation.*

[615] Per Nortvedt, "Subjectivity and Vulnerability: Reflections on the Foundation of Ethical Sensibility," *Nursing Philosophy* 4, no. 3 (2003).

This recalls the Genesis account of Creation and Fall (Gn 1:1-3, 24). It is a classic illustration of humanity's vulnerability to manipulation, along with the desire to deny the vulnerability inherent in the human condition. On the other hand, the story of Jesus' life, death and resurrection reveals that God works through acceptance of the innate vulnerability of the human condition. Jesus accepts the risks of being human–of being outcast, rejected, criminalised, marginalised and defeated. These risks result in his death, but he is glorified in his self-giving death as the exemplar and source of salvation.[616] The Resurrection of the crucified Jesus is the vindication of his free entering into solidarity with the limits of the human condition: he "emptied himself, taking the form of a slave, being born in human likeness, and being found in human form" (Phil 2:7), and so humbles himself, "becoming obedient even to the point of death, even death on a cross" (Phil 2:8). It is precisely in his self-exposure to human limits and his self-surrender to God for the sake of all, that he is glorified as the true image of the human, and, indeed, in his likeness to God (cf. Phil 2:9-11). The Pauline hymn depicts the revelation of Christ as the contradiction to humanity's proclivity to transcend its limits, and to aspire to a quasi-divine status of a living in glorious transcendence over any possibility of vulnerability to suffering or death. It is true that application of new technologies in health care have greatly extended the boundaries of human life, minimising infant mortality

---

[616] Gregersen, "Risk and Religion..."

and reducing deaths through injury and disease. This is an undeniably positive achievement.

It is also true that advances in health care have been bought at a terrible cost to others—either through misuse or misappropriation of scarce public resources, or through the inhumane treatment of the poor and vulnerable. Examples such as the Tuskegee Syphilis Experiment, in which African American men were deliberately infected with syphilis in order to track the natural history of the disease, caused the suffering and deaths of their sexual partners and children. Recent scandals in the United States of illegal cadaveric-tissue harvesting for use in cosmetic surgery, and the payment of young healthy people to participate in Phase 1 clinical trials of drug treatments in Britain raise concerns about the lengths that we are prepared to go to overcome the boundaries of human existence. The current debates over the ethics of embryonic stem-cell research raise similar questions: how much can the other, even in its most embryonic state, be regarded as the raw material for possible medical advances in the future?

In contrast, Christian revelation suggests that limitation is not overcome by denying the humanity of ourselves or others, but through embracing it in compassionate solidarity. The ultimate victory over death in life eternal is not achieved by aspiring to god-like status, but by accepting the mortal limits of

human earthly existence.   In this understanding, the grace of God operates most effectively through our shared acceptance and experience of human weakness and vulnerability, not in spite of it.

2. Patient-Centred, Person Centred: an Anthropological Approach

I have argued against the secularistic and rationalist directions that have become the modern temptation in health care practice.   Yet neither the secularistic exclusion of the religious dimension of the human person nor a rationalistic reduction of all meaning and value to the scientifically provable or possible, is anthropologically adequate.   But when a sense of relational personhood is promoted, the anthropological basis for the holistic conduct of health care is more secure.

For health care to be "patient-centred" is necessarily—and more challengingly—to be "person-centred" in a way that appreciates the dignity of the person *and* the network of relationships that comprise each personal existence.   Ideally, the recognition of the person understood in this way affects the style of health care in its every aspect—in regard, say, to the equipment used, the professional activities involved, the personal presence of the staff or visitors, even the manner in which conversations concerning the

patient are conducted.[617]   Such recognition entails acknowledgement of an interpersonal relationship between patient and health care professional, along with an awareness of the inevitable asymmetry in the relationship arising from the position of authority and power enjoyed by the practitioners involved, and their distinctive responsibility for the vulnerable other.

The relational focus I have commended allows for the inclusion of the religious dimension of human experience in health care, since this, at least in many cases, touches on the heart of personhood itself.   The testimony of Nancy Eiesland, a sociologist of religion, who was born with a severe disability is striking in this connection. She describes her awakening to a new Christ-centred sense of God in the midst of her need:

> My epiphany bore little resemblance to the God I was expecting or the God of my dreams. I saw God in a sip-puff wheelchair, that is, the chair used mostly by quadriplegics enabling them to maneuver by blowing and sucking on a straw-like device. Not an omnipotent self-sufficient God, but neither a pitiable, suffering servant.   In this moment, I beheld God as a survivor, unpitying and forthright. I recognised the incarnate Christ in the image of those judged "not feasible", "unemployable", with "questionable quality of life".   Here was God for me.[618]

Eiesland's personal epiphany communicates something of broader significance.   It puts the focus, not on the optimal functioning of an individual, but on the other in need. Yet it also moves beyond a self-pitying

---

[617] Zaner, "Encountering the Other," 24-25

[618] Eiesland, *The Disabled God: Toward a Liberatory Theology of Disability*.

attitude on the part of the sufferer to a deeper sense of union with God present in the experience of suffering: "Here was God for me"—understood in terms of the incarnational and trinitarian perspectives already presented, as the disabled are freed to own their place—before God, and in society itself.[619] Understood relationally, each of us is "responsible for the construction of the personhood and the life experiences of those whom we relate with directly or indirectly."[620]

The constant human temptation is to view the vulnerable as the exception, as outsiders in either the "success story" of culture, or even the religious story of salvation, to be regarded as less acceptable, or punished or "in-valid" in some way. Any list of such vulnerable persons must include young unemployed people who see themselves as unwanted and life as meaningless, the elderly languishing and often unattended even in nursing homes, the chronically sick isolated in public hospitals with declining standards of care, the mentally ill and intellectually disabled who have become homeless wanderers and who contribute growing numbers to our prison populations, and Indigenous people suffering high infant mortality rates, chronic illness and destined to premature death.

---

[619] Eiesland, *The Disabled God: Toward a Liberatory Theology of Disability*.

[620] Swinton, "Constructing Persons..." 241-242

I contend that a Christian anthropology, if it is genuine, must include these vulnerable people. By focusing on the vulnerable Other, a more authentic vision of the person can be generated, to provide a richer and more humane basis for health care and the moral issues it involves, right to the point of canonical and legal considerations.[621]

3. An Exemplary Instance: *Deus Caritas Est*

This particular exercise of a practical theology of relational personhood has potential applications in many related areas. Clearly, it enriches the context of the specific discipline of medical ethics, and will be a component in the theology and spirituality of pastoral care. Beyond this health care context, there are further applications possible in the areas of social work, counselling, education and social justice advocacy.

In the final stages of drafting this thesis, Pope Benedict XVI's first papal encyclical *Deus Caritas Est* was published.[622] In the brief references that follow, I appeal to it as an exemplary instance of application of the model of relational personhood that I have argued is necessary. While it is a formal

---

[621] See the Catholic Church, "Codex Iuris Canonici," in *The Code of Canon Law* (London, Sydney, Dublin: Collins, 1983), especially Canons 914, 1041 n.1 and 1084 What appears to operate is a theological paradigm of a pre-Fall perfection: the ideal human person is not only without sin, but also without illness, disease, impairment.

[622] Pope Benedict XVI, *Deus Caritas Est* (Rome: Vatican Publishing House, 2005). All references to this Encyclical are provided in text, according to usual convention and numbers refer to paragraph numbers in the document.

ecclesiastical document of a particular Christian tradition, couched in appropriate theological and exhortative language, I believe it is helpful to appeal to it for support in making connections between theoretical aspects of theology and their practical connections to the life and social mission of the Church (n. 15).

Pope Benedict's basic approach is expressed in the very first paragraph, when he writes,

> Being a Christian is not the result of an ethical choice or a lofty idea, but the encounter with an event, a person, which gives life a new horizon and a decisive direction [n. 1].

In line with the theological dimensions of the interpersonal relational encounter I have developed in this thesis, this sentence compactly criticises reducing Christian praxis simply to a form of ethics, or to abstract theory, operating above the interactive personal world. Rather Christian praxis flows from a primal and personal encounter with Christ so as to affect the whole horizon and direction of life in all its relationships.

However, the Pope is not suggesting that this other-directed love is a purely interior or mystical notion, without practical application. In order to have real effect, it must be organised in the very structure of the Church itself: "As a community, the Church must practise love. Love thus needs to be

organized if it is to be an ordered service to the community" [n. 20]. The encyclical suggests that: "For the Church, charity is not a kind of welfare activity which could equally well be left to others, but is a part of her nature, an indispensable expression of her very being" [n. 25].

Charity, understood in this manner, is expressed in the form of different particular vocations, but all based on the same organising principle: an other-directed relationship. The encyclical refers to a number of significant 'heroes' of the tradition of Charity in the Church including, Blessed Teresa of Calcutta, the martyrs Lawrence and Martin of Tours, the saints Francis of Assisi, Ignatius of Loyola, John of God, Don Bosco, and others [n. 40]. Remarkable in all such lives was the service of the poor, the needy and the sick. Pope Benedict also notes that, from earliest times, Christians have sought to participate in the creativity and compassion of this love by being pioneers in their care for the sick and the poor, the widows, the orphaned and the imprisoned—as Emperor Julian the Apostate was forced to concede [n. 24]: in fact, modern health care and social services had their beginnings in the earliest years of Christianity.

Pope Benedict is clearly highlighting the original sense of *caritas*. Charity, in this sense, is not fundamentally found in the good will of a generous person, nor as the quality of a particular good act, nor as the structuring a welfare

agency, let alone the "charity" that has often been a substitute for the demands of justice. The love that is the focal theme of this encyclical is founded on the very character of God, and derives from it. A deeply trinitarian vision permeates the encyclical, as indicated when it cites the words of Augustine: "If you see charity, you see the Trinity" [#19]. The inter-relationships necessary to genuine charity find their source, model and goal in the inter-relational life of the Trinity itself, as I sought to elaborate in Chapter Five in which I developed the social dimensions of personhood.

Speaking of this social dimension, the encyclical makes clear that, for Christian charity, the concept of the "neighbour" is inherently open-ended or "universalised" [ns. 15-16]. It appeals to the parables of Dives and Lazarus (Lk 16:19-31), the Good Samaritan (Lk 10:25-37), and especially the great parable of judgment of Matthew 25:31-46. Love of neighbour is never a matter of merely loving one's own, but always an impetus to loving God's own, wherever and however they are met.

Again, I find support for my understanding of the person-forming nature of positive interpersonal relationships, in the following words from the encyclical: "No longer is it a question, then, of a 'commandment' imposed from without and calling for the impossible, but rather a freely-bestowed experience of love from within, a love which by its very nature must be

shared with others" [n. 8]. The love that comes from God and works within persons is, then, an ever open circle, a growing communion, until it reaches consummation so that God might be might be "all in all" (1 Cor 15:28) [n. 18].

These general perspectives focus on a Christological centre: divine and human love meet in Jesus Christ who incarnates all that God is in this regard, and all that we are called to be [nn. 12-13]. The self-giving of Jesus is sacramentalised in the eucharist [nn. 13-14]. In this ritual action Jesus invites his followers to assimilate all that he is in body, blood, imagination and action: "Do this in memory of me". The adoration of God, occurs through Jesus and with him, but it always occurs in the company of others—a community, and is dedicated to others. It is not possible to join with Jesus in joining with the Father unless we also go with him to the world. Christian faith, then, is always practical, always ex-centric.

In a manner reminiscent of the views of the philosophers referred to in this thesis, especially Levinas, Pope Benedict notes that only "the look of love" [n. 18], that comes from the heart, can hold the sufferer in its gaze, and respond adequately to the neighbour in need. But he develops this line of thought, calling for a "formation of the heart", of "the heart that sees where love is needed and acts accordingly" [n. 31]. This phrase, the "formation of the heart" could well have figured in the title of this thesis, for this exercise of

practical theology has sought precisely to contribute an element to such formation, especially in the professional context of health care. Let me quote the Pope's words more fully, for, in addition to the fundamental requirement of professional competence, those who staff the institutions of human services such as hospitals, welfare agencies and so on, need,

> a "formation of the heart": they need to be led to that encounter with God in Christ which awakens their love and opens their spirits to others. As a result, love of neighbour will no longer be for them a commandment imposed, so to speak, from without, but a consequence deriving from their faith, a faith which becomes active through love (cf. *Gal* 5:6) [n. 31; cf. n. 33 also].

The Pope is obviously referring to church-based agencies which can appeal to an explicitly Christian inspiration. Nonetheless, without a similar "formation of the heart" at the deepest personal and interpersonal level, all institutions and professions that have human health or welfare as their goal, cannot regard this requirement as an "optional extra", so to speak. In the course of this thesis, I have implicitly looked to a "formation of the heart" from both theological and philosophical perspectives on the inter-relational character of the human person, in the hope that these explorations will provide a resource to all human agencies intent on helping and healing the suffering other. In all this, I have endeavoured to articulate elements of a new or refreshed humanism in the conduct of health care. While the standpoint of the thesis has been both Christian and theological, I have been intent on expanding this

into a broadly human horizon. On the issue of humanism, the *Compendium of the Social Doctrine of the Church* expresses its hope for

> A humanism that is up to the standards of God's plan of love in history, an integral and solidary humanism capable of creating a new social, economic and political order, founded on the dignity and freedom of every human person…"then under the necessary help of divine grace, there will arise a generation of new human beings, the moulders of a new humanity" (*Gaudium et Spes*, n. 30) [*CSDC*, n. 19].

The lofty language of this statement should not prevent the recognition of a realistic requirement—a fresh and deeper way of looking at things to reshape a more human and personal world.

4. Orientation to Liberation

Theologies of liberation have challenged Christians to attend to the "faces" of those who suffer.[623] This metaphor of the "face" was used by the Latin American Bishops at Puebla to call attention to the fact that those who suffer are not an amorphous, fictional group; rather, they bear witness to their suffering, they are unique individuals with their own stories. They are united in solidarity in their experiences of suffering, loss of identity and powerlessness.[624] This point highlights the overall concern of this thesis that an anthropology is required for health care ethics which holds the concerns of

---

[623] Enrique D. Dussel, *Ethics and Community*, ed. Leonardo Boff et al., trans. Robert R. Barr, Liberation and Theology, vol. 3 (Maryknoll, NY: Orbis Books, 1986).

[624] Cited in Rebecca S. Chopp, *The Praxis of Suffering* (Maryknoll, New York: Orbis Books, 1986).

those who are ill as central to ethical discourse. The Bishops at Puebla did not limit their attention to Latin America, though this was their main focus, they highlighted the plight of minority groups in other countries and also of the elderly who are increasingly marginalized in individualistic production-oriented cultures.

This relational anthropology, likewise, calls for persons to attend to the needs of those who suffer. Recognition of the essentially relational nature of persons, and of the Gospel demands that we are to respond to those most in need as though they were Jesus, means that this anthropology is inherently liberationist. This anthropology of relational personhood demands that social structures reflect our inter-relationality, the mutual dependencies which bind us together. While this is a position removed from the concerns of Latin American Liberation theologians, it is equally valid in the context of health care where persons must confront their essential dependency, the reality of their suffering and their capacity for transcendence.

Participation in the mission of Jesus demands of the Christian community that it champion those who are most vulnerable. This relational analysis highlights the diminishment suffered by all when the value of any one person is denied. To argue, therefore, that the vulnerable have a lesser moral status is unacceptable within a Christian worldview. As noted in Chapter Six, such

an argument is rarely publicly advanced, though the views of Peter Singer stand out. It is more common that particular categories of persons are simply accorded lesser moral status precisely due to their acutely compromised situation—for example, children, the elderly, the impaired and disabled. The fact of their diminished moral status is that they are more likely to be subject to adverse outcomes in terms of their life and health. It is among these, the least of our world, that Jesus is to be recognised according to The Parable of the Last Judgement.

The challenge for a practical theology of health care is to shape the style of communication, the meanings and values communicated, and the responsibilities involved around fundamental beliefs. Only in this way can the challenges of Alasdair MacIntyre, identified in Chapter Two be met,[625] and the dominant secular criteria of modern Western health care be constructively criticised. I have argued that the connections between Christian beliefs, moral thinking, action and health care can best be made through a relational anthropology. For a theology of relational personhood in health care prioritises the needs of the most vulnerable. I have presented the view in this thesis that only if a theological perspective is welcomed in the discourse of health care can it attain its own goals. This argument does not rely on a sectarian or exclusivist view. Relational personhood is open to both religious

---

[625] MacIntyre, "Theology, Ethics, and the Ethics of Medicine and Health Care."

and secular interpretations. It is, however, within a Christian theological perspective that the meanings and values relevant to health care can come to their fullest expression from a trinitarian, incarnational and eschatological perspective. Such a position assists any movement away from a mechanistic, scientific view of health and sickness, wholeness and impairment. More positively, it promotes a retrieval of the fundamental goals of wholeness and integrity in health care in an interpersonal context embracing both carers and patients and the communities involved.

4. The Meaning of Relational Personhood: Dimensions and Carriers

Throughout this thesis, my aim has been to promote and defend a particular meaning in a particular context—namely, the concept of relational personhood. The manner of articulating this meaning is necessarily multi-dimensional. Lonergan, for instance, outlines four dimensions or "functions" of meaning, which he identifies as the cognitive, the constitutive, the communicative and the effective ranges of meaning,[626] no one of which is independent of the others. There is a kind of holographic inter-relationship of meaning in its various dimensions and functions.

---

[626] Lonergan, *Method in Theology.*

The cognitive dimension is the most obvious, since we mean *this* and not *that*, this object and not something else—in the case of the subject of this thesis, the reality of the human person in its fullest ontological reality. Here, I have been affirming personal reality in terms of an interactive field of relationships, and denying any understanding of that reality as an all-sufficient independent entity, or as limited to a purely rational functionality. In so arguing for a particular understanding of human personhood, and, as a consequence, against reductive versions of personhood, I have aimed to secure and promote a cognitive advance of fundamental importance for the theory and conduct of health care.

But is not merely a matter of understanding and affirming a cognitive object. There is also a constitutive dimension. When the relational reality of the human person is cognitively and objectively intended, such a meaning informs the conscious identity of anyone who would make such a judgment. The community or group or individuals are, in deep sense, "constituted" at a new level of self-awareness and in their recognition of others: it might be said that there is an interior resonance in the consciousness of the relational reality that has been affirmed. To this degree, by affirming personal reality, it is not only saying something about a generalised "someone else" as a relational entity, but also that *I* become a relational someone in my own consciousness. Needless to say, the opposite is also the case: to maintain that the other is only

a bio-physical individual or an autonomous, rational centre of consciousness or a disabled invalid, is to be constituted by such a meaning in one's own life and conduct.

Related to the cognitive and constitutive dimension of meaning is the communicative dimension. It informs a community as a shared or shareable meaning to structure its relationships and patterns of belonging. Clearly this is the case in the relational understanding of the person which has been explored throughout the thesis. To speak of the person as the centre of relationships and as socially and psychologically constituted through relationships, is to speak of "persons-in-community", as each one lives from and for the other—in accord with the philosophical and theological positions already outlined. In short, this whole thesis can be taken as an exercise in communicative meaning.

Nonetheless, the cognitive, constitutive and communicative dimensions of the meaning of relational personhood lead to certain kinds of action. This is to say that there is an "effective" or world-shaping, or at least context-shaping, dimension involved. Put most simply, if personhood is understood in the way I have argued, in relational terms, it affects the conduct of health care at all levels and serves as a critique for defective practices and as support for a

larger and more complete vision of health, healing and the care of the suffering other.

These dimensions of meaning have pervaded this present study and been interwoven in its argument. But these concluding observations would be too limited if I did not also suggest how the multi-dimensional meaning of the relational person is communicated—in accord with this particular exercise of practical theology. Here, too, there is convenient support in Lonergan's *Method* at the point where he treats what he terms, "the carriers of meaning".[627] As Lonergan suggests, "meaning is embodied or carried in human intersubjectivity, in art, in symbols, in language, and the lives and deeds of persons".[628] This approach to "relational personhood" within a practical theology of health care would not be adequately concluded without treating the various manners in which this focal meaning of the human person is carried and embodied in the health care context. A whole thesis or other work could be devoted to this, with a chapter on each type of "carrier"; but here a brief mention of each must suffice, given the particular direction this thesis has taken. I treat these carriers or embodiments of meaning in the following order, moving from the more general to the particular: the

---

[627] Lonergan, *Method in Theology*.

[628] Lonergan, *Method in Theology*.

intersubjective, symbolic, artistic, the linguistic, and, finally, the incarnate expressions of the meaning of the relational person.

The *intersubjective* carrier of meaning involves two levels, first a kind of primal intersubjectivity of spontaneous feeling and then an intentional type of intersubjectivity.[629] In the first kind, human beings, whatever their status, are united as a "we". On this level there is an emotional identification with the other that gives rise to spontaneous sympathy with the suffering other, and of delight in the face of a child or of compassion when the child is hurt or in pain. This generates a sense of fellow feeling for the child's parents in their anxiety; and would be registered as a violent rejection of our common humanity if we did not shout a word of warning when danger threatened the child. In some primal sense, the self feels united to the other as our own. Obviously, there are endless varieties of this basic feeling of intersubjectivity in joy and celebration or in pain, dread, or anger. It takes on positive forms in the mood of a group, neighbourhood or city, and can turn sour in the emotional contagion of a violent mob. Nonetheless, it is fundamental information; while I have written these thousands of words on the subject of "the relational person" and what flows from this perspective in the context of health care, in a basic sense the reality is already fundamentally experienced

---

[629] Lonergan, *Method in Theology*.

through the care of one human being for another, and of society for its sick and suffering.

But then there is the intentional intersubjectivity. On this level it is not so much a matter of a primal emotional identification with the other—what Doris Lessing calls the "spontaneous feeling of we" [630]—but of intentional relationships: in the conventional language used in this instance, an "I" has freely entered into a relationship with another, a "thou". It is expressed in words and silence, tones of voice, facial expressions and bodily gestures, attitudes, and the deliberate cultivation of warmth—or coolness—as the case might be. This field of relational awareness and intention includes previous encounters, the acknowledgement of the present bond—or disaffection—and determines the possibilities of the future. (McFadyen's approach to the "sedimentation" of person-forming relationships captures this well). The meaning of what has been explored regarding the dialogical character of interpersonal communication appeals to this intersubjective "carrier of meaning". It has consequences for the way in which the suffering other is treated in the practice of health care, and determines whether she or he is regarded more or less as a pathological case, an impersonal object in an impersonal system—or regarded as a person, dependent in health and

---

[630] Doris Lessing, *Shikasta: Re, Colonised Planet 5: Personal, Psychological, Historical Documents Relating to Visit by Johor (George Sherman) Emissary (Grade 9) 87th of the Period of the Last Days*, Canopus in Argos Archives (New York: Knopf, 1979).

sickness on relationships as determinative of human existence itself. Again, it might be noted that much of this argument comes down to promoting a better quality of intersubjectivity in the treatment of the sick, the disabled and the terminally ill. For such intersubjectivity affects the sense of community, with its pervasive moods and motivations, or the lack of the same, in which sufferers find themselves.

Secondly, the meaning of the relational person has a *symbolic* carrier.[631] Symbols express, in considerable depth and peculiar compactness, the meanings and values, the mood and atmosphere of the process of communication. In health care, symbols embody the affective tone and imaginative sense of what is taking place. Symbols of light and life, of healing, relationship and transformation, of hope and community are endlessly varied. In the context of this theological exploration, I have appealed to the Christian symbols of the cross and resurrection of Christ, the sacraments of eucharist, and those of healing and forgiveness. Any understanding of the relational person cannot be adequate without them. Though big Catholic hospitals, for instance, must confront all the problems inherent in the increasingly impersonal health system, the central position of the chapel, and the crucifix or depiction of Our Lady in the ward or room are well-known symbols in such institutions. Their purpose is to embody aspects

---

[631] Lonergan, *Method in Theology.*

of the relational personal being presented in this thesis. Needless to say, this symbolism—and health care symbols generally, can grow weary and accumulate tired and routine connotations. There is the question, then, of purifying the symbols already in place—e.g., to ensure that the crucifix on the wall communicates hope in the resurrection—and to develop where possible new symbols of the relational person that I have proposed. A theological example of this is Trinitarian mystery itself, not as an inconceivably complex mathematical theorem, but as revealing a symbol of primordial intersubjectivity that is the origin, form and goal of our relational existence.

The need to revitalise traditional symbolism and routine patterns of experience introduces the importance of the third carrier of meaning, namely, *art*.[632] To speak most generally, the creativity of artistic expression challenges the routine and, as a result, refreshes awareness. Art brings out some striking patterns of experience. It works with the colours, shapes, movements, space and sounds inherent in the way that humanity exists in the world, to produce the painting and the dance, the music, sculpture, architecture and so on to reinvigorate our sense of reality. Art in this respect has the capacity to re-animate traditional symbols, to make them shine with new life. Both religion

---

[632] Lonergan, *Method in Theology*. Also, B. Lonergan, "Topics in Education: The Cincinnati Lectures of 1959 on the Philosophy of Education.," in *Collected Works 10*, ed. Robert M. Doran and Frederick E. Crowe, (Toronto: University of Toronto Press, 1993), 208-231

and health care have a long history of alliances with various forms of artistic expression, and it is these that continue in the secular consciousness even if any appreciation of the religious tradition that inspired them has waned. A classic example, dating from the early 16th century, is Grünewald's Issenheim Altar, originally in the chapel of the Antonine community which ran the hospital. It is remarkable for its depiction of crucifixion and resurrection, as well as other Gospel scenes and saintly figures.[633] The therapeutic function of art is the subject of increasing contemporary interest.[634] I have already mentioned the art *of* healing, but here the question is more the role of art *in* healing, and its capacity to carry or inspire personal meaning in the clinical context. In some situations, a patient is encouraged to select instances of art that are most expressive for them. In others cases, especially where the patient is young, they are invited actively produce art in a way that expresses their hope of healing and recovery.[635] Remarkable innovations have been

---

[633] Pantxika Béguerie, *The Issenheim Altar*, trans. Pénénelope Denu (Strasbourg: Editions la Nuée Bleue, 1991).

[634] J. Angus, *A Review of Evaluation in Community-Based Art for Health Activity in the Uk* (Durham: Health Development Agency, 2002); R. Philipp, *Arts, Health and Well-Being* (London: Nuffield Trust, 2002); J. H. Baron, "Art in Hospitals," *Journal of the Royal College of Physicians of London* 29, no. 2 (1995).

[635] See the research sponsored by Durham University's Centre for Arts and Humanities in Health and Medicine, and Lindsay T. Farrell, "Art and Theology in Schools and Hospitals", a Paper presented at the Institute for Theology, Imagination and the Arts, St Andrew's University, UK, October, 2003; and "Art in Australian Hospitals", A Paper presented to the International Centre for Design and Health, Stockholm, 2003. Farrell is principal researcher in a current project, "Experiencing Art in Hospital", involving Australian Catholic University and the hospital, Holy Spirit North-side, Brisbane.

achieved in the architecture of the health care institution.[636]   This leads immediately to our precise concern, of how art communicates relational dimensions of personhood. For in each of these notable cases, the goal is to draw the patients—and those who care for them, out of a sense of meaningless isolation into a more relational sense of identity, into a kind of ecstatic sense of the wholeness of the reality in which they participate, despite the pain and debility they currently experience. Through the ministry of art, the imagination of those whose lives have been disrupted by illness in whatever form, encounters expressions of meaning that invite them beyond the inevitable isolation they experience. It offers a vision larger than the "totalisation" of a diminished state, to evoke a more gracious sense of a reality that can bring its own healing to the unrealistic expectations, while all the time countering the apathy that might threaten with suggestions of deeper freedom and a richer field of possible relationships.[637]

Another example of art as a carrier of meaning is the recent work of Bill Viola, *The Passions*, an exhibit of flat-screen, ultraslow motion video works.[638] Two features of Viola's art link him with the relational perspective on person that

---

[636] See Peter Scher, *Patient-Focused Architecture for Health Care* (Manchester: Manchester Metropolitan University, 1996).

[637] See William Lynch, *Images of Hope. Imagination as Healer of the Hopeless* (Notre Dame, Ind.: Notre Dame University Press, 1987).

[638] This section derives from my paper on Viola's art: Patrick McArdle, "Ecce Homo: Theological Perspectives on Personhood and the Passions," *The Australian E-Journal of Theology*, no. 7 (2006).

has been developed here: his focus on the emotional life of persons and how that fundamentally shapes personhood and, secondly, the way Viola seeks to shape the social space between persons. I want to explore each of these with reference to what I consider to be the pinnacle of the collection: *Emergence.* This artwork is a twenty-four minute representation of a figure emerging from within an altar that is attended by two grieving women. It is very obviously religious in character and investigates a fundamental religious theme. It is also most pertinent in terms of demonstrating the role of art as a carrier of meaning—in this case, what it means to be a human person.

Emergence is linked to a tradition of religious art which focuses on the dead Christ figure and on the grief of the women surrounding him, particularly his mother. In *Emergence,* Viola uses the possibilities opened by video and instead of static images, focuses on the emotional power, the idea of death being a re-birth and the cycle of death within life in discrete stages.

Watching the entire sequence of this video it is impossible not to see the images as joined and as representing the life of every person. From the moment of conception, through our emergence into life, we are intimately and profoundly linked to other persons and, at the same time, the seeds of our mortality are present in each phase. Part of that sense of mortality or

recognition of the connections between life and death is the impact that the phases of a person's life have on the relationships which give shape, meaning and context to our lives.

Part of the fallacy of the model of personhood so often dominant in health care and, more generally, in the modern era, is that the pinnacle of human existence is the autonomous rational individual who is able to choose and function independently of all other persons. The reality is that such a life is not worth living and that such a person, if it is actually possible to be such a person, is not someone most of us would want to know. Instead, Viola presents in *Emergence* persons as beings who are fundamentally in relationship with each other.

It is significant to note that in this particular work the central emerging figure is never really alive. The emerging person is the dead person; the pain of grief is never separate from the joy of witnessing a person's self creation or emergence. The supporting women are not crippled by their grief but motivated by their connections to each other and to the emerging one. This is one perspective on the story of human personhood, it is one way in which art functions as a carrier of meaning. I do not think that the scenario need be grief or other emotions usually considered in a negative light but, as George Khushf indicated, it is these moments of pressure, of confrontation, which

highlight for humanity the frailty, the need for relationships which is always present but able to be ignored. It is in our insufficiency that we turn to others; it is in our times of crisis that our truly relational natures are revealed. The grief or other crisis emotions do not create this need, rather it is unveiled by the crisis.[639] Viola captures not just the imagery of the grief or even the story of the human life-cycle. He is also representing the need of persons for persons; even though we know relationships are always tied to loss and to suffering they are what enables us to be persons. *The Passions* demonstrate how art functions as a carrier of meaning. This form of art blurs the boundaries of what is permissible and what is not; what is possible and what is not. From a relational perspective, this is a key feature of human existence. Viola's art challenges our preconceptions of art both through the forms he uses, the subject matter he explores and in that he attempts to call forth the viewer through an engagement which allows the person watching to, as it were, enter the art. The setting of the exhibition, in silence and darkness, disengages the audience from the outside world but, on reflection, it is also the case that the boundaries between the art and the viewer are blurred. The time necessary to watch these images unfold functions to draw in the viewer so that passivity is rejected and engagement and participation are demanded. This is also the story of what it means to be a person. There are times when all of us wish we could simply live the life of the autonomous rational

---

[639] cf. Khushf, "Illness, the Problem of Evil..."

individual or the member of the collective whose identity is assured because of an unassailable metaphysical status. Human personhood is more wonderful and more tenuous than that: the only way to be a person is to engage with others and to participate in the relationships to which we are called to commit ourselves. It is our relationships which call us forth, which shape the kinds of persons we can be.

The fourth carrier of meaning is *linguistic*.[640] As embodied in words and language, the meaning of the person I have been attempting to communicate comes to its most precise theoretical expression. By employing the phrase "relational personhood", along with its cognates, "persons-in-relation", "persons-in-community", and so forth, I have endeavoured to promote a fuller understanding of the human person, and in this way to bring into sharper focus what is meant by the term. Through that critical focus, the meaning of personhood is more clearly established in the world of our interactions and more adapted to shape the particular world of health care that has been the special interest of this investigation. Rather obviously, to write a thesis is to be plunged into the world of words. It is necessary to "word" what is meant in order to communicate in a critical and constructive manner. Yet the routinely available language often foreshortens the possibilities of such communication. For example, there is social awareness of

---

[640] Lonergan, *Method in Theology*.

the distortions inscribed in "sexist" language as it precludes the recognition of equality in a democratic society. Otherwise, the very language being spoken alienates many of those who are hearing the words. Similarly, any racist tendency in language is rightly criticised. Further, many are revolted by the flat, quantitative, purely economic description of society, so much in favour in modern politics, to demand a more humane communication. Others, too, note with alarm the increasing "robotisation" of language applied to human experience. It is evidenced in such terms as "stimulus and response", "conditioning", "input and output", "turned on and switched off", being "programmed", "hard-wired", and so on. There is the obvious danger of linguistically restricting the total range of consciousness to the model of the machine, the computer, or chemical interactions. Health care is particularly susceptible to this tendency. In the common parlance associated with the public's notion of life support technologies, the use of the phrase "turning off the machine" has a double meaning that is not consciously intended but which describes how the person receiving treatment has come to be seen— certainly, this was the situation in the Bland and Cruzan cases discussed earlier.

Many languages have dozens of ways of addressing the personal other in terms of status or relationship in regard to the addressee. The more intimate "thou" has effectively disappeared from contemporary English in favour of

an all-purpose "you"—even if the modern European languages preserve a more personal mode of address, as in second person singular of *tu*, *du*, etc. How much passes unnoticed because it is linguistically unable to be expressed, can only be a topic for conjecture. For language both reveals and blinds a culture to the complete inter-relational character of the person. Hence, the aim of this thesis, to put into words, however inadequately, the elusive mystery of the human person.

Lastly, meaning is *incarnate*.[641] The witness of a person's life and deeds is an elemental carrier of meaning. As the phrase has it, a person may "mean the world to me", in the sense of that he or she embodies something profoundly meaningful and valuable in the horizon of one's life. In the course of this investigation, I have approached the reality of the "relational person" from different points of view with practical concerns in mind. But this would not be effective unless all this took shape in the lives of those dedicated, either professionally or vocationally, to being relational persons in practice. While there have been aspects of criticism, overt or implied, of health care professionals in this thesis, it must not be forgotten that most such professionals, in fact, witness to the central claim of this thesis in their everyday working lives. Health care professionals engage in their healing arts in a number of specific ways, but central to them all is the relationship

---

[641] Lonergan, *Method in Theology*.

with those who suffer and who are in need of their care. The close and perennial contact between health carers and the sick or impaired may, on occasion, lead to a jaded approach to their work but this is the exception. The witness of health care professionals is that health care is best provided when the mysteries of relational personhood are incarnated in the relationships between professional and patient.

The communication of meaning, then, flows in several avenues. It is carried by the mood and interactions of a community, by the symbols it inherits and employs, by the art it sponsors or produces, and by the witness of significant persons or groups. The five carriers of meaning here referred to is each effective in the manifold process of "making sense" of the meaning of the person in all the relationships that inform health care. The simple listing of such carriers of meaning may suggest further ways of communicating the focal meaning of the person to meet the requirements of different mentalities, on the part of the professionals involved, or the patients that are treated–in a manner that respects the conditions of age, clinical situation, education, different religious outlooks, and so forth. I suggest this reference to the multiple carriers of meaning is the basis for a critique of any health care situation that has become, however unwittingly, restricted to one or other carrier of meaning, to the exclusion of the rest. There is always a broader, deeper, more refined or articulated field of communication possible. "Making

sense" of the relational person within health care must involve both professional clinicians, doctors and patients, managers and systems, pastoral workers and families, in the full play of the meaning that must constitute the care of patients directed to their healing and wholeness.

6. Summary

The opening chapter of this thesis posed the research problem under investigation in this thesis—the meaning and exercise of personhood, especially in the field of health care. The Introduction also sketched the fundamental aspects of the argument, the philosophical and theological sources and the basic, flexible methodology through which the argument would be developed.

I took the view that the theological discipline of practical theology was the most appropriate to the subject matter and the argument of the thesis. Practical theology seeks to engage in dialogue with other disciplines in order to develop a critical praxis in relation to the significant social, cultural and theological concerns of humanity. This exalted task is made possible due to the fact that practical theology tries to ensure that it is grounded through reference to concrete situations that are relevant to the real lives of people. Application in the context of health care is, therefore, one of the ways in

which practical theology can seek to meet its own goal of dynamic critical enquiry. Since practical theology is an exercise in critical investigation it also serves as the appropriate theological method that can critique the practice of health care. Finally, given that practical theology recognises the fundamental importance of engagement and dialogue, it is a field of theology well suited to investigation of the relational dimensions in theology, health care and personhood.

The approach I have taken through practical theology differs from the mainstream theological approach to reflection in health care—using theological ethics. In this regard, I distinguished my approach from that of David Kelly who likewise has recognised the limitations of the traditional Catholic Christian method in health care ethics. Kelly and I differ in two ways: firstly, he bases his anthropology on the concept of divine election; secondly, he utilizes his anthropological view as the foundation for ethical reasoning. My own stance is that divine relationality is the foundation of anthropology and that it provides not only the content for an understanding of personhood but also the methodology of personhood. In terms of the second point, I am more focussed on the human person and how the various understandings of personhood shape the practice of health care. Clearly, this has ethical significance, but the focus is broader than simply health care ethics.

The general framework which informs this exercise in practical theology derives from the thinking of Bernard Lonergan. His contribution to theological thought, particularly theological method is well known. In this thesis a very small aspect of his thought is utilized to form a framework within which I have found it helpful to shape my own thinking—the eightfold process for collaborative interdisciplinary study, involving the theological activities of research, interpretation, history, dialectics, foundations, doctrines, systematics and communications. As I indicated, the whole thesis is really an exercise in the eighth theological speciality of Communications "for in this final stage… theological reflection bears fruit."[642]

This value of this way of proceeding is obvious in that it has permitted me to use diverse sources in a flexible methodology. I have brought together the thinking of philosophers like John Macmurray and Emmanuel Levinas, who, in very different ways focus on the person as a relational being. For each of these philosophers, the person is only intelligible in relational terms. I have brought Macmurray and Levinas into dialogue with theologians such as Alistair McFadyen and John Zizioulas. McFadyen's insight into person formation parallels the work of Macmurray and Levinas but does not directly draw on them. His thinking reflects the so-called social doctrine of the Trinity

---

[642] Lonergan, *Method in Theology*.

and hence emphasises the relational aspects of Trinitarian theology. Zizioulas acknowledges both philosophers but takes the main aspects of his own relational theology from his understanding of the Trinity as a relationship of divine persons. Below I comment on the significance of their thinking for this project.

The Introduction also referred to a number of cases in health care which have proved useful throughout the thesis to test the philosophical and theological positions I adopted, and emphasized the character of my investigation as an exercise in practical theology.

The second chapter contributed to the overall argument of the thesis by demonstrating that religious commitments and theological reflection assist people to face the ultimate questions inherent in the experience of illness and suffering.[643] That is not to suggest that religious and theological perspectives on the world are completely distinct from others which emerge within particular cultures and contexts. Rather they emerge from the same milieux. The beliefs and commitments which theologians and people of faith bring to society and, in particular, to health care are able to sustain a critique of contemporary society and of health care in particular. Religions, and the theologies they generate, tend to challenge the physicalist, materialist and

---

[643] Sulmasy, "Every *Ethos* Implies a *Mythos*," 244

rationalist views which predominate in Western cultures. Because religions necessarily involve commitment to communities, they constitute an inherent challenge to the radical individuality and economic imperatives that seem to drive Western societies.

The third chapter, *The Question of Personhood in Health Care*, as the title indicates addressed the concept of personhood especially as it has taken on an urgent quality in health care. Here I sketched the context of the historical and linguistic treatment of the term "person" with its attendant social and moral implications. Within health care such implications are particularly poignant, as in the doctrine of informed consent in health care. I have contested this view, and proposed that greater attention should be paid to more relational philosophies and theologies.

The philosophical dimensions of the argument were then developed in Chapter Four which drew on the work of John Macmurray, Emmanuel Levinas and Alistair McFadyen. All three focus on different aspects of interpersonal communication and relationship. Macmurray uses the image of "mother-child" as an archetype to explore the structure of human relationships.[644] Levinas, in contrast, looks to relationships that emphasise alterity and asymmetry. Alistair McFadyen looks not to the structure of

---

[644] Macmurray, *Persons in Relation.*

relations between persons but to how communication between persons is formative of personhood itself.

None of these theories of person-in-relation is beyond criticism, at least in terms of this exercise of practical theology in application to health care. What they offer is a convergence of views about relational personhood and a degree of complementarity. Each presents a way of structuring an understanding of human relationality and how it leads to the formation of persons.

In Chapter Five, *A Christian Vision of the Person*, after noting the paradigmatic nature of relationality in the contemporary context, I examined the biblical accounts of creation and God's interactions with Israel and theological considerations arising in the New Testament. Here, I drew on the theology of John Zizioulas to explicate the relational character of the Trinity as a communion of persons, and how this affects our understanding of the human person. This was further elaborated in reference to the relationality inherent in the identity and ministry of Christ.

I was then in a position to indicate how such theological positions have implications for health care. The interactions which constitute health care are necessarily a field of inter-relating persons at their most vulnerable, in the situations of illness, debility and suffering. The Christian vision of faith makes a difference in how persons relate to one another. Accordingly, health

care is not merely a profession or specialised activity oriented to healing but a profound relational enterprise.

I have been careful to point out that health care is not merely a subject of theological criticism but also a source of illumination for theological reflection. The witness of the dedicated carer and the courage and hope of the patient have the capacity to, as it were, "embarrass" theology into taking health care seriously as a field of human experience.

A practical theology of health care expands the possibility of interdisciplinary approaches in which theology, medicine, nursing, social work and chaplaincy are able to best play their roles to promote the care of the suffering person.

The exercise in practical theology, because it seeks to engage with the concrete circumstances of people's lives, lead me, in Chapter Six, to return to the cases described earlier in the thesis. Through analysis of a number of cases, but principally those of the Attard twins and of Nancy Crick, I illustrate the effectiveness of the relational personhood that I have articulated in this thesis.

The cases considered in this chapter focus on the marginalised and those at risk of having their person-status diminished. I argue, therefore, for special recognition of the most vulnerable. These, the *anawim*, are the priority of God

and, hence, they should be a priority for the Christian community and for health care itself.

Chapter Seven turned to answer the questions posed in the second chapter of the thesis. Here I argued in a more systematic manner that a practical theology of relational personhood offers health care and the ethics of health care a new vision of their own goals and objectives and a greater chance to assist human flourishing.

The relationships that structure the clinical setting are multi-valent and include medical expertise, the appropriate use of economic resources, contractual arrangements, management structures, and so forth. But all this, I argue, is meant to be a field of interpersonal communication through which the relationality of the persons is promoted. The contribution of theology is that of integration of the various aspects in the light of an ultimate understanding of the human condition and its destiny.

7. Conclusion

In the opening chapter of the thesis I introduced the challenge to theological engagement in health care posed by Alasdair MacIntyre. Chapter Seven re-focused attention on this challenge—in short, what unique contribution can theology make to health care? The theological answer that I have developed

in the thesis presents a relational model of the human person as indispensable to contemporary health care.

Though unable to resolve all the dilemmas of modern health care, thinking about personhood in relational terms opens the possibility of a series of dialogues between, for example Gracie and Rosie Attard, and their parents, together with those who provided health care for them. In this case, thinking in relational terms will not have saved Rosie's life, but would have brought her into the conversation. In the case of Nancy Crick, making use of a theology of relational personhood might have enabled a wider conversation that included voices which argued that life should be cherished instead of those who simply expect it to be pain free.

Relational personhood represents a pathway to a fundamental shift in the discourse of health care and of theology. Since it is neither sectarian, nor exclusivist, it may provide a bridge between religious and secular thinkers. Since it focuses on relationships, it inspires a priority for the vulnerable and gives rise to an ethic of responsibility. Since I have situated this understanding of persons within practical theology, a field of theological enquiry directed to interdisciplinary dialogue, it can bring about a rapprochement between religious concerns and health care. These are not

dramatic claims but they do have the capacity to transform both disciplines and to enable them to more adequately meet their own goals.

There are times when all of us wish we could simply live the life of the autonomous rational individual or as a member of the collective whose identity is assured because of an unassailable metaphysical status. Human personhood is more wonderful and more tenuous than that: the only way to be a person is to engage with others and to participate in the relationships to which we are called to commit ourselves. It is our relationships which call us forth, which shape the kinds of persons we can be. This call has its origins and destiny with the Triune God who is relationship and who invites all persons to participate in the divine relationship.

This theology has application more broadly within the Christian community and provides a principle by which Christians can engage more fully with the various communities within which they form their multiple relationships. For Christians, the task of participating within societies is not optional: the Parable of the Last Judgement makes clear that the obligation to reach out to those in need, tangibly, as determined by that need, is central to faith in Jesus. The only way to be authentically Christian, authentically human, is to seek to serve the Other, particularly the most vulnerable.

BIBLIOGRAPHY

Alison, James. *The Joy of Being Wrong: Original Sin through Easter Eyes*. New York: Crossroad Pub. Co., 1998.

Anderson, R. S. *The Shape of Practical Theology*. Downers Grove, Ill.: InterVarsity Press, 2001.

Angus, J. *A Review of Evaluation in Community-Based Art for Health Activity in the Uk*. Durham: Health Development Agency, 2002.

apotemnophilia, n. *Oxford English Dictionary Online* Oxford: Oxford University Press, 2003, accessed February 13 2006; Available from http://dictionary.oed.com/cgi/entry/00316647?single=1&query_type=word&queryword=apotemnophilia&first=1&max_to_show=10.

Aquinas, Thomas. *Summa Theologiae*. Translated by Fathers of the English Dominican Province. Vol. 1 (ST 1 QQ 1 - 119 and ST 2/1 QQ 1 - 114). 3 vols. New York: Benziger Brothers, Inc., 1947.

————. *Summa Theologiae*. Translated by Ceslaus Velecky. Vol. Volume 6 (The Trinity 1a. 27 - 32). 60 vols. London: Eyre & Spottiswoode, 1964.

Arnett, Jerome C. "The Bioethics Movement: An Emerging Culture of Death." *Medical Sentinel* 7, no. 2 (2002): 48 - 49, 57.

Arnold, F. X., ed. *Handbuch Der Pastoraltheologie*. Feiburg: Herder, 1972.

Ashley, Benedict M., and Kevin D. O'Rourke. *Health Care Ethics: A Theological Analysis*. 4th ed. Washington, D. C.: Georgetown University Press, 1997.

Aves, J. "Persons in Relation: John Macmurray." In *Persons, Divine and Human*, ed. C Schwöbel and Colin Gunton, 120 - 137. Edinburgh: T & T Clark, 1991.

Bailie, Gil. "The Christological Truth About History, the Paschal Truth About Human Culture, the Eucharistic Truth About the Human Person." *Australian EJournal of Theology*, no. 5 (2005).

Banton, M., ed. *Anthropological Approaches to the Study of Religion*. London: Tavistock, 1963.

Barna, G. *State of the Church 2005*. Ventura, CA: The Barna Group, 2005.

Baron, J. H. "Art in Hospitals." *Journal of the Royal College of Physicians of London* 29, no. 2 (1995): 131 - 144.

Batstone, David, Eduardo Mendieta, Lois Ann Lorentzen, and Dwight N. Hopkins, eds. *Liberation Theologies, Postmodernity, and the Americas*. London: Routledge, 1997.

Bauman, Zygmunt. *Postmodernity and Its Discontents*. Cambridge: Polity Press, 1997.

Beauchamp, Tom L., and J. F. Childress. *Principles of Biomedical Ethics*. 5th ed. New York: Oxford University Press, 2001.

Béguerie, Pantxika. *The Issenheim Altar*. Translated by Pénénelope Denu. Strasbourg: Editions la Nuée Bleue, 1991.

Belkin, Lisa. *First, Do No Harm*. London: Hodder and Stoughton, 1993.

Benso, Silvia. "Of Things Face-to-Face with Levinas Face-to-Face with Heidegger: Prolegomena to a Metaphysical Ethics of Things." *Philosophy Today* 40, no. 1 (1996): 132.

Blackburn, Simon. "Humanism." In *The Oxford Dictionary of Philosophy*, ed. Simon Blackburn. Oxford: Oxford University Press, 1996.

Boff, Leonardo. *Trinity and Society* Liberation and Theology Series ; 2. Tunbridge Wells: Burns & Oates, 1988.

Bookman, Myra, and Mitchell Aboulafia. "Ethics of Care Revisited: Gilligan and Levinas." *Philosophy Today* 44 (2000): 169.

Brazelton, T. B. *Touchpoints*. Sydney: Doubleday, 1993.

Brazelton, T. Berry. "Saving the Bathwater." *Child Development* 61, no. 6 (1990): 1661 - 1671.

Brown, Neil. *The Worth of Persons.* Vol. 7 Faith and Culture. Manly, Sydney: Catholic Institute of Sydney, 1983.

Brown, Raymond E., Joseph A. Fitzmyer, and Roland E. Murphy, eds. *Jerome Biblical Commentary.* London: Geoffrey Chapman, 1969.

Brueggemann, Walter. *Theology of the Old Testament.* Minneapolis: Fortress Press, 1997.

Buber, Martin. *I and Thou.* Edinburgh: T & T Clark, 1937.

Byrne, Brendan. *Romans.* Vol. 6 Sacra Pagina. Collegeville, Mn.: The Liturgical Press, 1996.

Cahill, L. S. *Theological Bioethics: Participation, Justice, Change* Moral Traditions, ed. J. F. Keenan. Washington, D. C: Georgetown University Press, 2005.

Cahill, Lisa Sowle. "Can Theology Have a Role In "Public" Bioethical Discourse?" In *On Moral Medicine*, ed. Stephen E. Lammers and Allen Verhey, 57 - 63. Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 1998.

Callahan, D. "Religion and the Secularization of Bioethics." *Hastings Center Report* 20, no. 4 (1990).

Campbell, C. S. "Religion and Moral Meaning in Bioethics." *The Hastings Center Report* 20, no. 4 Special Supplement (1990): S4, 7 pages.

_____. "Gifts and Caring Duties in Medicine." In *Duties to Others*, ed. C. S. Campbell and B. A Lustig, 4, 181 - 197. Dordrecht: Kluwer Academic Publishers, 1994.

_____. "Bearing Witness." In *Notes from a Narrow Ridge: Religion and Bioethics*, ed. D. S. Davis and L. Zoloth. Hagerstown, Maryland: University Publishing Group, 1999.

Campbell, C. S., and B. A Lustig. "A Call to Respond: Duties to Others." In *Duties to Others*, ed. C. S. Campbell and B. A Lustig, 4, vii - xvii. Dordrecht, NL: Kluwer Academic Publishers, 1994.

_____, eds. *Duties to Others.* Edited by E. E. Shelp. Vol. 4, Theology and Medicine. Dordrecht, NL: Kluwer Academic Publishers, 1994.

Capaldi, Nicholas. "What Is Bioethics without Christianity?" *Christian Bioethics* 5, no. 3 (1999): 246 - 262.

Carr, Brian. "Pity and Compassion as Social Virtues." *Philosophy* 74, no. 3 (1999).

Carson, Ronald A. "Focusing on the Human Scene: Thoughts on Problematic Theology." In *Notes from a Narrow Ridge: Religion and Bioethics*, ed. D. S. Davis and L. Zoloth, 49 - 63. Hagerstown, Maryland: University Publishing Group, 1999.

"Case of the Siamese Twins." In *Johnson J.*, B1/2000/2969: Supreme Court of Judicature Court of Appeal (Civil Division), 2000.

Casey, Damien. "Levinas and Buber: Transcendence and Society." *Sophia* 38, no. 2 (1999): 69 - 92.

Cassil, Alwyn. "Commision Balances Patients' Rights with Free Market." *AHA News* 33, no. 42 (1997): 1.

Cavalieri, Paola, and Peter Singer. "The Great Ape Project." In *Unsanctifying Human Life*, ed. Helga Kuhse, 128 - 141. Oxford: Blackwell Publishers, 2002.

Childs, James H. *Christian Anthropology and Ethics.* Philadelphia: Fortress Press, 1978.

Chopp, Rebecca S. *The Praxis of Suffering.* Maryknoll, New York: Orbis Books, 1986.

Christopherson, J. "The Human: Its Import for Ethical Decision-Making." In *Persons in Community*, ed. William H. Lazareth, 44 - 47. Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 2004.

Church, Catholic. "Codex Iuris Canonici." In *The Code of Canon Law*. London, Sydney, Dublin: Collins, 1983.

Clarke, W. Norris. *Person and Being.* Milwaukee: Marquette University Press, 1993.

_____. *The One and the Many: A Contemporary Thomistic Metaphysics.* Notre Dame, Indiana: University of Notre Dame Press, 2001.

Clifton-Soderstrom, M. "Levinas and the Patient as Other: The Ethical Foundation of Medicine." *Journal of Medicine and Philosophy* 28, no. 4 (2003): 447 - 460.

Clines, D. J. A. *What Does Eve Do to Help?* Journal for the Study of the Old Testament. Sheffield: JSOT Press, 1990.

Coakley, Sarah. "'Persons' in the 'Social' Doctrine of the Trinity: A Critique of Current Analytic Discussion." In *The Trinity: An Interdisciplinary Symposium on the Trinity*, ed. Stephen T. Davis, Daniel Kendall and Gerald O'Collins. Oxford; New York: Oxford University Press, 1999.

Cobb, John B. "Does Theology Make a Contribution to Bioethics?" In *Theology and Bioethics: Exploring the Foundations and Frontiers*, ed. E. E. Shelp. Dordrecht, Holland: D. Reidel Publishing, 1985.

Coffey, David. "The Holy Spirit as the Mutual Love of the Father and the Son." *Theological Studies* 51, no. 2 (1990).

————. *Deus Trinitas: The Doctrine of the Triune God*. New York: Oxford University Press, 1999.

Cohen, Richard A. *Ethics, Exegesis and Philosophy: Interpretation after Levinas*. Cambridge: Cambridge University Press, 2001.

Collins, Steven. "Categories, Concepts or Predicaments? Remarks on Mauss's Use of Philosophical Terminology." In *The Category of the Person: Anthropology, Philosophy, History*, ed. Michael Carrithers, Steven Collins and Steven Lukes. Cambridge: Cambridge University Press, 1985.

Connolly, T. J. "Should This Baby Live?" In *Living the Gospel Today*, ed. Margaret M. Press and Neil Brown, 13, 67 - 80. Manly, NSW: Catholic Institute of Sydney, 1987.

Costello sj, Jack. "The Life and Thought of John Macmurray." In *John Macmurray: Critical Perspectives*, ed. D Fergusson and N. Dower, 1 - 34. New York: Peter Lang, 2002.

Crick, Nancy. *The Diary of Nancy Crick* [website]. 2002, accessed 26 August 2003; Available from Http://pandora.nla.gov.au/pan/24513/20020424www.proctection.net.au/nancycrick/htm.

_____. "Transcript of the Nancy Crick Video." *The Sydney Morning Herald,* 24th May 2002.

Cunningham, David S. *These Three Are One: The Practice of Trinitarian Theology* Challenges in Contemporary Theology. Malden, Mass.: Blackwell Publishers, 1998.

Curran, Charles E. "Natural Law in Moral Theology." In *Natural Law and Theology,* ed. Charles E. Curran and R. A. McCormick, 7, 247 - 295. New York: Paulist Press, 1991.

Curran, Charles E., and Richard A. McCormick. *The Distinctiveness of Christian Ethics* Readings in Moral Theology ; No. 2. New York: Paulist Press, 1980.

Damascus, John of. *On the Divine Images: Three Apologies against Those Who Attack the Divine Images.* Translated by David Anderson. Crestwood, NY: St Vladimir's Seminary Press, 1980.

Daugherty, Christopher K, G. Fitchett, P. E. Murphy, A. H. Peterman, D. M. Banik, F. Hlubocky, and J. Tartaro. "Trusting God and Medicine: Spirituality in Advanced Cancer Patients Volunteering for Clinical Trials of Experimental Agents." *Psycho-Oncology* 14, no. 2 (2005): 135 - 146.

Davies, B. *The Thought of Thomas Aquinas.* Oxford: Clarendon Press, 1992.

Davis, D. S. "It Ain't Necessarily So: Clinicians, Bioethics, and Religious Studies." In *Note from a Narrow Ridge: Religion and Bioethics,* ed. D. S. Davis and L. Zoloth, 9 - 19. Hagerstown, Maryland: University Publishing Group, 1999.

Davis, D. S., and L. Zoloth, eds. *Notes from a Narrow Ridge: Religion and Bioethics.* Hagerstown, Maryland: University Publishing Group, 1999.

Del Colle, Ralph. *Christ and the Spirit: Spirit Christology in Trinitarian Perspective.* New York: Oxford University Press, 1994.

_____. "Person and Being in John Zizioulas' Trinitarian Theology: Conversations with Thomas Torrance and Thomas Aquinas." *Scottish Journal of Theology* 54, no. 1 (2001): 70 - 86.

Devine, Miranda. "The Death Knell for Euthanasia." *The Sydney Morning Herald*, 30 May 2002.

Dixon, John W. "Toward a Trinitarian Anthropology." *Anglican Theological Review* 80, no. 2 (1998): 169 - 185.

Downie, Graham. "No Need to Legislate for Euthanasia." *Canberra Sunday Times*, 9 July 2006, 16.

Dudhwala, Yunus. "Winning the Lottery." *Nursing Management* 12, no. 6 (2005): 14 - 15.

Duffy, James. "Rediscovering the Meaning in Medicine: Lessons from the Dying on the Ethics of Experience." *Palliative and Supportive Care* 2, no. 2 (2004): 207 - 211.

Dussel, Enrique D. *Ethics and Community*. Translated by Robert R. Barr. Vol. 3 Liberation and Theology, ed. Leonardo Boff, S. Torres, Gustavo Gutiérrez and Et al. Maryknoll, NY: Orbis Books, 1986.

Dworkin, Ronald W. *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom*. New York: Alfred A. Knopf, 1993.

Edelstein, Ludwig. "The Hippocratic Oath." In *On Moral Medicine: Theological Perspectives in Medical Ethics*, ed. Stephen E. Lammers and A. Verhey, 1 (p. 107). Grand Rapids, Mi.: W. B. Eerdmans, 1998.

Editor. "Amputations That Are Legal but Unacceptable." *The Scotsman*, 22 August 2000, 13.

Edleman, Gerald M. *Bright Air, Brilliant Fire: On the Matter of the Mind*. New York: Basic Books, 1992.

Eiesland, Nancy L. *The Disabled God: Toward a Liberatory Theology of Disability*. Nashville: Abingdon Press, 1994.

Elliott, C. *A Philosophical Disease*. New York: Routledge, 1999.

_____. "Putting Your Best Face Forward." *Psychology Today* June (2004): 48 - 49.

Engelhardt, H. Tristram. "The Concepts of Disease and Health." In *Concepts of Health and Disease*, ed. A. L. Caplan, H. Tristram Engelhardt and J. J.

McCartney. Reading, Massachusetts: Addison-Wesley Publishing Group, 1981.

_____. "Looking for God and Finding the Abyss." In *Theology and Bioethics: Exploring the Foundations and Frontiers*, ed. E. E. Shelp. Dordrecht, Holland: D. Reidel Publishing, 1985.

_____. "Whose Religion? Which Moral Theology? Reconsidering the Possibility of a Christian Bioethics in Order to Gauge the Place of Religious Studies in Bioethics." In *Notes from a Narrow Ridge: Religion and Bioethics*, ed. D. S. Davis and L. Zoloth. Hagerstown, Maryland: University Publishing Group, 1999.

_____, ed. *Christian Bioethics, Vol. 5*, 1999.

Epperly, B. G. "Prayer, Process, and the Future of Medicine." *Journal of Religion and Health* 39, no. 1 (2000): 23 - 37.

Fergusson, David A. S. *The Cosmos and the Creator: An Introduction to the Theology of Creation.* London: SPCK, 1998.

Ferreira, M. Jamie. ""Total Altruism" In Levinas's "Ethics of the Welcome"." *Journal of Religious Ethics* 29, no. 3 (2001): 443 - 470.

Ficino, Marsilio. *Platonic Theology*. Translated by M. J. B. Allen and J. Warden. 2001 - 2002 ed. Cambridge, Mass.: Harvard University Press, 2001.

FitzGerald, Desmond, J. "Rene Descartes - the Human Person as a Dualism." In *Images of the Human - the Philosophy of the Human Person in a Religious Context*, ed. Hunter Brown, Dennis L. Hudecki, Leonard Kennedy, A. and John Snyder, J., 147 - 181. Chicago: Loyola Press, 1995.

Fletcher, Joseph. "Technological Devices in Medical Care." In *On Moral Medicine: Theological Perspectives in Medicine*, ed. S. E. Lammers and A. Verhey, 277 - 283. Grand Rapids, Mi: W. B. Eerdmans Publishing Company, 1998.

Folland, M. "Hope for the Future." *Nursing Management* 12, no. 6 (2005): 16 - 21.

Ford, David F. *Theology: A Very Short Introduction* Very Short Introductions. Oxford: Oxford University Press, 1999.

Fries, H. "Myth." In *Encyclopedia of Theology: The Concise Sacramentum Mundi*, ed. Karl Rahner. New York: Crossroad, 1982.

Gadamer, Hans-Georg. *The Engima of Health: The Art of Healing in a Scientific Age*. Translated by J. and Walker Gaiger, N. Standford: Stanford University Press, 1996.

Gargett, Eric. "Beyond Nancy Crick." *Monash Bioethics Review* 21, no. 4 (2002): 34 - 35.

Gleeson, Gerald P. "C. S. Lewis: Doctrine and Metaphor." In *Reflections on Faith and Culture*, ed. Neil Brown. Manly, NSW: Catholic Institute of Sydney, 1981.

_____. "Speaking of Persons, Human and Divine." *Sophia* 43, no. 1 (2004): 45 - 60.

Glover, Jonathan. *Causing Death and Saving Lives*. London: Penguin Books, 1977.

Goodin, R. E. "The Political Theories of Choice and Dignity." *American Philosophical Quarterly* 18, no. 2 (1981): 91 - 100.

Gormally, L. "Against Voluntary Euthanasia." In *Principles of Health Care Ethics*, ed. Raanan Gillon and Anne Lloyd, 763 - 774. Chichester, England: John Wiley and Sons, 1994.

Graff, Ann Elizabeth O'Hara. *In the Embrace of God: Feminist Approaches to Theological Anthropology*. Maryknoll, NY: Orbis Books, 1995.

Green, D. G., B. Irvine, M. McKee, A. Dixon, and E. Mossialos. "For and Against: Social Insurance -- the Right Way Forward for Health Care in the United Kingdom?" *British Medical Journal* 325, no. 7362 (2002): 488 - 490.

Gregersen, N. H. "Risk and Religion: Toward a Theology of Risk Taking." *Zygon* 38, no. 2 (2003): 355 - 376.

Groppe, Elizabeth T. "Catherine Mowry Lacugna's Contribution to Trinitarian Theology." *Theological Studies* 63, no. 4 (2002): 730 - 763.

Gunton, Colin. "Trinity, Ontology and Anthropology: Towards a Renewal of the Doctrine of the *Imago Dei*." In *Persons, Divine and Human: King's*

College Essays in Theological Anthropology, ed. C. Schwobel and Colin Gunton. Edinburgh: T&T Clark, 1991.

Gunton, Colin E. *The Triune Creator : A Historical and Systematic Study* Edinburgh Studies in Constructive Theology. Grand Rapids, Mich.: Wm. B. Eerdmans Pub. Co., 1998.

Gustafson, J. M. *Can Ethics Be Christian?* Chicago: University of Chicago Press, 1975.

————. "Theology Confronts Technology and the Life Sciences." In *On Moral Medicine:Theological Perspectives in Medical Ethics*, ed. Stephen E. Lammers and Allen Verhey. Grand Rapids, Michigan: William B. Eerdmans, 1998.

Gustafson, James M. *Theology and Ethics*. Oxford: Basil Blackwell, 1981.

————. *Ethics from a Theocentric Perspective*. Vol. 2. 2 vols. Chicago: University of Chicago Press, 1984.

Gutiérrez, Gustavo. *A Theology of Liberation*. London: SCM Press, 1973.

Hahnenberg, E. P. *Ministries: A Relational Approach*. New York: The Crossroad Publishing Company, 2003.

Hall, Stuart, and Bram Gieben, eds. *Formations of Modernity*. Edited by Stuart Hall, Understanding Modern Societies: An Introduction. Cambridge: Polity Press, 1992.

Hanson, Mark J., and Daniel Callahan. *The Goals of Medicine: The Forgotten Issue in Health Care Reform* Hastings Center Studies in Ethics. Washington, D.C.: Georgetown University Press, 1999.

Hardwired to Connect: The New Scientific Case for Authoritative Communities. New York: Insitute for American Values, 2003.

Hardy, D. W. "Created and Redeemed Sociality." In *God's Ways with the World*, 188 - 205. Edinburgh: T & T Clark, 1996.

————. *God's Way with the World*. Edinburgh: T&T Clark, 1996.

Harré, Rom. *One Thousand Years of Philosophy*. Oxford: Blackwell Publishers, 2000.

Harris, Harriet. "Should We Say That Personhood Is Relational?" *Scottish Journal of Theology* 51, no. 2 (1998): 214 - 234.

Hatley, J. *Suffering Witness: The Quandary of Responsibility after the Irreparable.* Albany, NY: State University of New York Press, 2000.

Hauerwas, Stanley. "Salvation and Health: Why Medicine Needs the Church." In *Suffering Presence*, 63 - 83. Notre Dame, Indiana: University of Notre Dame Press, 1986.

————. *Suffering Presence.* Notre Dame, Indiana: University of Notre Dame Press, 1986.

Hay, David. *The Spirit of the Child.* 2nd ed. London: Jessica Kingsley Publishers, 2006.

Health Care Committee, National Health and Medical Research Council. *Guidelines for Medical Practitioners on Providing Information to Patients.* Canberra: National Health and Medical Research Council, 1993.

Health, Department of. *Medicare Statistics - December Quarter 2005* [website]. Canberra: Australian Government, February 10, 2006 2006, accessed February 13 2006; Available from http://www.health.gov.au/internet/wcms/publishing.nsf/Content/medstat-dec05-contents.

Health, Department of Community Services and. *Consultation Paper No. 5: Report of the Working Panel on Testing for Hiv/Aids.* Canberra, Australia: Department of Community Services and Health, 1989.

Healy, Edwin F. "Natural Law." In *The Historical Development of Fundamental Moral Theology in the United States*, ed. Charles E. Curran and R. A. McCormick, 11, 150 - 154. New York: Paulist Press, 1999.

Heiser, W. Charles. "Catholicism USA: A Portrait of the Catholic Church in the United States." *Theology Digest* 50, no. 4 (2004): 366 - 367.

Hellwig, Monika. "Christology." In *A New Handbook of Christian Theology*, ed. D. W. Musser and J. L. Price. Cambridge: The Lutterworth Press, 1992.

Hill, William J. "Theology." In *The New Dictionary of Theology*, ed. J. A. Komonchak, M. Collins and Dermot A. Lane, 1011 - 1027. Dublin: Gill and Macmillan, 1987.

History of the Nhs The Department of Health, accessed February 9 2006; Available from http://www.nhs.uk/england/aboutTheNHS/history/default.cmsx.

Hollins, Susan. "Spirituality and Religion: Exploring the Relationship." *Nursing Management* 12, no. 6 (2005): 22 - 26.

Hubbeling, H. G. "Some Remarks on the Concept of Person in Western Philosophy." In *Concepts of Person in Religion and Thought*, ed. H. G. Kippenberg, Y. B. Kuiper and A. F. Sanders. Berlin and New York: Mouton de Gruyter, 1990.

Humanism [Internet encyclopaedia]. Stanford University, 2001 2001, accessed 29th August 2003; Available from http://www.utm.edu/research/iep/h/humanism.htm#Character%20of%20the%20Movement.

Hunt, Anne. *Trinity: Nexus of the Mysteries of Christian Faith*. Vol. 1 Theology in Global Perspective, ed. Peter C Phan. Maryknoll, NY: Orbis Books, 2005.

Hursthouse, Rosalind. *Beginning Lives*. Oxford: Basil Blackwell Ltd., 1987.

Hurtado, Larry. *Lord Jesus Christ, Devotion to Jesus in Earliest Christianity*. Grand Rapids, Mi.: W. B. Eerdmans, 2003.

"In Re a (Children)." In *Ward, LJ. Brooke, LJ. Walker, LJ.*, B1/2000/2969: Supreme Court of Judicature Court of Appeal (Civil Division) on Appeal from Family Division, 2000.

Ireland, Ian. *Choice, Quality of Life and Self-Control: Summary Arguments in Support of Euthanasia*. Canberra: Parliamentary Library, 1996-1997, Research Note 12.

Jonsen, Albert R. *A Short History of Medical Ethics*. New York: Oxford University Press, 2000.

Kaiser, Christopher B. "The Incarnation and the Trinity: Two Doctrines Rooted in the Offices of Christ." *Greek Orthodox Theological Review* 43, no. 1 - 4 (1998).

Kamya, Hugo, and Maureen R. O'Brien. "Interprofessional Education in Theology and Social Work: Postmodern and Practical Theological Dimensions." *Teaching Theology and Religion* 3, no. 1 (2000): 20 - 32.

Kasper, Walter. *Jesus the Christ*. Translated by V. Green. Tundbridge Wells, Kent: Burns & Oates, 1976.

————. *The God of Jesus Christ*. Translated by M. J. O'Connell. New York: Crossroad, 1989.

Kass, L. R. "Regarding the End of Medicine and the Pursuit of Health." In *Concepts of Health and Disease*, ed. A. L. Caplan, H. Tristram Engelhardt and J. J. McCartney. Reading, Massachusetts: Addison-Wesley Publishing Group, 1981.

Kaufman, Gordon D. *An Essay on Theological Method*. 3rd edition ed. Atlanta, Georgia: Scholars Press, 1995.

Keenan, James F. *The Works of Mercy: The Heart of Catholicism* The Church Book Series, ed. Karen Sue Smith. Lanham, Maryland: Rowman and Littlefield Publishers, 2005.

Kelly, Anthony. "A Trinitarian Moral Theology." *Studia Moralia* XXXIX, no. 1 (2001): 245 - 289.

————. *Eschatology and Hope* Theology in Global Perspectives, ed. Peter C Phan. Maryknoll, NY: Orbis, 2006.

Kelly, Anthony J., and Francis F. Maloney. *Experiencing God in the Gospel of John*. New York: Paulist Press, 2003.

Kelly, David F. *Contemporary Catholic Health Care Ethics*. Washington, DC: Georgetown University Press, 2005.

Kelly, Kevin T. *New Directions in Moral Theology: The Challenge of Being Human* Geoffrey Chapman Pastoral Studies Series. New York, N.Y: G. Chapman, 1992.

Kennedy, Stephanie. "Government Reviews Plan to Cut Ivf Funding." *The World Today*, May 5, 12: 18: 00 2005.

Khushf, George. "Illness, the Problem of Evil, and the Analogical Structure of Healing." In *On Moral Medicine: Theological Perspectives in Medical Ethics*, ed. Stephen E. Lammers and Allen Verhey, 30 - 41. Grand Rapids, Michigan: William B. Eerdmans, 1998.

Kippenberg, H. G. "Name and Person in Ancient Judaism and Christianity." In *Concepts of Person in Religion and Thought*, ed. H. G. Kippenberg, Y. B. Kuiper and A. F. Sanders. Berlin: Mouton de Gruyter, 1990.

Kirkpatrick, Frank G. *The Ethics of Community* Blackwell Religious Ethics. Malden, Mass.: Blackwell, 2001.

Koenig, H. G. "Religion, Spirituality, and Medicine: Research Findings and Implications for Clinical Practice." *Southern Medical Journal* 97, no. 12 (2004): 1194 - 1200.

Konner, M. *The Trouble with Medicine*. Sydney, NSW: ABC Books, 1993.

Kuhse, Helga, and Peter Singer. *Should the Baby Live?* Oxford: Oxford University Press, 1985.

————. "Should All Seriously Disabled Infants Live?" In *Unsanctifying Human Life*, ed. Helga Kuhse, 215 - 232. Oxford: Blackwell Publishers, 2002.

Küng, Hans. *Eternal Life*. Translated by Edward Quinn. London: Collins, 1984.

Kushner, T. K., and D. C. Thomasma, eds. *Ward Ethics: Dilemmas for Medical Students and Doctors in Training*. Cambridge: Cambridge University Press, 2001.

La Fontaine, J. S. "Person and Individual: Some Anthropological Reflections." In *The Category of Person: Anthropology, Philosophy and History*, ed. Michael Carrithers, Steven Collins and Steven Lukes. Cambridge: Cambridge University Press, 1985.

La Puma, John, and Edward F. Lawlor. "Quality-Adjusted Life-Years: Ethical Implications for Physicians and Policymakers." In *Bioethics: Basic Writings on the Key Ethical Questions That Surround the Major, Modern*

Biological Possibilities and Problems, ed. Thomas A Shannon, 404 - 418. Mahwah, New Jersey: Paulist Press, 1993.

LaCugna, Catherine Mowry. *God for Us: The Trinity and Christian Life*. 1st ed. San Francisco: HarperSanFrancisco, 1991.

Lammers, Stephen E. "The Medical Futility Discussion: Some Theological Suggestions." In *Secular Bioethics in Theological Perspective*, ed. E. E. Shelp, 115 - 128. Dordrecht, NL: Kluwer Academic Publishers, 1996.

Lammers, Stephen E., and Allen Verhey. *On Moral Medicine: Theological Perspectives in Medical Ethics*. 2nd ed. Grand Rapids, MI: William B. Eerdmans Pub., 1998.

_____. "Preface to the First Edition." In *On Moral Medicine: Theological Perspectives in Medical Ethics*, ed. Stephen E. Lammers and Allen Verhey, xv - xvii. Grand Rapids, Michigan: Eerdmans, 1998.

Laurance, Jeremy. "Parents of Siamese Twins to Fight Judge's Ruling." *The Independent*, 31 August 2000.

Lebacqz, Karen. "Bioethics: Some Challenges from a Liberation Perspective." In *On Moral Medicine:Theological Perspectives in Medical Ethics*, ed. Stephen E. Lammers and Allen Verhey. Grand Rapids, Michigan: William B Eerdmans, 1998.

_____. "Religious Studies in Bioethics: No Room at the Table?" In *Notes from a Narrow Ridge: Religion and Bioethics*, ed. D. S. Davis and L. Zoloth, 201 - 214. Hagerstown, Maryland: University Publishing Group, 1999.

Lehmkuhl, August. "Moral Theology." In *The Historical Development of Fundamental Moral Theology in the United States*, ed. Charles E. Curran and R. A. McCormick, 11, 75 - 80. New York: Paulist Press, 1999.

Lessing, Doris. *Shikasta: Re, Colonised Planet 5: Personal, Psychological, Historical Documents Relating to Visit by Johor (George Sherman) Emissary (Grade 9) 87th of the Period of the Last Days* Canopus in Argos Archives. New York: Knopf, 1979.

Levinas, Emmanuel. *Totality and Infinity: An Essay on Exteriority*. Translated by Alphonso Lingus. Pittsburgh: Duquesne University Press, 1981.

_____. "Ethics as First Philosophy." In *The Levinas Reader*, ed. Séan Hand, 75 - 87. Oxford: Blackwell Publishers, 1989.

_____. "Ideology and Idealism." In *The Levinas Reader*, ed. Séan Hand, 235 - 248. Oxford: Blackwell Publishers, 1989.

_____. "The Face of a Stranger." *The Unesco Courier*, no. 7-8 (1992): 66.

_____. *Outside the Subject*. Translated by M. B. Smith. Stanford, CA: Stanford University Press, 1994.

_____. *Difficult Freedom: Essays on Judaism*. Translated by Séan Hand. Baltimore: The Johns Hopkins Press, 1997.

_____. *Entre Nous, Thinking-of-the-Other*. Translated by M. B. Smith and B. Harshav. New York: Columbia University Press, 1998.

_____. *Of God Who Comes to Mind*. Translated by B. Bergo. Stanford: Stanford University Press, 1998.

_____. *Ethics and Infinity, Conversations with Philippe Nemo*. Translated by Richard A. Cohen. Pittsburgh: Duquesne University Press, 1999.

_____. *Is It Righteous to Be? Interviews with Emmanuel Levinas*, ed. Jill Robbins. Stanford, California: Stanford University Press, 2001.

Lillegard, Norman. "No Good News for Data." *Cross Currents* 44, no. 1 (1994).

London, Nick, and Suzanne Rock. "Amazing Gracie." 30 minutes. United Kingdom: Grenada Television, 2001.

Lonergan, B. *Method in Theology*. London: Darton, Longman and Todd, 1971.

_____. "Topics in Education: The Cincinnati Lectures of 1959 on the Philosophy of Education." In *Collected Works 10*, ed. Robert M. Doran and Frederick E. Crowe. Toronto: University of Toronto Press, 1993.

Lynch, William. *Images of Hope. Imagination as Healer of the Hopeless*. Notre Dame, Ind.: Notre Dame University Press, 1987.

MacIntyre, Alasdair. "Theology, Ethics, and the Ethics of Medicine and Health Care." *Journal of Medicine and Philosophy* 4, no. 6 (1979): 435 - 443.

_____. *Whose Justice? Which Rationality?* Notre Dame, Ind: University of Notre Dame Press, 1988.

Mackey, James P. *The Critique of Theological Reason.* Cambridge: Cambridge University Press, 2000.

Macmurray, John. *The Self as Agent.* London: Faber and Faber, 1957.

_____. *Persons in Relation* The Form of the Personal Volume 2. London: Faber and Faber, 1961.

_____. *Reason and Emotion.* London: Faber, 1962.

_____. *Ye Are My Friends.* London: Quaker Home Service, 1979.

_____. *Persons in Relation.* Atlantic Highlands, N.J.: Humanities Press, 1991.

_____. *Search for Reality in Religion.* London: Quaker Home Service and the John Macmurray Society, 1995.

_____. "Prolegomena to a Christian Ethic." In *John Macmurray: Selected Philosophical Writings*, ed. Esther McIntosh, 183 - 195. Exeter: Imprint Academic, 2004.

MacNamara, Vincent. *Faith and Ethics: Recent Roman Catholicism*. Dublin: Gill and Macmillan, 1985.

Macquarrie, John. *In Search of Humanity: A Theological and Philosophical Approach*. New York: Crossroad, 1983, 1982.

Mahowald, M. B. "Commentary." In *Ward Ethics: Dilemmas for Medical Students and Doctors in Training*, ed. T. K. Kushner and D. C. Thomasma, 119 - 121. Cambridge: Cambridge University Press, 2001.

Marsh, Charles. "In Defense of a Self: The Theological Search for a Postmodern Identity." *Scottish Journal of Theology* 55, no. 3 (2002): 253 - 282.

Marty, Martin E. "Foreword." In *Notes from a Narrow Ridge: Religion and Bioethics*, ed. D. S. Davis and L. Zoloth, ix - xiv. Hagerstown, Maryland: University Publishing Group, 1999.

Mauss, M. "A Category of the Human Mind: The Notion of Person; the Notion of Self." In *The Category of the Person: Anthropology, Philosophy, History*, ed. Michael Carrithers, Steven Collins and Steven Lukes, 1 - 25. Cambridge: Cambridge University Press, 1985.

May, William F. *The Patient's Ordeal*. Bloomington, Indiana: Indiana University Press, 1991.

————. "Code and Covenant or Philanthropy and Contract?" In *On Moral Medicine: Theological Perspectives in Medical Ethics*, ed. Stephen E. Lammers and Allen Verhey. Grand Rapids, Michigan: William B. Eerdmans, 1998.

McArdle, Patrick. "Ecce Homo: Theological Perspectives on Personhood and the Passions." *The Australian E-Journal of Theology*, no. 7 (2006).

McCall Smith, Alexander. "The Separating of Conjoined Twins." *British Medical Journal* 321, no. 7264 (2000): 782.

McCormick, R. A. "Theology and Bioethics: Christian Foundations." In *Theology and Bioethics: Exploring the Foundations and Frontiers*, ed. E. E. Shelp. Dordrecht, Holland: D. Reidel Publishing, 1985.

————. "Theology and Bioethics." *Hastings Center Report* 19, no. 3 (1989): 5 - 11.

McFadyen, A.I. *The Call to Personhood: A Christian Theory of the Individual in Social Relationships*. Cambridge: Cambridge University Press, 1990.

McFadyen, Alistair I. *Bound to Sin: Abuse, Holocaust and the Christian Doctrine of Sin* Cambridge Studies in Christian Doctrine 6. Cambridge, U.K.: Cambridge University Press, 2000.

McFarland, Ian. "Who Is My Neighbor?: The Good Samaritan as a Source for Theological Anthropology." *Modern Theology* 17, no. 1 (2001): 57 - 66.

McKew, Maxine. "Friday Forum." *Lateline*, April 29 2004.

Metz, Johannes Baptist, and Edward Schillebeeckx. *No Heaven without Earth* Concilium 1991/4. London: SCM Press, 1991.

Micco, G. "Commentary." In *Ward Ethics: Dilemmas for Medical Students and Doctors in Training*, ed. T. K. Kushner and D. C. Thomasma, 116 - 119. Cambridge: Cambridge University Press, 2001.

Milbank, John. *The World Made Strange*. Oxford: Blackwell, 1997.

Moltmann, Jurgen. *Experiences in Theology*. Translated by Margaret Kohl. London: SCM Press, 2000.

Moltmann, Jürgen. *The Trinity and the Kingdom of God: The Doctrine of God*. London: SCM Press, 1981.

_____. *The Church in the Power of the Spirit*. London: SCM Press, 1993.

Morris, Steven. "Jodie and Mary: The Point Where the Law, Ethics, Religion and Humanity Are Baffled." *The Guardian*, September 9 2000.

Morrison, Glen J. "Emmanuel Levinas and Christian Theology." *Irish Theological Quarterly* 68 (2003): 3 - 24.

Morrison, Glenn. "A Critical Review of Michael Purcell's Theological Development of Levinas' Philosophy." *Heythrop Journal* 44, no. 2 (2003): 147 - 166.

Murphy-O'Connor, Cormac. *A Submission by Archbishop Cormac Murphy-O'connor, Archbishop of Westminster, to the Court of Appeal in the Case of Central Manchester Healthcare Trust V Mr and Mrs a and Re a Child (by Her Guardian Ad Litem, the Official Solicitor)*. London: Roman Catholic Diocese of Westminster, 2000. Submission to the Court of Appeal.

Murray, John Courtney. *The Problem of God*. New Haven, CT.: Yale University Press, 1964.

Naef, Rahel. "Bearing Witness: A Moral Way of Engaging in the Nurse-Person Relationship." *Nursing Philosophy* 7 (2006): 146 - 156.

Nagler, M. *America without Violence*. Covelo, Ca.: Island Press, 1982.

Nelson-Pallmeyer, J. *The Politics of Compassion*. Maryknoll, New York: Orbis Books, 1986.

Nicholson, Richard. "Should Doctors Separate the Siamese Twins? - No." *The Independent*, 10 September 2000.

Nitschke, Philip. *Voluntary Euthanasia - a New Radicalism* [web site]. Online Opinion, 2002, accessed 17 December 2003; Available from http://www.onlineopinion.com.au/2002/May02/Nitschke.htm.

Nolan, Brian M. "Person, Divine." In *The New Dictionary of Theology*, ed. J. A. Komonchak, M. Collins and Dermot A. Lane, 757 - 759. Dublin: Gill and MacMillan, 1987.

Nordenfelt, L. *On the Nature of Health*. Dordrecht, Holland: D. Reidel Publishing Company, 1987.

Nortvedt, Per. "Subjectivity and Vulnerability: Reflections on the Foundation of Ethical Sensibility." *Nursing Philosophy* 4, no. 3 (2003): 222 - 230.

Nussbaum, Martha Craven. "Compassion: The Basic Social Emotion." *Social Philosophy and Policy* 13, no. 1 (1996).

O'Connell, K. A, and S. M Skevington. "The Relevance of Spirituality, Religion and Personal Beliefs to Health-Related Quality of Life: Themes from Focus Groups in Britain." *British Journal of Health Psychology* 10, no. 3 (2005): 379 - 398.

O'Grady, John F. *Christian Anthropology: A Meaning for Human Life*. New York: Paulist Press, 1975.

O'Murchu, Diarmid. *Quantum Theology*. New York: The Crossroad Publishing Company, 1997.

Online, BBC News. *Iranian Twins Die in Surgery* [Website]. London: British Broadcasting Corporation, July 8, 2003 (GMT 18:18) 2003, accessed March 8 2006; Available from http://news.bbc.co.uk/2/hi/asia-pacific/3053638.stm.

Ormerod, Neil. "Faith and Reason: Perspectives from Macintyre and Lonergan." *Heythrop Journal* 46, no. 1 (2005): 11 - 22.

Otlowski, M. "Discussion: The Nancy Crick Case." *Monash Bioethics Review* 21, no. 3 (2002): 10 - 12.

Pagels, Elaine H. "Exegesis of Genesis 1 in the Gospels of Thomas and John." *Journal of Biblical Literature* 118, no. 3 (1999): 477 - 496.

Panikkar, Raimon. *The Trinity and the Religious Experience of Man: Icon - Person - Mystery*. New York: Orbis Books, 1973.

Paris, J. J., and A. C. Elias-Jones. ""Do We Murder Mary to Save Jodie?" An Ethical Analysis of the Separation of the Manchester Conjoined Twins." *Postgraduate Medical Journal* 77, no. 911 (2001): 593 - 598.

Parks, Jennifer A. "Why Gender Matters to the Euthanasia Debate: On Decisional Capacity and the Rejection of the Woman's Death Request." *Hastings Center Report* 30, no. 1 (2000): 30 - 36.

Parsons, T. *Definitions of Health and Illness in the Light of American Values and Social Structure*. Reading, Massachusetts: Addison-Wesley Publishing Group, 1981.

Peach, Hedley G. "Religion, Spirituality and Health: How Should Australia's Medical Professionals Respond?" *Medical Journal of Australia* 178, no. 2 (2003): 86 - 88.

Pecknold, C. C. "How Augustine Used the Trinity: Functionalism and the Development of Doctrine." *Anglican Theological Review* 85, no. 1 (2003).

Pellegrino, Edmund D. "Ethics in Aids Treatment Decisions." *Origins* 19, no. 33 (1990).

Pence, Gregory E. *Classic Cases in Medical Ethics*. New York: McGraw-Hill, Inc., 1995.

Philipp, R. *Arts, Health and Well-Being*. London: Nuffield Trust, 2002.

Plato. "Euthyphro." In *The Last Days of Socrates*, ed. Hugh Tredennick, 19 - 41. Hammondsworth, Middlesex: Penguin Classics, 1954.

Press, Associated. "Terri Schiavo Right-to-Die Case." *The Age*, March 21 2005.

Pullman, Daryl. "Universalism, Particularism and the Ethics of Dignity." *Christian Bioethics* 7, no. 3 (2001): 333 - 358.

Purcell, M. "'Levinas and Theology'? The Scope and Limits of Doing Theology with Levinas." *Heythrop Journal* 44, no. 4 (2003): 468 - 479.

Rahner, Karl. *The Trinity*. Translated by J. Donceel Mysterium Salutis. London: Burns & Oates, 1970.

_____, ed. *Encyclopedia of Theology: A Concise 'Sacarmentum Mundi".* London: Burns and Oates, 1975.

Ramsey, Paul. *The Patient as Person.* New Haven: Yale University Press, 1970.

Ratzinger, Josef. *Introduction to Christianity.* New York: Herder and Herder, 1970.

_____. "Concerning the Notion of Person in Theology." *Communio* 17, no. 3 (1990): 439 - 454.

Research, National Commission for the Protection of Human Subjects of Biomedical and Behavioral. *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research.* Washington, D.C.: Department of Health, Education, and Welfare., 1979.

Research, NCLS. *Australian Spirituality* [website]. National Church Life Survey, n/a 2005, accessed 08 December 2005; Available from http://www.ncls.org.au/default.aspx?sitemapid=6.

Rhees, Rush, ed. *Recollections of Wittgenstein: Hermine Wittgenstein--Fania Pascal--F.R. Leavis--John King--M. O'c. Drury.* Oxford: Oxford University Press, 1984.

Riddell. "Pity Us, but Pity Jodie More." *The Observer*, 10 September 2000.

Robertson, John. "Cruzan: No Rights Violated." *Hastings Center Report* 20, no. 5 (1992).

Rock, Suzanne, and Nick London. "Amazing Gracie." Leeds, Yorkshire: Granada Television, 2001.

Rudman, Stanley. *Concepts of Person and Christian Ethics* New Studies in Christian Ethics. New York: Cambridge University Press, 1997.

Rumbold, Bruce D. "Caring for the Spirit: Lessons from Working with the Dying." *Medical Journal of Australia* 179, no. 6 (supplementary) (2003): S11 - S 13.

Russell, Edward. "Reconsidering Relational Anthropology: A Critical Assessment of John Zizioulas's Theological Anthropology." *International Journal of Systematic Theology* 5, no. 2 (2003): 168 - 186.

Sachs, John Randall. *The Christian Vision of Humanity: Basic Christian Anthropology* Zacchaeus Studies. Theology. Collegeville, MN: Liturgical Press, 1991.

Savolaine, John, and Paul F. Granello. "The Function of Meaning and Purpose for Individual Wellness." *Journal of Humanistic Counseling, Education and Development* 41, no. 2 (2002): 178 - 189.

Scanlon, M. J. "Christian Anthropology and Ethics." In *Ethical Viewpoints in the Catholic Tradition*, ed. Judith A. Dwyer, 27 - 51. Washington, DC: Georgetown University Press, 1999.

Scher, Peter. *Patient-Focused Architecture for Health Care.* Manchester: Manchester Metropolitan University, 1996.

Schwöbel, C. "Introduction." In *Persons, Divine and Human*, ed. C Schwobel and Colin Gunton. Edinburgh: T & T Clark, 1991.

Scotton, Richard B. "Medibank: From Conception to Delivery and Beyond." *Medical Journal of Australia* 173, no. 1 (2000): 9 - 11.

Scruton, Roger. *Modern Philosophy, a Survey.* London: Sinclair-Stevenson, 1994.

Sennett, James F. "Requiem for an Android?: Lillegard Traps Us in a False Dilemma." *Cross Currents* 46, no. 2 (1996): 195 - 216.

Shannon, Thomas A. "Bioethics and Religion: A Value Added Discussion." In *Notes from a Narrow Ridge: Religion and Bioethics*, ed. D. S. Davis and L. Zoloth, 127 - 150. Hagerstown, Maryland: University Publishing Group, 1999.

Shuman, J. J. *The Body of Compassion.* Boulder, Colorado.: Westview Press, 1999.

Sider, J. Alexander. "Image, Likeness, and the Ethics of Memory." *Scottish Journal of Theology* 54, no. 4 (2001): 528 - 547.

Simkins, Ronald A. "Gender Construction in the Yahwist Creation Myth." In *Genesis: The Feminist Companion to the Bible (Second Series)*, ed. Athalya Brenner, 32 - 52. Sheffield: Sheffield Academic Press, 1998.

Singer, Peter. *Rethinking Life & Death: The Collapse of Our Traditional Ethics.* Melbourne: Text Publishing, 1994.

————. "Is the Sanctity of Life Ethic Terminally Ill?" In *Unsanctifying Human Life*, ed. Helga Kuhse, 246 - 261. Oxford: Blackwell Publishers, 2002.

————. *Unsanctifying Human Life.* Helga Kuhse ed. Oxford: Blackwell Publishers, 2002.

Singer, Peter, and Helga Kuhse. "Allocating Health Care Resources and the Problem of the Value of Life." In *Unsanctifying Human Life*, ed. Helga Kuhse, 265 - 280. Oxford: Blackwell Publishers, 2002.

Singer, Peter, John McKie, Helga Kuhse, and Jeff Richardson. "Double Jeopardy and the Use of Qalys in Health Care Allocation." 2002.

Slocum, R. B. "Kingdom Come: Preliminaries for a Relational Theology of Hope." *Anglican Theological Review* 82, no. 3 (2000).

Smail, Thomas A. "In the Image of the Triune God." *International Journal of Systematic Theology* 5, no. 1 (2003): 22 - 32.

Smart, Ninian. *World Philosophies.* London: Routledge, 1999.

Soskice, J. M. "Creation and Relation." In *Medicine and Moral Reasoning*, ed. K. W. M. Fulford, G. Gillett and J. M. Soskice, 19 - 28. Cambridge: Cambridge University Press, 1994.

Speake, J., and S. Mitchell, eds. *A Dictionary of Philosophy.* Edited by A. Isaacs. London: Pan Books, 1979.

Spohn, William C. "Notes on Moral Theology - Parable and Narrative in Christian Ethics." *Theological Studies* 49, no. 1 (1990): 100 - 114.

Starck, P. "The Human Spirit: The Search for Meaning and Purpose through Suffering." *Humane Medicine* 8, no. 2 (1992).

Statistics, Australian Bureau of. *Year Book Australia - Culture and Recreation - Religious Affiliation* [website]. ABS, 18 March, 2005 2005, accessed 08 December 2005; Available from http://www.abs.gov.au/Ausstats/abs@.nsf/0/E4F6E98AA14943F3CA256F7200832F71?Open.

Stern, Julian. "John Macmurray, Spirituality, Community and Real Schools." *International Journal of Children's Spirituality* 6, no. 1 (2001): 25 - 39.

Stinson, R., and P. Stinson. *The Long Dying of Baby Andrew*. Boston: Little, Brown, 1983.

Studebaker, S. "Jonathan Edwards's Social *Augustinian* Trinitarianism: An Alternative to a Recent Trend." *Scottish Journal of Theology* 56, no. 3 (2003): 268 - 285.

Sulmasy, Daniel P. "Every *Ethos* Implies a *Mythos.*" In *Notes from a Narrow Ridge: Religion and Bioethics*, ed. D. S. Davis and L. Zoloth, 227 - 246. Hagerstown, Maryland: University Publishing Group, 1999.

Swinton, John. "Constructing Persons: John Macmurray and the Social Construction of Disability." In *John Macmurray: Critical Perspectives*, ed. David Fergusson and Nigel Dower, 239 - 248. New York: Peter Lang, 2002.

Swinton, John, and Elizabeth McIntosh. "Persons in Relation: The Care of Persons with Learning Disabilities." *Theology Today* 57, no. 2 (2000).

Syme, Rodney. *Nancy Crick* [website]. Voluntary Euthanasia Society of Victoria Inc., 2002, accessed 26 August 2003; Available from http://www.vesv.org.au/docs/crick050602.htm.

————. "Response to the Nancy Crick Case." *Monash Bioethics Review* 21, no. 4 (2002): 32 - 34.

Tan, H. M., A. Braunack-Mayer, and J. Beilby. "The Impact of the Hospice Environment on Patient Spiritual Expression." *Oncology Nursing Forum* 32, no. 5 (2005): 1049 - 1055.

Taylor, Charles. *Sources of the Self: The Making of Modern Identity*. Cambridge: Cambridge University Press, 1989.

Thogmartin, J. R. *Report of Autopsy: Schiavo, Theresa*. Largo, Florida: Medical Examiner, Sixth District, 2005. Autopsy Report.

Thompson, J. *Modern Trinitarian Perspectives*. New York: Oxford University Press., 1994.

Tobias, Pete. "Twin Dilemmas of God and Man." *The Guardian*, September 16 2000.

Toolis, Kevin. "Hate That Dare Not Speak Its Name." *The Guardian*, September 15 2000.

Toulmin, Stephen. *Cosmopolis: The Hidden Agenda of Modernity*. Chicago: University of Chicago Press, 1990.

Traynor, Kate. "More Americans Than Ever Lack Health Insurance." *American Journal of Health-System Pharmacy* 62, no. 24 (2005): 2583 - 2590.

Trevarthen, Colwyn. "Proof of Sympathy: Scientific Evidence on the Personality of the Infant and Macmurray's 'Mother and Child'." In *John Macmurray: Critical Perspectives*, ed. D. Fergusson and N. Dower, 77-118. New York: Peter Lang, 2002.

Trevarthen, Colwyn, and Kenneth J. Aitken. "Infant Intersubjectivity: Research, Theory, and Clinical Applications." *Journal of Child Psychology and Psychiatry* 42, no. 1 (2001): 3-48.

Trujillo, Alfonso L. "Liberation, a Permanent Value." In *Liberation Theology: A Documentary History*, ed. Alfred T. Hennelly, 163 - 173. Maryknoll, NY: Orbis Books, 1990.

Tubbs, J. B. jr. "Theology and the Invitation of the Stranger." In *Duties to Others*, ed. C. S. Campbell and B. A Lustig, 4, 39 - 54. Dordrecht, NL.: Kluwer Academic Publishers, 1994.

————. *Christian Theology and Medical Ethics, Four Contemporary Approaches*. Dordrecht, The Netherlands: Kluwer Academic Press, 1996.

Turcescu, Lucian. "'Person' Versus 'Individual', and Other Modern Misreadings of Gregory of Nyssa." *Modern Theology* 18, no. 4 (2002): 527 - 539.

Turner, L. A. *Genesis* Readings: A New Biblical Commentary, ed. John Jarick. Sheffield, England: Sheffield Academic Press, 2000.

Tzeng, Huey-Ming, and Chang-Yi Yin. "Learning to Respect a Patient's Spiritual Needs Concerning an Unknown Infectious Disease." *Nursing Ethics* 13, no. 1 (2006): 17 - 28.

van Beeck, F. J. "Trinitarian Theology as Participation." In *The Trinity*, ed. Stephen T. Davis, Daniel Kendall and Gerald O'Collins. Oxford: Oxford University Press, 1999.

van Gend, David. "Nancy Crick's Death Not in Vain." *Human Life Review* 28, no. 3 (2002): 87 - 88.

Vanier, Jean. *Becoming Human*. London: Darton, Longman and Todd, 1999.

Vaux, Kenneth. "Law and Lamb: Akedah and the Search for a Deep Religious Symbol for an Ecumenical Bioethics." *Christian Bioethics* 5, no. 3 (1999): 213 - 219.

Vawter, Bruce. *On Genesis*. London: Geoffery Chapman, 1977.

Veling, Terry A. "'Practical Theology': A New Sensibility for Theological Education." *Pacifica* 11, no. 2 (1998): 195 - 210.

————. *Practical Theology: "On Earth as It Is in Heaven"*. Maryknoll, NY: Orbis Books, 2005.

Villagomeza, Liwliwa R. "Spiritual Distress in Adult Cancer Patients: Toward Conceptual Clarity." *Holistic Nursing Practice* 19, no. 6 (2005): 285 - 294.

von Balthasar, H. *The Glory of the Lord, Volume 7: Theology and the New Covenant*. Translated by Brian McNeil. Edinburgh: T & T Clark, 1989.

von Balthasar, H. U. *The Glory of the Lord: A Theological Aesthetics*. Translated by various translators. 7 volumes vols., ed. J. and Riches Fessio sj, J. San Francisco: Ignatius Press, 1982 - 1991.

————. "On the Tasks of Catholic Philosophy in Our Time." *Communio* 20 (1993).

Waldron, Jeremy. "Who Is My Neighbor?: Humanity and Proximity." *The Monist* 86, no. 3 (2003): 333 - 354.

Ward, Graham. "Introduction." In *The Postmodern God*, ed. Graham Ward, xv - xlvii. Malden, Mass.: Blackwell Publishers Inc., 1997.

————. *Theology and Contemporary Critical Theory*. 2nd ed. Studies in Literature and Religion, ed. David Jasper. Basingstoke, Hampshire: MacMillan Press, 2000.

Warren, Mary Anne. *Moral Status: Obligations to Persons and Other Living Things.* Oxford/ New York: Clarendon Press/ Oxford University Press, 1997.

Warry, Richard. *Conjoined Twin Surgery Highly Risky* London: British Broadcasting Corporation, 8 July, 2003 GMT 10:47 2003, accessed 21 March 2006; Available from http://news.bbc.co.uk/2/hi/health/3053862.stm.

Weiss, Roslyn. "The Perils of Personhood." In *What Is a Person?*, ed. M. F. Goodman, 115 - 126. Clifton, New Jersey: Humana Press, 1988.

Whittier, G. "The Ethics of Metaphor and the Infant Body in Pain." *Literature and Medicine* 18, no. 2 (1999): 210 - 235.

Wiggins, J. B. "Religion." In *A New Handbook of Christian Theology*, ed. D. W. Musser and J. L. Price. Cambridge: The Lutterworth Press, 1992.

Williams, Bernard. *Problems of the Self*. Cambridge: Cambridge University Press, 1973.

Wolf, Susan M. "Gender, Feminism, and Death: Physician-Assisted Suicide and Euthanasia." In *Feminism and Bioethics: Beyond Reproduction*, ed. Susan M. Wolf, 282 - 317. New York: Oxford University Press, 1996.

Word, Ron. "Appeals Court to Consider Schiavo Request." *ABCNews*, March 30 2005.

XVI, Pope Benedict. *Deus Caritas Est*. Rome: Vatican Publishing House, 2005.

Zagzebski, L. "The Uniqueness of Persons." *Journal of Religious Ethics* 29, no. 3 (2001).

Zaner, R. M. "Encountering the Other." In *Duties to Others*, ed. C. S. Campbell and B. A Lustig, 4. Dordrecht, NL: Kluwer Academic Publishers, 1994.

Zizioulas, J. "On Being a Person: Towards an Ontology of Personhood." In *Persons, Divine and Human: King's College Essays in Theological Anthropology*, ed. C. Schwöbel and C.E. Gunton. Edinburgh: T&T Clark, 1991.

Zizioulas, John. "Human Capacity and Human Incapacity: A Theological Exploration of Personhood." *Scottish Journal of Theology* 28, no. 5 (1975).

_____. *Being as Communion.* Crestwood, NY: St Vladimir's Seminary Press, 1993.

Zoloth, L. "Faith and Reasoning(S): Bioethics, Religion, and Prophetic Necessity." In *Notes from a Narrow Ridge: Religion and Bioethics*, ed. D. S. Davis and L. Zoloth. Hagerstown, Maryland: University Publishing Group, 1999.