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Dialogue Between Hinduism And Islam : The Unborn Life and Family Planning

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Introduction

Both Hinduism and Islam* are ethics-based religions. Hinduism is classified amongst the "Eastern" religions, whereas Islam, together with Judaism and Christianity, are classified as the major monotheistic religions - the three constituting the "Abrahamic faiths".

The essentially ethical nature of Hinduism and Islam together with their reverence for life, would lead us to expect many similarities between the two religions in considering the unborn life and family planning. There are, of course, differences to be expected between the two "ways of life", but it appears from our first dialogue that some of the apparent differences are, in terms of practical behaviour, not that large. We have ended, at this stage, by identifying a number of issues that need further dialogue.

We have concentrated here on discussing the issues surrounding abortion. Towards the end, we will touch upon matters related to family planning, where the Muslim position is presented, pending a more detailed exposition of the equivalent Hindu position.

* The Muslim co-author is a Sunni and the comments about Islam pertain mainly to the Sunni tradition of Islam

General Comparison of Hinduism and Islam

Value Formation

1. Revelation

In Hinduism, the equivalent of the notion of ethics is encompassed in the overarching concept of "dharma", which is so wide in meaning that it has been defined simply as "right conduct" The defining elements of dharma are to be found initially in the body of revealed literature, the Vedas. The Vedas are subdivided into two, three, or four layers. The threefold division is most convenient for our purpose. These layers are, respectively, the Samhita (Mantra), the Brahmanas and the Upanisads.

In Islam, "right conduct" is based also fundamentally upon the teaching and values enshrined in the Holy Qur'an, which is Allah's divine and unaltered Word, as revealed to the Prophet Muhammed (SAW), recorded in his life time and gathered together within a few years of his death.

2. Tradition

The second defining element in both religions is received tradition. Hindu texts embodying this are called Smrtis, of which Manusmrti is pre-eminent. Although many of of these deal with caste-conduct, they do have a much wider influence on everyday behaviour, including the protection of women, which does not seem to be based on caste.

In Islam, the prophet Muhammad provides ideal conduct. There is no divinity about him. He was a human being, chosen to be the last in a long line of Prophets. His life, sayings and behaviour were minutely observed and recorded, and constitute the accepted body of tradition known as the Sunna of the Prophet. Much of the setting and collating of the traditions was done in the early phases of Islam, and the traditions are thus informed by the behaviour of the early Muslim communities, based as they were upon their understanding of the Prophet's tradition.

3. Conduct

Hinduism is interesting in that it accords a high place to conduct in its value sourcing. The conduct in question is both the conduct of the elite (sistacara) and that of the masses (lokakara). People are expected to do the right thing, and in turn, what they do is considered the right thing to do, within limits.

In Islam, it is the conduct of the Prophet and early Muslim communities which is considered exemplary and which informed the early development of Sharia. It is the minor differences in interpretation of that tradition/conduct (and to some extent, exegesis of the Holy Qur'an) that led to the formation of the 4 different schools of Islamic Jurisprudence, namely Hanbali, Hanafi, Maliki and Shafii (after the jurists who originally expounded the law). In the modern era, conduct per se as source of value formation plays no formal role. Nevertheless, Sharia is very capable of adapting to new social and scientific realities using the fundamental sources of the Qur'an, the Sunna (or Hadith, the sayings of the Prophet), together with the techniques of Qiyas (analogy) and ijmaa (consensus).

We have not yet had an opportunity to compare Islamic and Hindu jurisprudence, but have already noted the common approach to choosing the lesser of 2 evils when evil cannot be avoided. (See below also on Principles of Islamic Jurisprudence)

4. Conscience

This is a more difficult issue to grapple with. It tends to be more emphasized in Hinduism than Islam, and might on the surface appear to be a significant difference. It warrants further discussion. In Hinduism it connotes the understanding that each individual must make his or her own ethical decisions, because each person alone suffers or enjoys the karmic consequences. In Islam, the very basis of judgement and sin is predicated upon individual choice, and in that sense is not different from the Hindu position.

Conscience as a source of value formation in Hinduism can be seen as mediating between opposing positions. A pertinent example here would be mediating between the pro-life and pro-choice camps, affirming "the arguments of each camp while differing from both." It accepts the pro-life view that the fetus is alive but parts company with it "on the grounds that the right to life of the fetus ought not to be absolutized. In place of absolute rights, Hinduism advocates addressing competing rights and values. Ethical dilemmas arise in case of rape and nicest and when the mother runs the risk of grave injury or death. Each situation is unique and its own moral tragedy. The best one can do in such situations is evil, but then it boils down to a question of degree."

Unless "conscience" is understood as the use of the individual's own values, even if they are at variance with fundamental Muslim values, in deciding what is right or wrong then the Islamic position is little different from the Hindu position. In the specific example above, Islam also accepts that the fetus has life, but does not absolutize the latter's right to life. This is more so before "ensoulment" (see below), but even after ensoulment, if the terrible choice is between the mother's life and that of her fetus. W. Somerset Maugham has defined conscience as "the guardian in the individual of the rules which the community has evolved for its own preservation." In that sense, again, there would be little difference in the positions of Hinduism and Islam.

Destiny of the Human Being: Reincarnation vs. Resurrection

Both Hinduism and Islam hold individuals accountable for their actions, accountability implying reward or punishment in the future. In Hinduism, repeated reincarnation, with the individual soul going on the occupy a different body in the next incarnation, provides opportunity for expression of the individual soul's karma. Thus, good conduct accrues good karma, and the soul occupies a better body and better circumstances in the next incarnation. The soul is the vehicle for choice, accountability and propagation through time.

In Islam, good conduct by an individual person (body + soul - since the soul will only occupy that particular body at the time of resurrection) is rewarded with "thawab", which

is the exact opposite of sin*, which is accrued as a result of bad conduct. In simplified terms, on the day of judgement thawab is weighed against sin and the person is punished or rewarded accordingly. Willful, unrepented , unforgiven and unmitigated sin leads to a period in hell. When good overweighs bad, or after punishment or atonement, the reward is heaven. [Whether these are physical entities, and how they relate to Hindu concepts of Nirvana and its opposite, could be another subject for discussion).

Similarities in adjudication

Both Hinduism and Islam, as we have seen, hold individuals accountable for their actions. When determining a course of action, both religions take into account the *context* of the question. With fundamental values informing the analysis, it is possible for the same action to be correct in one circumstance but not in another. In Islamic jurisprudence, the following principles are used in adjudication:

- Need and necessity are equivalent
- Necessity allows prohibited matters
- Injurious harm should be removed
- Prevention of evil has priority over obtaining benefit
- The greater benefit prevails over a lesser benefit

Both religions are fervently pro-life and pro-morality. Ethics is often portrayed in black/white terms. Islam departs from this in assigning degrees of ethical probity to individual actions. In Islamic jurisprudence (and everyday life) an act can be:

Haram	Forbidden
Makruh	Discouraged
Mubah	Neutral
Mustahabb	Recommended
Fardh	Obligatory

There are no priests in Islam - only learned people and functionaries. When a new situation arises, a Mufti (learned, both a legal and theological expert) can be called upon to provide a ruling (Fatwa). It is quite possible that different Muftis can give different rulings; in most Islamic countries there would be one Mufti whose ruling would be considered most binding. (In Shiaism, the Imam's Fatwa has more binding authority).

* As transgression rather than as fault or shortcoming

The question of abortion: similarities

1. Mother vs. Fetus

In Hinduism, the individual is seen as progressing from a rudimentary state to a more evolved state. Thus the adult human being, having arrived at a karmic state in which there is much more at stake for that individual's spiritual destiny, and having acquired familial and societal obligations, is in a position to be favoured over an equal human being whose evolution is by comparison rudimentary, and who has not yet established a social network of relationships and responsiblities. Hence, when it comes to choosing between the life of the fetus and its mother, Hinduism places greater weight on the mother's life.

The position in Islam may be predicated on a different set of considerations, but the conclusion is the same. In fact, it would be correct to save the mother's life and sacrifice that of the fetus, even after ensoulment. (See below)

2. Abhorrence of Abortion

Both Hinduism and Islam clearly distinguish between miscarriage and abortion, holding no one accountable for spontaneous miscarriages. Islam, however, has a specific set of punishments for those who effect an aggression of any sort against the fetus that results in a miscarriage. These include the payment of a specific amount of "blood money" or blood ransom.

Both religions view abortion with abhorrence, and would favour contraception for family planning. There is probably a greater degree of theoretical abhorrence in Hinduism than in Islam, although a clear dichotomy emerges in actual practice, in the sense that it seems India has a higher per capita incidence of induced abortions than do Islamic societies. Even in Hindu society, there are major differences in the rate of abortion: in India abortion is common, and has been legalized, whereas in Nepal the other major Hindu country, it is much less prevalent and is illegal.

In Muslim countries, on the whole, abortion is illegal and can only be performed legally for very strict, usually medical, reasons.

One possible explanation for the Hindu dichotomy between belief and practice is that, *internally*, Hinduism is inherently more diverse than Islam; while an explanation for the difference between India and Nepal may be that in India, Hinduism has been exposed to secularizing forces to a much greater extent than in Nepal.

It would be interesting to record the incidence of abortion in more secular Muslim countries such as Turkey.

3. Permissible abortion/contraception

In both religions, it would be wrong to perform an abortion unless there was good reason. In Islam, before ensoulment, abortion has been allowed under the following conditions:

- Danger to the mother's life
- Danger to the life of an infant totally dependent on the mothers milk
- (Extreme) social deprivation
- There is now debate as to whether severe fetal abnormalities could also permit abortion, but there is no agreement yet. It would be preferable to do genetic tests for common diseases and avoid marriage in the first place; or failing that, to do pre-implantation genetic diagnosis and forego implantation (this, too, would require more discussion that it has had so far in Islamic circles, but then the technique is in its early stages of development and application).

Once a marriage is entered into, there is a strong leaning towards making it productive of offspring (even though sex is not seen as only for procreation, its enactment must not continuously exclude procreation).

As we have noted before, contraception is allowed in both religions; and abortion must not be used for family planning.

The question of abortion: differences

1. Timing of ensoulment

a) Hindu position

The Hindu position enunciated in the well-known Ayurvedic text *Caraka Simhita*, is that the "spirit" is already manifest at conception, and is the causal agent in the embryo's progressive development. This creative manifestation of the spirit in the microcosmos is similar to the process of creation in the macrocosmos. On the human side, the moral character of the individual is also given at conception. Karma is carried over from one life to the next. Together the spiritual and moral constituents of the individual make for the production of a person through a *continuous process that is developmental but not disjunctive.* It is therefore pointless to discriminate between different degrees of human potentiality in terms of "ensoulment" "variability" and "brain waves". The new life is an intimate, inseparable blending of human and physical-biological existence.

b) The Islamic position

The idea of ensoulment is strong and well formed in Islam. It has quite important implications. Ensoulment occurs either at about 40 days or at about 120 days, depending on varying interpretation of sources of authority.

(i) Ensoulment as watershed

Ensoulment is such a key event that it warrants some exposition to convey just how much of a watershed it is considered to be. The soul is seen as being breathed into the developing fetus by Allah. It converts the fetus, until then alive but vegetative, into a human being, albeit not yet with full legal human rights and obviously not yet with obligations. Its status is that of "incomplete dhimma" i.e. it has rights but owes no duties). It is ensoulment with the breath of Allah, the "Ruh" (what Christians call "Ruah Jahwe"), that converts the fetus into an Insan* that elevates humans above all other creatures, giving humans enormous powers to exploit the rest of creation. At the same time, however, ensoulment encumbers Insan with the terrible responsibilities of stewardship. H. sapiens then becomes Allah's "khalifa" (vicegerent, viceroy) on earth.

* H. sapiens is called Insan in the Qur'an. This is closer to the Latin "Homo" and the German "Mensch" than to the English "Man."

(ii) Ensoulment, volition and neuromuscular coordination

That ensoulment imparts an element of volition is well described by Ibn al Qaim thus:

"If it is asked: does the embryo, before the breathing of the soul into it, have perception and movement? It is answered that the movement it possesses is like that of a growing plant. Its movement and perceptions are not voluntary. When the soul is breathed to the body, the movements and perceptions become voluntary and are added to the vegetative type of life it had prior to the breathing of the soul"

When seen as occurring at about 120 days, it corresponds approximately to the time when the fetus begins to make purposive movements, i.e. developing neuromuscular coordination. The fetus soon begins to "quicken", confirming the pregnancy to the mother and to the world.

(iii) Resonance with Qur'anic embryology

Islam does not bestow high regard to miracles. About the only miracle emphasized in Islam is the miracle of the Qur'an. There is only one version of the Qur'an, the Holy Book of all Muslims.

The language of the Qur'an itself is considered miraculous - it is said that no human is capable of creating such beautiful language. Another miracle is its contents, and germane here is the amount of intricate detail of embryological development scattered in various parts of the Qur'an. Muslims consider it miraculous that such micro-anatomical (and conceptual) accuracy preceded the microscope by a millennium. The emphasis on embryology in the Qur'an resonates in the Muslim's view with the emphasis on ensoulment, and the two subjects are often discussed together.

(iv) Abortion

Since ensoulment imparts proper "humanness" to the fetus, it imparts with it a demand for a higher level of moral regard, leading to specific aspects of jurisprudence. Abortion before ensoulment can be permitted for a number of reasons, as noted above. After ensoulment, however, abortion is allowed only under extreme circumstances, usually to save the life of the mother.

(v) Iddah

In Islamic law (Shariah) when a woman is widowed, she cannot remarry if she is pregnant. She is required to wait (Iddah) for 4 months and 10 days*. If she is in the early stages of pregnancy, at the end of that period (which would also coincide with ensoulment at about 120 days) there would be quickening, the fetus will be felt, and the woman would have to wait for parturition. If not, she can proceed to another marriage.

(vi) Fetal rights

After ensoulment the fetus has a right to inherit if the father dies; if miscarried, and shows signs of life (eg movement) then there is the right to be inherited if the fetus will have owned property at its birth. The punishment for aggression against the fetus is more after ensoulment, and if the fetus is killed or aborted through this aggression, the perpetrator has to pay a blood ransom to the family.

Ritual prayers and forms of burial are also different for the aborted fetus before and after ensoulment.

2. *Pre-determination*

In Hinduism a question that a determined predeterminist may pose is this: *if everything happens according to Karma*, why should abortion be a sin? Islam would not be so pre-deterministic. Insan has been given (limited) free choice — indeed, with intelligence, this is probably humankind's greatest gift.

However, these rather different perspectives on pre-determination certainly warrant further elaboration.

3. *Other reasons for abhorrence of abortion*

Hinduism is aversion to abortion is in the first instance based on the fact that the spirit is inherent at conception (and guides subsequent development of the embryo and fetus). Wide social context, solicitude for the mother "in general" and the implications of birth for human destiny are additonal considerations of why there is such abhorrence to abortion in classical

* 3 months or 3 consecutive menstrual cycles, if for a divorce.

Hinduism . In Islam the abhorrence is primarily due to the solicitude for the life of the fetus - the other considerations play a much lesser role.

Additional factors to consider are that:

- A son is needed to perform the last rites for the parents. Abortion could lead to the loss of an only son.
- The "holistic" conception in Hinduism requires that the fetus not be interfered with.
- Human rights have a special implication for human destiny, and this renders abortion particularly heinous. [We need to explore further whether there is a similar idea in Islam].

Glorification of the womb

Another aspects of abhorrence of abortion in Hinduism is the expression of the value of life in the Samhit portions of the Vedas, which glorify the womb itself, and elsewhere in charms to protect the embryo. We are unaware of such an attitude to the womb in Islam. Charms are used by Muslims in many countries, but they are often considered "superstitious."

Intentionality

A very important consideration in Islam is that an act may be judged to be right or wrong depending on the intention of the agent. Committing a crime with good intentions may be punishable in this life when humans apply the Shariah, but may well be judged differently and be forgiven by Allah. This kind of analysis finds reflection in the (western) philosophical ethical concept of the Law of Double Effect.

Re-calibrating the Hindu and Muslim positions

In reality the positions regarding ensoulment/abortion may not be that far apart either. While Caraka's Samhita gives the impression that at no time within embryonic/fetal development is there a state of pure matter in which the termination of that life is morally justified, the Sasruta* Simhita recommends abortion in difficult cases where the fetus is irreparably damaged or defective and the chances for a normal birth are nil. In such circumstances, the

* Sasruta is regarded as one of the greatest surgeons in history, and the father of plastic surgery.

surgeon should not wait for nature to take its course but should intervene by performing craniotomy and remove the fetus.

We have also already noted that in both religions, perhaps for different reasons, the mother's life takes precedence over the fetus. Perhaps the key to understanding that there may not be much difference between the two is to ask what is meant by "life." Both hold that life is present at conception; but whereas Hinduism would hold that life is equally "human" at all stages of development, Islam would add that ensouled human life is different and special.

The two religions certainly agree that no abortion is better than any abortion, and that the earlier it is the less of a moral issue it is in degree, and that both traditions value life as such.

Areas requiring further dialogue

1. *Embryo as symbolising life*

   There is in Hinduism a rather strong symbolism attached to the embryo as representing life in general. We are not aware of this role of the embryo in Islamic discourse. Perhaps the bigger question is in the whole area of symbols and the roles they play in the two religions. This will require greater expertise than is available to the current Islamic co-author of this paper.

2. *Harmonization with nature*

   An insight we share is that Islam sees the rest of creation and the environment in term of *stewardship* responsibilities, while Hinduism, in the sense that it is meant to "empathise and harmonize with natural forces and processes rather than to exploit or dominate them", is more *holistic*.

   Muslims in general will say that the more harmonious they are with nature and the environment, the better. They would add, however, that the following need to be taken into account:

   - The saving of human life takes precedence over almost anything else. Islam is fervently pro-life, as enshrined in the famous Qur'anic verse:

     (It was ordained for the Children of Israel)

"that if anyone slew a person...it would be as if he slew the whole people (mankind); and if anyone saved a life, it would be as if he saved the life of the whole people." (Qur'an, Al Maida, 32)

- Insan is Allah's vicegerent on earth, and is elevated above the rest of creation. Humankind, therefore, has the right to exploit the rest of creation and the environment ((counterbalanced by stewardship responsibilities and obligations, which call for respect and preservation).

This difference, and its implied differences in Weltenschaaung, may also not be all that real in the practical unfolding of the two traditions. We would need to assess this in a much more rigorous and scientific way to see whether there is a real difference in how other species and the environment are treated by adherents of the two traditions.

3. *Caste status of the embryo*

It has been held in classical Hinduism that the embryo of a caste Hindu (especially a Brahmin) is more deserving of protection than that of a slave. However, deeper analysis indicates that caste seems to play a lesser role. Why this is so is an interesting point worthy of further study.

Family planning, embryo experimentation, assisted reproduction, genetic engineering etc.

We did not have the opportunity to go into the details of these issues. Below is a summary of the understanding of the Islamic co-author of this paper, presented as an opening to further dialogue between these two ethical world religions.

1. Family Planning.

This has a long history of acceptance and has been permitted for health and socio-economic reasons; and sometimes for lesser reasons.

a) Coitus interruptus is well known, and acceptable, in Islam. All the schools of jurisprudence, however, insist that this must be with the specific consent of the wife, as she has the right to bear children, and fully to enjoy sex.

b) Family Spacing through prolonged breast feeding. In recent years this has been encouraged in societies with high fertility rates. The Quran mentions 2 years as being the appropriate length of breast-feeding. Breast feeding has a specific and special status in Islam, especially in relation to "suckling motherhood" whereby a child suckled by a woman who is not that child's biological mother becomes a sibling of the woman's children, who therefore cannot get married to each other, as this would be tantamount to incest.

c) Other Methods. e.g. the pill. While opinions vary, on the whole this is seen as acceptable, provided account is taken of the fact that the key (though not the only) purpose of the sexual act is procreation. Contraception must give way to procreation at some stage.

d) Intrauterine contraceptive devices (IUD's) and the preimplantation embryo. IUD's, work by stopping implantation; the fact that their use is permitted would imply that the embryo before implantation (or as some would prefer, the "pre-embryo"), is not yet considered as having much moral consideration. This needs to be reconciled with Al Ghazali's conception of the phase of "imperceptible life" before quickening.

e) Abortion as a family planning method is unacceptable.

f) Sterilization - is frowned upon, but may be allowed when both partners agree, provided it is temporary; i.e. permanent methods are not allowed unless in a woman with a reasonable number of children and coming to the end of her reproductive life; or for strict medical indications.

2. **The beginning of life; preimplantation genetic diagnosis and chorionic villous sampling.**

subsequent developmental stages of life as we know them.

1. It must contain the full genetic endowment of a human being as a species

We have previously noted that the 5 criteria for the beginning of life imply that a zygote, after fertilization of the ovum by the sperm, would be considered alive.

However, the use of IUD's has been permitted, and in some Muslim countries, so has of *pre-implantation genetic diagnosis* with a view to not implanting the embryo when, say, thalassemia major is diagnosed. Even *chorionic villous sampling* and abortion has been practised in some Muslim countries. What this implies is that although the pre-implanted embryo has moral worth and is considered to have a form of life, the moral consideration extended to it is much less than that extended to the established fetus especially after ensoulment; it is not considered a full person yet, and has fewer legal rights accorded to it. (See above re "ensoulment')

3. Experimentation on the embryo or fetus.

Islam encourages research and learning. In principle, research would be allowed on aborted fetuses, provided the pregnancy was not planned specifically for this purpose, and the abortion occurred spontaneously or was otherwise permitted. Creating embryos specifically for the purpose of research would likely not be permitted in Islam.

4. Assisted Reproduction.

The pursuit, by a couple, of the wife's pregnancy is legitimate. IVF is allowed and widely practised - one of the busiest clinics in the world is in Saudi Arabia. Proviso: the gametes (sperm and ova) must be from a couple who are *currently* married. Sperm or ova donation from third parties is strictly forbidden. Thus, AIH (artificial insemination by husband) would be perfectly legitimate, but AID (by donor) is forbidden.

5. Surrogacy:

Islam sees genetic and biologic motherhood as one, and that it should be kept that way. Surrogacy has therefore been ruled impermissible.

6. **Genetic Engineering,**

Genetic Engineering per se, is not forbidden; as in most things in Islam, it all depends on what the *intention* is, and what the science is *applied* for. In this context, the important

consideration would be that much is still unknown, and the consequences for future generations must be taken into account. Thus, while diagnostic applications and safety ensured therapeutic interventions would be permitted, germ-line interventions would not; creating transgenic micro-organisms to manufacture therapeutic products would be permitted, but producing dangerous micro-organisms for germ warfare would not.

7. Genealogy.

Islam is very concerned with genealogy, and so anything that might confuse genealogy would not be permitted. Thus, testicular or ovarian implants that would continue competent gametogenesis would not be allowed; the same, but without gametogenetic capability would theoretically (say for hormonal needs, although it is difficult to see a medical need) be perfectly acceptable.

8. **Organ transplantation: the anencephalic**.

Brain death as constituting death of the person has been accepted, and is practised extensively in Saudi Arabia, for example, but there are significant opinions to the contrary. In relation to our topic here, the main issue would be that of the anencephalic fetus who is born alive. It boils down to this: it must not be killed, but if it dies naturally (as they always do quite soon after birth), it would be permissible to use its organ for transplantation.

Life must be saved; it is the prolongation of life, and not the prolongation of the process of dying, that is called for. In other words, when medical intervention will only prolong death and has no possibility of saving life, a point of *futility* has been reached, and it is then permissible to withhold further intervention; however, normal life's requirements, like food and water must not be withheld. When there is the possibility that analgesics may also hasten death, it is the *intention* of the intervention that is given moral consideration. Euthanasia is not permitted.

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THE STATUS OF UNBORN LIFE IN HINDUISM

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I

The question just posed – regarding the status of unborn life in Hinduism – is a question which is ethical or moral in nature, or a question which pertains to what Hindus call *dharma.* This is a key Hindu term which "includes not only religion but all the ethical, social and legal principles associated with religion and which together constitute the real meaning of life for the Hindu. The word is so wide in meaning that Radhakrsnan can only define it as 'right conduct'".[1] In addressing issues which pertain to *dharma* one is advised in Hinduism to consult what in Hinduism are called the roots or principles, or the defining elements of *dharma.* These are four according to one standard listing and may be broadly described as (1) revelation; (2) tradition; (3) conduct and (4) conscience. In other words, these four constitute our sources of value. Therefore in dealing with, or even wrestling with issues pertaining to *dharma,* one should take four factors into account: (1) what do revealed scriptures have to say on the point; (2) what light does received tradition shed on the point; (3) how have people in general, and specially those more estimable among them in particular, conducted themselves in relation to the issue and (4) what does your own conscience say in the matter. The status of the unborn life should therefore be assessed from these four points of view.

II

REVELATION

The body of revealed literature in Hinduism is collectively called the Veda in the singular or Vedas in the plural, on account of they being four in number. Another word for it is □*ruti*, or what was divinely seen or heard. The Vedas are again subdivided into two, or three, or four layers. The threefold division is most convenient for our purpose. These layers are respectively called (1) the *Samhita* (or *Mantra),* (2) the *Brahmanas* and (3) the *Upanisads.*

References to unborn life in these three sections clearly establish the point that, according to the revealed texts of Hinduism, anything with a human DNA constitutes human life. Unborn life, in this sense, has the status of life. This is expressed indirectly in the *Samhit*□ portions of the Vedas in the glorification of the womb[2] itself and elsewhere in charms to protect the embryo.[3] In one famous *Brahmana* text, in the *Satapatha Brahmana.* "abortion is used as a criminal yardstick to illustrate the despicable character of ritualistic sins and their punitive consequences".[4] In one of the *Upanisads,* the *Kausitaki Upanisad,* the killing of embryo is classed along with the most reprehensible crimes, which include patricide and matricide. A passage with a similar implication is also found in the better known and larger *Brhadaranyaka Upanisad.* Both the Upanisads "assume that abortion is among the most deplorable evils, subject to consequences that karmically affect both this life and the next, and that only through enlightenment is one delivered from its malevolent force".[5]

Normally a reference to the relevant material in the scriptural texts suffices on points of *dharma.* However, the question of the status of unborn life has a medical dimension to it also. The texts which deal with medicine in Hinduism are called *Ayurueda* (or the Veda of longevity) and belong to the category of *Upavedas,* i.e., Secondary Vedas. They do not possess revelatory stature but are worth consulting given the nature of our inquiry.

One well-known text of *Ayurueda* is the *Caraka Samhita.* An examination of the text shows that it too is opposed to

> abortion as morally evil. It does so on the assumption that spirit is present in matter from the moment of conception, and is the causal agent in its progressive development. This creative manifestation of the spirit in the microcosmos is similar to the process of creation in the macrocosmos. On the human side, the moral character of the individual is also given in conception. Karma is carried over from one life to the next. Together, the spiritual and moral constituents of the individual make for the production of a person through a continuous process that is developmental but not disjunctive. It is therefore pointless to discriminate between different degrees of human potentiality in terms of "ensoulment," "viability," and "brain waves." The new life is an intimate, inseparable blending of human and physical-biological existence.
>
> The upshot of Caraka's view is that at no time withing embryonic development is there a state of pure matter in which the termination of that life is morally justified.[6]

Another medical text, the *Susruta Samhita*

> recommends abortion in difficult cases where the fetus is irreparably damaged or defective and the chances for a normal birth are nil. In such instances the surgeon should not wait for nature to take its course but should intervene by performing craniotomic operation for the surgical removal of the fetus.[7]

TRADITION

Texts which embody tradition are called *Smrtis,* of which no less than twenty texts are known. Among these the *Manusmrti* is considered preeminent. Although many of these deal with rules of caste-conduct, they all emphasize the protection of women and strikingly

such "female protection does not seem to be based on caste. Life is at stake, and hence all women have the right to protection",[8] as is "the birthright of that most vulnerable form of all existence – a child in the womb".[9]

CONDUCT

Hinduism as a religion is interesting in that it accords a high place to conduct in its scheme of sources of value. Normally, within a religion, the sacred revelation and tradition lay down the norms and one is supposed to adjust one's conduct to it. In Hinduism, however, the conduct of the elite *(sistacara)*, or even widespread practice *(lokacara)*, can itself be treated as a source of value-formation. Not only should people do the right thing; what the people do can also be regarded as the right thing to do; within limits, of course, which raises the question of who sets the limits.

This principle of Hinduism comes into full play, both positively and negatively, in dealing with the status of unborn life. First what, from a modern liberal perspective, we would consider the positive side: despite the fact that both Hindu revelation and tradition are opposed to abortion:

> In the late 1980s 3.9 million induced abortions were reported annually in India. Abortion has been legal in India since 1971, when the Medical Termination of Pregnancy Act was passed. It allows for abortions when "the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health" or when "there is substantial risk that, if the child were born, it would suffer such physical or mental abnormalities as to be seriously handicapped." Two appendices state that when a pregnancy is caused by rape of the failure of a birth control device, "grave injury" will be assumed.[10]
>
> It must be noted at the same time that "many Hindus are disturbed by the use of elective abortion as birth control".[11]

The negative side is represented by the phenomenon of gender-bias in abortion: "Between 1978 to 1983, 78,000 female fetuses were aborted".[12] It is also worth noting that Hindu leaders "consider the use of abortion for sex selection, usually used to secure male children, to be immoral. It is considered infanticide".[13]

We are obviously dealing here with a matter of some complexity within the category of conduct, particularly in relation to its twofold character as (1) *Sistacara* or the conduct of the elite and (2) *lokacara* or the conduct of the people. The first question is: who constitutes the elite? By normative criterion, Hindu leaders should constitute the elite. As a practical matter, however, the Westernized elite in India could constitute the elite, an elite which may or may not overlap with the Hindu elite. There could be leaders of society who are not Hindu leaders, specially in a secular country like India. Then there is the question of relationship of this elite to the masses. To what extent in a democracy, for instance, must the leaders follow their electorate in order to lead it! These issues must be left unresolved here, to be addressed later.

CONSCIENCE

This is important in both a general and a particular way. "Hinduism is a religion which recognizes that each person must make his or her own ethical decisions, because each person alone suffers or enjoys the karmic consequences".[14]

It is also important because it is through this source of value formation that Hinduism mediates its position between the pro-life and pro-choice camps, affirming "the arguments of each camp while differing from both".[15] It accepts the pro-life view that the fetus is alive but parts company with it "on the grounds that the right to life of the fetus

ought not to be absolutized. In place of absolute rights, Hinduism advocates addressing competing rights and values. Ethical dilemmas arise in case of rape and incest and when the mother runs the risk of grave injury or death. Each situation is unique and its own moral tragedy. The best on can do in such situations is evil, but then it boils down to a question of degree".[16] To that extent Hinduism is pro-choice, or rather pro 'moral' choice.

III

RECALIBRATING THE ISSUE

The specific position of Hindu revelation and tradition is pro-life but an overall exploration of the argument in terms of all the sources of *dharma* reveals the complexity of the issue, specially at three levels:

(1) at the level of the *acara* or conduct vis-à-vis other sources;

(2) within *acara,* or conduct, in terms of *sistacara* and *lokacara* and within them in terms of what constitues the elite and the people;

(3) at the level of the individual, between his *karma* or what he does and his *dharma* or what she should do.

The following points need to be taken into account in terms of the contemporary specificity of Hinduism, so that we can remain on guard against false specificity and false abstraction.

(1) Within the category of revelation, the secondary forms of it turn out to be more significant than the primary. Moreover, in terms of revelation, contraception is acceptable but not abortion.[17]

(2) There is hardly any moral resistance within modern Hinduism, its revalational and traditional teaching notwithstanding, against abortion per se, but abortion as a means of birth control and as a means of sex-selection arouses genuine moral indignation.

(3) The relevant elite in India today turns out to be the legislative elite, which has taken over the role of the □*istas* or moral exemplars; and it is the electorate which now constitutes the people (or *loka).* Hence the bonding between the two is political and legal in form, though still moral in content. However, it does create the possibility that the legislators may say one thing in public life and act differently in private. Is what they say, thereby compromised.

(4) Within the legal framework, the individual may then take his or her own moral vision, by using *karma* and *dharma* as its two eyes, as indicated in the following passage.

> In a pregnancy where the mother's life is in a balance, Hindu ethics places greater weight on maternal right than of fetal rights. The adult human being, having arrived at a karmic state in which there is much more at stake for her spiritual destiny, and in which there are existing obligations to be performed for family and society, is in a position to be favored over an equal human being whose evolution in this life is by comparison rudimentary, and who has not yet established a social network of relationships and responsibilities.[18]

POINTS FOR DISCUSSION

(1) Classical Hinduism distinguishes abortion from miscarriage.[19] Is a similar distinction drawn within Islam?

(2) Classical Hinduism distinguishes between kinds of miscarriage in terms of periods of pregnancy, but does not seem to distinguish between kinds of abortion in relation to fetal development.[20] What is the situation within Islam?

(3) According to the majority view in classical Hinduism, ensoulment occurs at the time of conception.[21] When does ensoulment occur according to Islam?

(4) In classical Hinduism, the attitude against abortion reflects an element of solicitude for the mother in general.[22] Is such the case in Islam?

(5) In classical Hinduism, abortion is considered particularly heinous.[23] What is the position on this point in Islam?

(6) In classical Hinduism, the "embryo of a caste Hindu (especially a Brahmin) is more deserving of protection than the embryo of a slave...".[24] Is there a comparable provision in Islam?

(7) There is an important social dimension to the Hindu attitude towards abortion, in addition to the moral.[25] Is such the case in Islam?

(8) According to classical Hinduism, abortion violates the integrity of both the victim and the abortionist as a human person.[26] Is such the case in Islam?

(9) If the live fetus cannot be safely delivered, maternal life takes precedence over fetal life.[27] What is the position within Islam on this point?

(10) In classical Hinduism, the status of the unborn child is not affected if it is the product of an adulterous union.[28] Can a position on this point be identified within Islam?

(11) It has been argued that the distinction made in Western thought between a human being and a human person does not apply to classical Hinduism.[29] Is it applicable in Islam?

(12) Human birth has a special implication for human destiny, which renders abortion particularly heinous.[30] Is human birth also considered special in Islam?

(13) If everything happens according to Karma, why should abortion be a sin? – This is a question which could be posed by a determined predeterminist within Hinduism.[31] Is a comparable position possible within Islam?

(14) Abortion can be considered unHindu.[32] Can it also be considered unIslamic?

(15) The embryo is symbolic of life in Hinduism.[33] Is it so in Islam?

(16) The aversion to abortion within Hinduism may in part be attributed to its tendency to "empathise and harmonise with natural forces and processes rather than to exploit or dominate them".[34] Is this the case in Islam?

(17) There are strong ritualistic reasons underlying the Hindu attitude to abortion.[35] Is such the case in Islam?

(18) Hindu ethics does not confine itself to consideration of timeless rational factors but also involves context.[36] Does ethical discussion in Islam provide a point of convergence or divergence in this context?

(19) India, although predominantly Hindu, has legalised abortion.[37] What is the situation in Islamic countries?

(20) Classical Hinduism treats of abortion in a context of "wider social and moral obligations" rather than as "a matter of exclusively individual rights (especially of the mother)".[38] What is the Islamic position in this regard?

(21) In some cases, in classical Hinduism, an abortionist has been identified as a murderer.[39] Is this ever the case in Islam?

(22) Some aspects in classical Hinduism in relation to abortion are very striking. To mention only three: (1) killing "the embryo (even) of a stranger...is tantamount to killing a Brahmin"[40]; (2) one suffers ritual-deprivation upon harming "the embryo or its mother"[41] and (3) "...the Smrti of K□ty□yana allows the execution of a Br□hman for procuring abortion".[42] (The inviolability of the Brahmin is the gold standard of conservative orthodoxy; the treatment of women that of modern liberalism. The bracketing of these in the above-mentioned provision is striking. Are similar examples identifiable within Islam?

NOTES

1. Louis Renou, *Religions of Ancient India* (London: The Athlone Press, 1953) p. 48.

2. S. Cromwell Crawford, *Dilemmas of Life and Death: Worldviews and Contemporary Issues* (Albany, NY: State University of New York Press, 1995) p. 21.

3. *Ibid.*, p. 22.

4. *Ibid.*, p. 23.

5. *Ibid.*, p. 24.

6. *Ibid.*, p. 30-31.

7. *Ibid.*, p. 32.

8. *Ibid.*, p. 27.

9. *Ibid.*, p. 28.

10. William A. Young, *The World's Religions: Worldviews and Contemporary Issues* (Englewood Cliffs, New Jersey: Prentice Hall, 1995) p. 127.

11. *Ibid.*, p. 128.

12. S. Cromwell Crawford, *op.cit.*, p. 34.

13. William A. Young *op. cit.*, p. 128.

14. *Ibid.*

15. S. Cromwell Crawford, *op. cit.*, p. 31.

16. *Ibid.*

17. *Ibid.*, p. 196.

18. *Ibid.*, p. 32.

19. Julius J. Lipner, "The Classical Hindu View on Abortion and the Moral Status of the Unborn", in Harold G. Coward, Julius J. Lipner and Katherine K. Young, *Hindu Ethics: Purity, Abortion and Euthanasia* (Albany, NY: State University of New York Press, 1989) p. 42-43. Also see p. 65 note 32.

RJS - 7.3

Introduction

International Consultation on Interreligious Dialogue in Bioethics

Christoph Benn

Dear collegues and friends,

it is a great pleasure for me to give the introduction to our consultation. For a long time my collegues and me have been planning this event and it is difficult to express the amount of gratitude I feel that you have followed our invitation and are about to engage in two days of intensive dialogue and delibarations.

I would also like to remember those who have been part of the planning process and can not be with us today. Dr. Michael Akerman from the Institute of Judaism and Medicine in New York and Dr. Arvind Sharma of McGill Univiversity in Montreal, Canada had given their energy and thoughtfulness to the preparatory process but can not be with us today. Dr. Simon Mphuka from Zambia had to cancel his flight just one day before his anticipated arrival because his wife got ill. We include them in our prayers and hope that we will meet all of them at a different occassion.

Let me express another concern. If we look around we clearly miss a proper gender bias. All of us gathered here are men. I think this fact certainly requires some further thoughts. Of course, we could explain why there are no ladies present. We had invited some distinguished female scientists and ethicists as well as representatives of international organizations. But unfortunately, all of them could not accept our invitation for various reasons some just recently on a short notice. But probably it would be too easy to accept this explanation - we tried, but we failed. We are not satisfied with this answer because the virtual absence of women in interreligious dialogue has been complained about before. It has to do with the fact that in all organized religions women are not represented appropriately in the leadership. They are not represented according to their proportion in scientific and policy making institutions either. Therefore I really regret that we were not able to reverse this trend for our consultation and we should certainly pay attention to this issue when we plan future initiatives.
So what is the specific purpose of this consultation? I see mainly two purposes: We want to contribute to find answers to some of the most vital issues in international health and we want

to contribute to a deeper understanding between different faith communities and traditions so that peaceful relationships in a pluralistic world can be achieved and maintained.

We will try to approach some of the burning ethical issues in international health. There are many appropriate ways to deal with ethical questions and dilemmas. There are rational arguments, guidelines by international organisations and specific laws in individual countries. But without any doubt religions and faith communities do play a major role in the building of ethical opinion or what others have called moral formation.

Let me briefly introduce the subjects we will cover within the next two days.

1. The value of life and the cost-effectiveness considerations in international health. In recent years at least since the publication of the World Bank Report 1993: Investing in Health and the WHO publications on the Global Burden of Disease there is an intense debate whether this approach is ethically justified. The answer to this question has very important implications as currently many decisions on resource allocation in health are based on the assumptions that the value of life in general and healthy life in particular can be measured and interventions prioritized accordingly. Religions have always shaped the perception of the value of life in their cultural context. Therefore this issue has to be explored more intensively.

2. Demographic developments and reproductive health are very high on the agenda of international organisations. The World Development Report 1999 has just been published with alarming figures concerning the lack of access to appropriate services particularly for women and the future projections for the relation between resources and population size on this globe. At least since the International Conference on Population and Development in Cairo in 1994 we know that the reactions and opinions of religions play a major role in the formulation of internationally accepted guidlines. There is a great need for a constructive dialogue with and among religions on these issues.

3. In many countries and regions some of the most burning ethical issues relate to the questions of death and dying and euthanasia. An ageing world population, the increase in chronic diseases, progress in medical technology and the lack of resources provide the background for an ethical discussion about the autonomy of individuals, the dignity of persons at the end of their lives and the role of health professionals in providing guidance for patients who cannot hope to recover from their illnesses. Ethicists like Peter Singer who advocate ethanasia under certain conditions have highlighted the need for intensive debate to which religions can contribute many valuable insights.

4. Everybody is aware of the devastating effect of HIV/AIDS in many regions of the world. It is by now the No. 1 cause of death in Africa and the NO. 4 worldwide. Many

countries are trying to implement effective prevention programmes. Unfortunately quite often organized religion has contributed to fear and blame and has sometimes hampered badly needed prevention methods including condoms, sex education for youth or needle exchange programmes for drug addicts. There is an urgent need that religions come to an agreement on what is appropriate and what is not acceptable so that people will be encouraged to protect themselves from HIV/AIDS by all scientifically proven methods.

5. There is hardly any other problem affecting health on a global scale as the dramatic inequalities and inequites between the different regions of the world. There are good reasons to conclude that the current inequities in the allocation of resources for health are the most devastating problem in global health requiring our urgent attention. Millions of deaths could be prevented each year if people had affordable access to basic quality health services and preventive measures. Therefore ethically it is one of the most important tasks to analyze the current inequities and to consider ways how these might be overcome. The religious communities can provide valuable insights for these considerations.

These are the issues we are going to address within the next few days and we hope that this consultation will come to conclusions and statements that will help the work of many people active in the different areas of public and international health.

Let me turn to the second purpose: promote a deeper understanding and peaceful relationships between religious communities. The eminent theologian Wesley Ariarajah who for many years had been leading the interreligious dialogue programme of WCC once borrowed an analogy from the health sciences when he was asked what his dialogue program was all about. He said:

"Dialogue is not an ambulance service; it is a public health programme." That is true. You cannot start with a dialogue programme when there is already ethnic or religious conflict. Rather interreligious dialogue is a preventive measure. It is supposed to build relationships, common understanding and peaceful cooperation so that tensions are reduced in advance and escalation is prevented.

Ariarajah continued:

"Dialogue is not so much about attempting to resolve immediate conflicts, but about building a community of conversation, a community of heart and mind across racial, ethnic and religious barriers where people learn to see differences among them not as threatening but as natural and normal. Dialogue thus is an attempt to help people to understand and accept the other in their otherness. It seeks to make people at home with plurality, to develop an

appreciation of diversity, and to make those links that may just help them to hold together when the whole community is threatened by forces of separation and anarchy." (Ariarajah: Not without my neighbour - Issues in Interfaith Relations. WCC 1999, p. 13)

I think this phrase captures very well what we are about to do here. We are not here to deny our diversity, to neglect differences of background or opinion, but we are here to feel at home in our plurality. We are here to express our deeply felt convictions and our perception of religious truths. But we can do so in mutual trust, sympathy and respect so that everybody should feel free to share with the others what he feels is important to him. We hope to come closer together, to find common grounds on important issues in international health and by doing this we sincerely hope that we will contribute to a public health programme in interreligious dialogue that will help us and others to reduce tension to to build peaceful relationships in the different communities and countries from which we come.

RJ5-7.4

Sexual Ethics in the Context of HIV/AIDS – A Christian Perspectives

Consultative Group on HIV/AIDS
World Council of Churches, Geneva
Moderator: Christoph Benn

Ethics is the systematic study of moral reasoning in theory and practice. It clarifies questions about right and wrong, but also demonstrates their complexity: most ethical theories and many moral judgements are contestable. Some norms, values or principles are sufficiently widely agreed for codes of professional practice or laws to be based on them. But no ethical theory or decision-making method yields unequivocal conclusions which convince everybody: too many different beliefs, philosophies, cultural backgrounds and life experiences influence our views of right and wrong. Meaningful and constructive frameworks developed by ethics over the ages are used to examine the facts and values in question. Such discussions can lead to a degree of consensus or at least a mutual understanding of divergent views.

This approach is akin to that adopted by the early Church in relation to Graeco-Roman philosophical concepts (without which much Christian theology is literally unthinkable). In health care ethics today, the conceptual framework most widely used in analyzing bioethical questions is some variation on the 'Principles of Bioethics': respect for persons, beneficence and non-maleficence, and justice. Each principle represents a prima-facie duty - that is, it is morally binding unless it conflicts with one of the others. The framework does not provide a method for choosing between the principles when they do conflict, or for determining the scope of their application (for example, who counts as a person?). However, in medical ethics in general and in ethics related to HIV/AIDS in particular we often encounter problems which are characterized by the fact that there are extremely complex issues which are intrinsically ambiguous. There has to be a choice between alternative decisions on right or wrong for all of which one can find conclusive arguments supporting one or the other opinion.

- 1 The theories or principles alone cannot solve these problems as there might be mutually exclusive decisions which all violate certain principles while they might be supported by others. This is what is called an ethical dilemma. We are often not faced with the question whether or not to violate a certain theory or principle, but which possible alternative violates them more or less. Therefore ethical principles are not in themselves sufficient to reach a conclusion in the case of ethical dilemmas, but they add an accessible ethical dimension to the international scientific vocabulary, and a common language in which to address, analyze and discuss medico-moral questions of cross-cultural concern.

- 2 *'The final outcome may be that reasonable people will disagree, but the process of debate and scrutiny of these perspectives is likely to produce the kind of thoughtful judgement that is always more valuable than simplistic conclusions reached without the benefit of careful, sustained reflection and discourse.'* (Reamer: AIDS and Ethics)

- 3 This framework of principles has an additional advantage: It can be employed by either deontologists or utilitarians. Broadly speaking, these are the two main schools of thought in philosophical ethics. It can also be accepted by the adherents of many religions. Even when those with different philosophical or religious views qualify the principles or their scope, the common core language remains ecumenical. These particular principles, moreover, were originally identified by examining ethical codes and standards (especially of the health care professions) which in turn had been deeply influenced by Christian history.

- 4 In the context of the HIV/AIDS pandemic the development of an ethical response to a variety of issues is crucial. Such a response by the Church, while inspired by the Gospel, will no doubt commend itself to reasonable people of good will in modern pluralistic and secularized societies.

- 5 There are high expectations by people in all societies to get answers to their burning questions through ethical considerations. The churches in particular are faced with expectations to exercise their role in

providing moral guidance. It is an unique opportunity to convey to the world a relevant message in a time of moral and political crisis. This message should be a contribution to a peaceful and just co-existence of people and nations. At the same time there is considerable disagreement among Christians themselves on ethical issues threatening the spirit of unity in diversity which is characteristic for the ecumenical movement. This is clearly expressed in a joint document of the World Council of Churches and the Roman Catholic Church:

- 6 *'At the same time, renewed expectations rise in and beyond the churches that religious communities can and should offer moral guidance in the public arena...Pressing personal and social moral issues, however, are prompting discord among Christians themselves and even threatening new divisions within and between churches...In a prayerful, non-threatening atmosphere, dialogue can locate more precisely where occur the agreements, disagreements and contradictions. And dialogue can affirm those shared convictions to which the churches should bear common witness to the world at large. Furthermore, the dialogue can discern how ethical beliefs and practices relate to that unity in moral life which is Christ's will.'*

- 7 Entry into ethical dialogue requires a comprehensive knowledge of the basic ethical principles, the facts of the situations in question and clear technical information related to it. These elements should enable a well informed, transparent and verifiable discussion and decision making process.

A.1.a Two Approaches to Ethical Reflection

- 1 Ethical reflection asks about the "rightness" of particular actions. Traditionally such reflection has proceeded from one of two starting points: either from the *norms* which are understood to govern human behaviour, or from the *consequences* which follow from that behaviour. A brief review of these two broad approaches, known as "deontology" and "consequentialism" (or "utilitarianism") respectively, will serve to introduce our discussion of specific forms of ethical reflection.

A.1.a.i Deontology

- 1 Deontology is the doctrine of duty and incorporates some of the oldest ethical systems in all cultures. It focuses on the intrinsic duties and values which determine our actions. These values formulated as commandments and rules for human behaviour are a matter of principle and have their own undeniable justification in themselves. The formulation and justification of these deontological values can originate from different perspectives.

- 2 The 'Ten Commandments' found in the Old Testament (Ex. 20, 1-17) are an ethical code based on divine revelation. The Golden Rule 'Do to others as you would have them do to you' (Luke 6, 31) which is found in the New Testament and similarly in many world religions serves as a general guideline for the assessment of human behaviour. Deontological philosophical reasoning like Immanuel Kant's „ Supreme moral law": 'Act only on that maxim through which you can at the same time will that it should become a universal law' are intended to convince all reasonable people by the force of this argument. Therefore there are moral rules and values which can be regarded universal and forming the basis for principles and ideals which have to be translated into concrete moral actions.

A.1.a.ii Consequentialism (Utilitarianism)

- 1 Consequentialism claims that the question of right or wrong action is decided by the consequences of these actions. The moral quality does not depend on the action itself but on its utility for the benefit of people which might be defined as happiness or greatest good. This theory is based on only one moral principle: the principle of utility. Therefore potentially there can be no conflicts between conflicting principles. To arrive at conclusions on right or wrong it is necessary to calculate net benefits and to balance alternative solutions taking into consideration resources and the needs of people concerned.

- 2 The fact that utility is the supreme principle does not mean that utilitarians would justify any type of action as long as it results in a greater benefit for a person or a group of persons. A particular version

of this theory is called rule utilitarianism. They regard moral rules such as truthtelling, respect for life, keeping promises etc. as essential elements of our fabric of life. These rules are to be observed because the overall benefit of keeping these rules is greater than their neglect. Even if in single cases there might be situations where disregard of these rules could produce some benefit, the long term results would be negative. Therefore these rules are to be kept. The principle of utility , however, would still be regarded as supreme principle in case that some of the moral rules got into conflict with each other.

A.1.b Principles of Medical Ethics

- 1 Apart from the two main perspectives on ethics there are the ethical principles which are widely referred to in ethical studies nowadays and can be applied to various ethical problems. The four most important principles are respect for persons, beneficence, non-maleficence and justice.

A.1.b.i Respect for Persons

- 1 Notwithstanding common agreement that 'a person' cannot, or should not, be considered as a distinct entity outside of relationships or community, the term here refers to a human being who is capable of exercising a degree of autonomy, however limited. Autonomy is literally 'self-rule', or the capacity to think, to make decisions and to act for oneself. It may be limited - by immaturity, by lack of relevant information, or by physical constraint; the capacity for autonomy is a matter of degree, greater or less in different people at different times. Special skills (listening, enabling or political) may be required to ensure maximum respect for the autonomy of people who are inarticulate, impaired or constrained.

- 2 To exercise their autonomy people need access to relevant information on which to base their autonomous decisions and a certain degree of liberty so that decisions can be made without undue coercion or manipulation.

A.1.b.ii Bneficence and Non-Maleficence

- 1 Beneficence is literally 'doing good' and non-maleficence, 'not doing harm'. These principles express the duty to enhance the welfare of other people if one is in a position to do so, and to avoid doing harm wherever possible. The latter has been considered the most important moral principle of physicians since the times of Hippocrates: 'Above all, do not harm', and the two duties together require physicians to produce net medical benefit with minimal harm. Here the skills, not just of evidence-based medicine, but also of other carers and friends, may be required to determine what is in the best interests of people temporarily or permanently unable to express their own autonomy.

A.1.b.iii Justice

- 1 The principle of justice or fairness is more wide-ranging than the others mentioned and may be appealed to if they are in conflict. It is especially concerned with the distribution of goods, services and resources: in this it presupposes that all human beings are of equal worth, and that attributes such as status, gender, wealth or merit do not justify inequalities. Not all inequalities are unfair: people have very different needs, and while those with equal needs should be treated equally, those with unequal needs should be treated unequally.

- 2 Justice is concerned with the formulation of criteria for solving potential conflicts between people which necessarily arise as the conception of what people deserve or do not deserve differs widely depending not only on convictions, but also on positions in the local, national or global community. In the context of HIV/AIDS justice is related both to bioethical questions of the distribution of scarce resources in health care as well as to the larger issues of poverty and economic constraints as contributing factors to the spread of HIV.

- 3 While the principles of respect for persons and beneficence are more, though not exclusively, concerned with individual ethics, justice is more concerned with social ethics, with the treatment of

persons in communities or even with the question of right and wrong actions within and between communities, societies or nations.

A.2 Further Approaches and Christian Ethics

- 1 These principles are acceptable to the two main schools of thought in philosophical ethics. Respect for persons reflects both Kant's (deontological) imperative to treat people always as ends and not means, and Mill's (utilitarian) requirement that everyone should be free to determine their own actions if these do not infringe on the autonomy of others. Both schools also accept beneficence and non-maleficence, although they may disagree on the scope of these principles, on how to work out their implications, and on whether beneficence is a praise-worthy virtue or an obligation to everyone. Justice, too, is an agreed goal, but maybe pursued by different strategies: Libertarian ethics leaves distributive justice largely to market forces, while egalitarian ethics demands that all people get the same share. Some theories restrict liberty, to achieve a greater degree of justice; others, for example Rawls' contract theory , give liberty priority over equality, but only if allowing inequalities is to the benefit of the least advantaged.

- 2 Most other contemporary theories or approaches to medical ethics are compatible with and complementary to the four principles approach. Case-based methods, for example (which attempt to revive the best methods of traditional casuistry) relate concrete examples to agreed principles; while narrative or story-telling ethics (which is not unlike the christian method of telling parables) can also relate constructively to the principles.

- 3 Virtue ethics (which emphasize that the right choices are most likely to be made by good people) focuses on other aspects of the moral spectrum which need to be taken into account, as do care approaches (which emphasize context, relationships, the particular and compassion rather than dispassion). The only approach which seriously seeks to replace the principles is the 'common morality' approach, which offers a deductive method which 'it is claimed', can find the correct answers to specific ethical questions. But the main difficulties with this approach as an alternative to the principles in relation to practical medical ethics are:

a) that its exclusive claims for its own interpretations of 'rationality' and 'common morality' are contestable; and

b) that the proposed deductive system of decision-making is not only very complicated but also depends on getting people to agree about a series of more or less abstract value judgements before they can reach the correct concrete judgement about the ethical question in hand.

- 4 Another approach to Christian ethics, which would also have meaning for general ethical behaviour, has been described by H. Richard Niebuhr in *The Responsible Self*. This has the advantage of describing ethics-in-a-relationship, which Niebuhr pictures as a dialogue of responsibility. The two ethical questions he discerns are: 1. 'What is going on in this situation?' (i.e. one must be well-informed), and 2. What is the fitting thing to do, the thing that fits the dialogue best here, and allows it to continue. The fitting action can never be specified in advance, because it will depend on particular circumstances, and thus requires responsibility.

- 5 Christian ethics on the other hand derives from theological reflection on Scripture and the churches' response to revelation. It owns no single comprehensive ethical theory, but embraces principles and values drawn from historical and personal Christian experience and, for some, from natural law theory. It is deontological in seeing obedience to God's living Word as the supreme rule for conscience and community. But its incarnational and eschatological orientation regards human freedom to respond to the complexity and ambiguities of ordinary moral experience as God-given - an opportunity to grow, through mutual forgiveness, in grace and understanding.

- 6 The joint WCC - Roman Catholic working group on moral issues mentions also other Christian resources for moral reflection such as: liturgy and moral traditions, catechisms and sermons, sustained

pastoral practices, the wisdom distilled from the past and present experiences, and the arts of reflection and spriritual discernment. However, there was a general agreement that:

'The biblical vision by itself does not provide Christians with all the clear moral principles and practical norms they need. Nor do the Scriptures resolve every ethical conflict. Nevertheless, there is a general consensus that by prayerfully studying the Scriptures and the developing traditions of biblical interpretations, by reflecting on human experiences, and by sharing our insights in community, Christians can reach reasonable judgements and decisions in many cases of ethical conduct.'

- 7 These judgments and decisions of Christian ethics are in harmony with the principles of modern bioethics as described above, but they also go beyond them, since they derive from notions of *relationship*. God relates to all creation, human and non-human, and they are in relation with each other. Thus a principle like the autonomy of persons may be found in e.g. the unconditional value of creatures (Matt.10.30), or in Paul's respect for the conscience of the gentile (Rom.2.4). Yet as God not only respected the freedom of the world, but *loved* it (Jn 3.16), so Christians not only respect the others' autonomy, but love their neighbours.

For Christians, beneficence is a basic duty; and because it comes under the command 'love your neighbour as yourself', beneficence wherever possible includes benevolence (or goodwill). Christian ethics goes beyond the moral rule of beneficence which is required by anyone at all times. Jesus taught not only to do what is required by law , but to do more out of love, to go the extra mile (Matt. 5, 41) as a characteristic feature of the values of the Kingdom of God.

- 9 While we may not find a comprehensive theory of distributive justice in the Bible, 'justice' is an important and frequently used biblical concept. The scriptural concept of justice is a relational one which asserts the inescapable inter-relatedness of all things. Equality is again supported by the story of creation itself , and repeatedly the Bible reminds us that our first and foremost concern have to be those who are in greatest need. In Old Testament terms those in greatest need were the widows, orphans and strangers to whom all Israelites had special obligations. In the New Testament the poor, despised and marginalized people are those who understand first the message of the Kingdom of God, and Jesus Christ meets us in the least of His brothers and sisters. Let us be reminded that all these groups are exactly those who are nowadays most affected by HIV/AIDS.

A.3 Ethics Applied to Some Issues Raised by HIV/AIDS

The bioethical problems raised by HIV/AIDS are often complex and ambiguous, with no conclusive arguments on either side, yet practical decision-making is urgently needed. Those involved in decision-making moreover, are of all faiths or none, and to differentiate between alternative solutions sound facts and technical information are required. To be more than rhetorical therefore, a Christian ethics must be translated into a language that can be shared with all informed people of good will; and thence translated into meaningful action. The application of the principles outlined above to the particular problems and questions posed by HIV/AIDS can be regarded as a touchstone for the validity and the soundness of the arguments.

A.3.a Discrimination

- 1 Discrimination against people living with HIV/AIDS unfortunately occurs in all societies and communities and has become an important factor preventing effective means against the further spread of the pandemic. Discrimination makes the whole community more vulnerable to the spread of HIV including the discriminators themselves and those who are discriminated. In a situation of stigmatization, prejudice and gossip both groups are less likely to accept the presence of HIV in the community and to cooperate in the prevention of the factors leading to the spread of the pandemic.

- 2 Therefore possibly for the first time in history the pevention of discrimination against people affected by an infectious disease is an integral part of the strategy to control the pandemic.

- 3 At the same time all ethical principles require that nobody is dicrimnated against because of attributes such as race, gender, religion or being affected by a particular disease. The respect for persons unequivocally demands that all people are respected in the same way and nobody can be ostracised because of a natural event such as a disease.

- 4 The principles of beneficence and non-maleficence are clearly violated in the case of discrimination as it causes considerable harm to those who are discriminated and as was shown above in the end also to those who are discriminating. Justice again demands that people are treated equally and fairly so that they receive the care and attention which is attributed to all people.

A.3.b Confidentiality

- 1 Confidentiality requires that information which persons wish to keep to themselves or to a person whom they trust (doctor, counsellor) is kept secretly and is not disclosed to anyone outside this relationship of mutual trust which is protected by special obligations. Confidentiality of personal health information is required both by the respect for persons and by traditional medical ethics. Lack of privacy inhibits responsible decision-making. This is particularly important in relation to sensitive information like HIV serostatus, ways of infection or symptoms of AIDS. By maintaining confidentiality and trust, doctors or counsellors are in a unique position to influence behaviour, thereby reducing the risk of HIV infection being transmitted to others. On the other hand disrespect for the principle of confidentiality might drive people infected with HIV underground, if they have reasons to doubt whether their status could be disclosed to others. This would impair the positive opportunities of the doctor-patient relationship.

- 2 However, there might be situations of conflict when one person discloses his/her HIV serostatus to a counsellor, but refuses to reveal this status to others at risk through mutual relationships. We have a situation of two conflicting principles. The doctor's or counsellor's dilemma (heightened if caring for both partners) is whether to respect the first client's autonomy or, in order to avoid potentially fatal harm to the partner, to breach confidentiality. The principle of autonomy demands strict confidentiality and prohibits the disclosure of this information to a third party.

- 3 On the other hand the principle of beneficence/non-maleficence demands that the life of persons is protected by providing the necessary information enabling that person to avoid a serious infection. But that may make it less likely that such information will be confined to doctors or counsellors in the future. So respecting the duty of non-maleficence in this case may have long-term consequences which are medically more harmful than beneficial.

- 4 Both principles have to be balanced and each particular case has to be treated with extreme carefulness of ethical judgement. What these tensions between the principles make clear is the need to treat each case of this kind with great sensitivity. Every attempt has to be made to help the client to disclose the information to his/her partner voluntarily. Only when this utterly fails may the doctor/counsellor consider to override the principle of confidentiality, on a strict 'need to know' basis.

- 5 Decisions of this kind are experienced as absolutely agonizing by those who have to make them. They are also rarely needed since normally a trustful doctor/counsellor-patient relationship should almost always be able to avoid steps which might violate the confidentiality. Much more common is the need to ensure that confidentiality is not breeched inadvertendly or carelessly.

A.3.c Sex, AIDS and health education

- 1 In some cultural environments, people refuse to talk about sex, AIDS and aspects of sexual health. Many people of good will fear that greater talk of sex or sex education will result in a corresponding increase in promiscuous behaviour. Clearly the Church also has a moral responsibility to minimise communal and personal vulnerability to conditions in which sexually transmitted disease might spread.

- 2 In spite of understandable reservations, reliable research has revealed that education about sex, AIDS and health in general, particularly with children and young people, does not result in increased sexual activity. On the contrary, trends indicate a delay or reduction in sexual activity due to education. Given this background, the responsibility of the Church in facilitating sound, well-resourced education is plain.

Stories of situations in which lack of/bad education resulted in or exacerbated bad moral behaviour...

'The highest incidence of HIV/AIDS is among young people in the productive age group of 20-40 years. In some areas, young girls are sold to pay the debts of parents and to augment the income of the family. We have received reports that men are looking for younger women and even children as marriage or sex partners on the assumption that they don't have HIV or that they could cure them from HIV.'

- 3 Equipping people, particularly children and youth, with the ability to make sound moral decisions is the most effective way of achieving responsible moral behaviour. Education, however, is more than knowledge. Increasing the number of facts known by a person will not necessarily result in well equipped decision-makers. Effective education is responsive to the cultural context into which information is introduced, and involves the mutual participation of educators and students in the education process.

A.3.d Condoms

- 1 The condom is a simple technical device to prevent the exchange of body fluids during sexual intercouse. While its efficiency raises technical problems, the condom itself poses no specifically ethical problem. Concerning the efficency of the condom in regard to the prevention of Sexually Transmitted Diseases (STD) there is clear scientific evidence to prove that the condom is a safe and effective means of protection.

The World *Health Organization is referring to a carefully designed study on:*

'A Response to Recent Questions about Latex Condom Effectiveness in Preventing Sexual Transmission of the AIDS Virus" prepared by the Program for Appropriate Technology in Health (PATH), Seattle, USA in January 1994:

"Condom breakage and slippage has been analyzed, both through studies in which participants have been surveyed about their condom use and through studies in which participants have keen given condoms and asked to report on various aspects of their use. One U.S. consumer survey of almost 3300 people reported condom breakage rates of less than one percent.

Laboratory studies have also been carried out to assess leakage of a variety of microorganisms, including HIV. These studies have demonstrated the ability of intact latex membranes to prevent the passing of HIV, herpes and hepatitis B viruses, cytomegalovirus and chlamydia trachomatis, even after mechanical stimulation. Even worst-case condom barrier effectiveness had been shown to provide 10.000 times more protection than no condom at all.

Conclusion of the study:

Condoms, when used consistently and correctly, are highly effective at reducing the risk of infection from HIV and other sexually transmitted diseases. Therefore, efforts focused on improving condom quality, availability and use represent a critical aspect of public health strategies to contain these diseases."

- 2 The ethical questions which might arise concern the effects of the use and the promotion of condoms on behaviour. Some would argue that the promotion of the use of condoms might have the effect of increased promiscuous sexual behaviour, while others argue that sexual behaviour is largely

determined by other factors and condoms do not effect the frequency of sexual intercourse but only the unwanted consequences of this behaviour, e.g. the transmission of Sexually Transmitted Diseases (STD). This is a question to be answered by social anthropologists or sociologists who study the effects of various factors on human behaviour. Up to now there are no conclusive studies showing that the promotion of condoms increases or discreases promiscuous sexual behaviour.

- 3 But the implications of the conflicting arguments on the use and promotion of condoms will be influenced by the ethical principles applied. There might be a conflict between the desire to protect people's moral integrity by reducing incentives for sexual promiscuity and the desire to protect human life by averting a potentially lethal infection.

- 4 Respect for persons would favour the self-determination of persons which requires to promote access to information on the means of protection from an infection and to the protective device itself. According to this view even if condoms had also negative effects, it would be paternalistic to withhold the necessary information so that people could decide for themselves. On the other hand if studies showed that the promotion of condoms could increase the risk of HIV transmission, then the principle of beneficence and non-maleficence would clearly require restricting the access to condoms.

- 5 But again, if studies showed that the promotion of condoms could reduce the risk of HIV transmission, the same principles would consequently lead to a moral obligation to save lives by enabling people to protect themselves. In addition justice would demand that all those who are in need of a protective method get access to it and not only those who live in societies where these methods are freely available or who have the ability to pay.

- 6 Because of these arguments many christian health professionals and counsellors have decided on the grounds of pastoral responsibility and after careful considerations to provide their clients with the protective device on demand without claiming that this is or should be the only answer or solution for the problem of HIV prevention.

- 7 It should be kept in mind, therefore, that condoms are only one of the different methods to prevent HIV transmission. The primary aim will be to change behaviour and social conditions in a way which puts people at a lower risk to get into contact with the virus. All choices have to be presented to the people concerned and all efforts have to be made to empower them to make responsible decisions for their lives based on the options available according to current knowledge and experience.

- 8 After careful consideration of the ethical questions and of the technical details the following conclusion was drawn:

- 9 **Without blessing or encouraging promiscuity, we recognize the reality of human sexual relationships and practice, and of the existence of HIV in the world. Statistical evidence demonstrates that education on positive measures of prevention and the provision and use of condoms help to prevent transmission of the virus and the consequent suffering and death for many of those infected.**

- 10 **Should not the churches, in the light of these facts, recognize the promotion of condoms as a method of prevention of HIV?**

A.3.e Needle Exchange

- 1 The sharing of needles and syringes between people addicted to injectable drugs is one of the principle ways of HIV transmission in this group. Therefore the provision of clean needles and syringes to those who need these devices is a method to prevent unintended HIV transmission caused by unsterile instruments. As a technique, this again does not pose any ethical problem. But since the use of drugs such as heroin is illegal in many countries and since societies try to discourage their use, the provision of the means for injecting these drugs might be questioned ethically.

- 2 Answering this question again depends on the results of reliable studies. It is beyond doubt that the provision of clean needles can eliminate the risk of HIV transmission with i.v. drug users via this route. There are also studies on programmes having introduced needle exchange schemes which have clearly shown that the introduction of these schemes has not increased the use of these drugs (Amsterdam). If the availability of needles does not influence the drug using behaviour significantly then there would be a strong moral obligation (based on all of the principles) to provide these devices as it has the potential to save lives.

- 3 Again it should be remembered that needle exchange programmes are only one method to reduce one of the many risks and threats to human life posed by the use of narcotic drugs. The best way of reducing HIV transmission through infected needles would be the primary or secondary prevention of drug use itself. Therefore the needle exchange programmes will come as a complement to the educational campaigns. All programmes should be culturally acceptable, accessible and based on voluntary participation.

- 4 After careful consideration of the ethical questions and of the technical details the following conclusion was drawn:

- 5 **Without blessing or encouraging the use of narcotic, intravenously applied drugs, we recognize the reality of human addiction to these drugs and the practice of sharing needles for the application of these drugs which carries a high risk of HIV transmission.**

- 6 **Well designed studies demonstrate the evidence that education and the provision of clean needles in exchange for used ones help to reduce the risk of viral transmission and the consequent suffering and death for many of those infected by this way.**

- 7 **Should not the Churches, in the light of these facts, promote free education for all those addicted to drugs and the provision of clean needles as long as the addiction is not avoided?**

A.3.f HIV Testing

- 1 Respect for persons requires that nobody is forced to undergo diagnostic or therapeutic procedures affecting his or her future life without proper information enabling them to make independent and informed decisions on whether or not these procedures should be performed. Explicit consent is not required for all laboratory tests: for routine investigations which carry no particular risk and are necessary for treatment, a patient's general consent or evident wish to be treated is sufficient. The HIV test is different from routine investigations, not only because the condition diagnosed is still incurable, but also because of its personal, social and economic consequences for the people concerned in form of discrimination and stigmatization once their infection is made public.

- 2 Therefore HIV testing should only be done if informed consent of the person concerned has been obtained without any form of coercion or persuasion and if appropriate pre- and post-test counselling services are provided. This implies that compulsory testing for whatever purpose is to be regarded as unethical, including testing for admission to jobs, education, entry into countries, medical treatment etc. Also testing before marriage if recommended must be voluntary for both partners.

- 3 Potentially there could be a conflict between the individual rights of a person infected with HIV and the rights of a society wishing to protect a large number of its members by control mechanisms restricting those individual rights. As in some epidemics of the past, arguments of utility could be used to justify overriding the individual's rights to informed consent, or to confidentiality, in favour of the rights of the majority. In practice however, these extreme measures are neither necessary nor useful in the case of HIV infection: reliable studies have shown that the best way of prevention is providing information and seeking voluntary cooperation, but not coercion or compulsory testing.

A.3.g Research

- 1 There are several ethical problems posed by research related to HIV/AIDS. These concern e.g. research on human subjects in the development of new drugs, the access to experimental drugs by desperately ill patients and ethical guidelines for the conduct of vaccine development and trials.

- 2 For all research studies involving human subjects there are international codes and guidelines regulating the ethical preconditions for these studies. The Nuremberg Code 1947, the Declaration of Helsinki of the World Medical Association 1975 and the International Guidelines for Ethics and Epidemiology of the Council for International Organisations of Medical Sciences (CIOMS) 1990 all protect the rights of those who take part in any form of trial in the search for new treatments or vaccines. These codes clearly state that persons should only be invited to participate voluntarily and after informed consent in trials which are scientifically worthwhile and in which the risks to subjects have been minimised.

- 3 Trials related to HIV/AIDS are no exception to this, but problems arise when taking part is the only way in which desperatly ill patients can hope to receive any potentially effective treatment. Non-maleficence obliges researchers to increase the numbers receiving an experimental therapy only slowly and in careful stages, as evidence of its effectiveness and lack of harmful side-effects accumulates. This can conflict with the autonomy of patients who wish to decide for themselves whether or not to risk the side-effects of a potentially beneficial therapy. Yet if the wishes of too many such patients are granted, the trial may be invalidated, an unproven or even harmful drug promoted, and research on promising alternatives delayed, to the detriment of future patients. Such conflicts can be overcome only by the ethical sensitivity, forbearance and mutual understanding of researchers and patients alike.

- 4 Research on experimental therapies may require that some subjects receive, for comparison, not the therapy itself, but a placebo (something harmless which looks similar). The ethical problems of this are intensified in HIV vaccine trials. When research into the effectiveness of an experimental vaccine requires the subjects to be at continuing risk if the trials are to demonstrate efficacy, the ethical problem is compounded by the possibility that participation may create a false sense of security, and also that the risk could be reduced by health education. In addition to these non-maleficence concerns there are those of justice, arising when those recruited are too poor or too ill-informed to decline to participate. At the very least, justice requires that risks and benefits in the development, production and distribution of potential therapies and vaccines are shared globally, without placing vulnerable groups or countries at a disadvantage.

A.3.h Allocation of Resources

- 1 The just allocation of resources is a major presupposition for an adequate care of people living with HIV/AIDS and for an effective prevention of the spread of the infection. This applies to the different levels of social and economic structures. On a community level personal , financial, emotional and spiritual resources have to be mobilized to achieve the full participation of PWAs in the communal life and to give them the care which is required for their physical and emotional well-being.

- 2 On a national level HIV/AIDS has to receive the attention, the support of the leaders and the mobilization of resources corresponding to the significance of the problem in terms of the human suffering involved and the social and economic consequences of the pandemic on the national level.

- 3 At a global level, the international community has to ensure that adequate measures are taken for the fight against a global pandemic affecting all regions and continents on the globe. Up to now resources for the treatment and care of AIDS patients and for the prevention of HIV transmission are distributed extremely unequally. Although more than 80% of all HIV infections occur in less-affluent countries,they receive only a small portion of the international resources spent on HIV/AIDS.

- 4 This raises serious questions about distributive justice. Justice requires the most care for those in greatest need. This means, in practice, that available resources should be redistributed, giving each

country a fair share and enabling them to establish programmes adapted to their local situation. This aim may seem unrealistic in a short-term politico-economic perspective. But its aim - to reduce both the burden on those directly affected, and the further spread of the infection - is consonant with the common good, at a time when, economically as well as epidemiologically, world populations are becoming increasingly interdependent.

A.3.i The Duties of Health Professionals to treat PWAs

- 1 Unfortunately there are reports about people living with HIV/AIDS being refused the entry to health care institutions (including those of the churches) and of being refused by individual health care professionals whom they have approached for treatment, help or advice. Ethically and historically these attitudes are not justified. Access to health care is a right for all persons including those who are infected with HIV. There are no medical or ethical reasons for any restriction of this right.

- 2 Some health professionals have referred to the increased risk of contracting HIV by treating PWAs. This is not justified by the studies which have been conducted on the occupational risks of health professionals so far. In fact up to now there are very few health professionals who are HIV-positive and who could be proven to have contracted the infection though actions related to their professional duties. In general health professionals are not considered to be at greater risk than the general population.

- 3 Given proper observation of normal precautions, the risk to aquire the infection occupationally is very small. Statistically a needle prick with HIV infected blood will lead to an infection in 0.3% of all cases. Therefore so far the international bodies regulating professional conduct have demanded that people infected with HIV should be treated in the same way as other patients and the refusal of treatment would be considered as gross violation of the rules of professional conduct. This view would be supported by all three biocthical principles.

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To Save or Let Go: An Ethical Dilemma for Thai Buddhists

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Introduction

In few areas have the advances in scientific knowledge and the new medical technologies raised more basic questions about the very nature, meaning and value of human life than in the whole area of death and dying. That health care professionals find themselves in conflict over ethical dilemmas in this area is not surprising, since there is a lack of public consensus on what is morally acceptable. Already in the West, there has begun a groundswell of cultural change in which traditional attitudes and ideas about death and the dying process are being modified or rejected by many and the same development is occurring now in Thai society. In this society, undergirded by the teachings of Theravada Buddhism, the replacement of traditional medicine with high technological medicine has raised new ethical issues that traditional Thai morality and accepted practices cannot adequately deal with. The new life-support technologies have blurred the line between prolongation of life and prolongation of the dying process, and have raised questions about the adequacy of the traditional definition of death as the cessation of all vital signs. At what moment in the dying process should we declare that "death" has occurred? Shall we continue the traditional definition of "death" or declare "death", when the new measuring devices detect the cessation of higher brain activity, or when both the higher and lower brain activities cease to function spontaneously, unassisted by machines or procedures like hyperalimentation.? There are also other questions such as: Is the refusal of life-preserving treatment by artificial means a morally acceptable option or does it constitute a kind of suicide prohibited by Buddhist teachings? Is it morally wrong for doctors, nurses and families to withdraw life-preserving treatments or to stop such treatment, once these have begun? Are such actions the same as "killing" patients or are there important ethical distinctions to be made between "letting-go-of-life" by withholding or stopping treatment, and actual "killing" or causing death? The lack of public and professional consensus on these questions creates the possibility for emotionally laden moral conflicts within the general public, between families and their doctors and even among medical professionals themselves. Therefore it is necessary for Thai Buddhists to make systematic reviews of Buddhist morality and traditionally accepted practices concerning death and dying, and to rethink or reinterpret Buddhist ethics in its application to these new issues that are no. so far clearly defined in Buddhism. Such a need and moral conflicts were brought to the attention of Thai Buddhists by the case of 86 year-old Venerable Buddhadasa, a leading Buddhist scholar-monk and teacher of this century.

Venerable Buddhadasa Bhikku was a highly revered religious figure in Thailand and one of contemporary Buddhism's most respected scholars. For many years, he had lived at a forest monastery, Wat Suan Mokkha, in Chaiya in southern Thailand, teaching faithful disciples, educating visitors from around the world and writing books that spread his wisdom far beyond his forest hemitage. He had an international reputation as a modern Buddhist saint.

In his early 80s, Venerable Buddhadasa suffered a series of small strokes. He declined to enter hospital. Although he permitted physicians to visit him at his monastery, he made clear to them that he did not want them to use the technologies of modern medicine on him. His belief in the healing power of Dhamma or Nature had convinced him that attempts to heal the body by chemical or mechanical means interfere with the body's own self-healing power. After each of these episodes, meditation, herbal medication, diet and simple living according to Dhamma seemed to restore his vitality. Also, one short visit to a hospital for another illness had convinced him that the atmosphere of the modern hospital was not conducive to humane care and was certainly not a place suited to have a good death. On his return from that hospitalization, he took the unusual step of writing a "living will," stating that in case of irreversible coma he did not wish his life sustained by such devices as ventilators and intravenous feeding. He spoke clearly and forcefully to his disciples about his wishes to die naturally.

On May 29, 1993, the Venerable Buddhadasa, now in his 86th year, suffered a major stroke. His monk disciples began to care for him at the monastery in accordance with his wishes. However, a lay disciple, who was a leading neurologist at technologically equipped Siriraj Hospital in Bangkok, was eager to save the life of his master and persuaded the monks to allow the venerable monk to be flown to Bangkok, promising that he would not be intubated. The doctor stated that if no improvement was seen within seven days, the venerable patient would be returned to Wat Suan Mokkha. The monks agreed and the patient was admitted on May 29, at 1 a.m. He was in a deep coma. During the next few days, the intensity of technological medicine accelerated, each step justified by an appropriate medical rationale, until Venerable Buddhadasa was on a ventilator and being parenterally fed and hydrated. The monks who had accompanied him to Bangkok protested; the physicians responded that they had a duty to continue once they had begun treatment. This duty was enhanced by the reputation of their patient. The physicians prevailed. But realizing finally that their life-support treatment could not restore health or a meaningful human existence for the Venerable Buddhadasa, the attending doctors were willing to let their patient be taken back to his own temple where he passed away on July 8, 1993, still with the medical technologies he had repudiated.

Moral Conflicts. How do they arise?

The case involving Venerable Buddhadasa has raised many moral issues concerning death and dying. Foremost among them is the question of how to decide who is right in the event of moral conflicts. The case at hand is the conflict of values and moral perceptions between the attending physicians who have faith in the healing power of modern technological medicine and, as part of their professional ethics, have the obligation to save life of the patient in their care when there is some sparks of hope, on the one hand, and on the other hand, the belief of Venerable Buddhadasa and his monk-disciples in the limitation of modern medicine particularly in its interference with the natural process of dying. As evident in his "living will" the venerable monk wanted to set an example of facing death without fear or anxiety, in keeping with the teachings of Buddhism. This religion places death at the heart of the human predicament while also recognizing it as the primary solution to this predicament. Liberation from death can be found not by denying its inevitability but only by confronting it with equanimity and

understanding. Such liberation is possible through the practices of meditation particularly that with concentration on the idea of death (*morananusati*) and on decomposing corpses (*asubha*) which will prepare us to face the fact of death in a realistic and intelligent manner and also free us from the clutch of the egoistic ego, and ultimately to attain *nibbana*[1], the final liberation from the endless cycle of life and death (*samsara*).[2]

Over sixty years Venerable Buddhadasa had devoted his life to the propagation of these teachings, and through his meditation practices had prepared himself to be faithful to them, so that the egoistic self would not be in command of either his life or his dying but be dissolved. The model for him was that of the Buddha's dying, a peaceful letting go of life in the presence of his disciples. The image of the Buddha hooked to machines or sustained at a meaningless level of human existence could have given an entirely different meaning and impact on Buddhist adherents. This was what inspired the well-know monk to write a "living will," to request that no extraordinary means, no hi-tech equipments be used on him when the state of irreversible coma occurred. At age of 86 he accepted the natural deterioration of his body and the decline of its functions, and was ready to let go of life to accept timely death (*kalamorana*). He did not want people to cling to him nor to his physical life as refuge, but wanted them to practice Dhamma, the Buddhist teaching, to which he had dedicated his life.

Venerable Budehadasa did not object to the use of modern high-tech medicine when it could clearly save lives and was the only available resource. But he rejected its use to prolong the dying process because, for him and for all Buddhists, the last conscious moments of life are precious. For some Buddhists these dying moments could be the occasion for final liberation from rebirths in samsara existence. For others these are occasions to fill the minds with remembrance of their good deeds (*kusala kamma*) and thus ensure a better rebirth. According to Buddhism, even a recollection, with true remorse, of previous bad deeds (*akusala kamma*) can mitigate bad consequences in the next life. Thus special care should be given to dying persons to help them to die a "good death" meaning death with the best possible rebirth or without rebirth.

In his writings Venerable Buddhadas underlined the Buddhist belief in the preciousness of human life[3]. But he made a distinction between a life that is truly viable in which the individual has full command of his faculties, is responsive, responsible and interrelated, and a life merely existing on the biological level without human awareness and human interactions. This is another important reason why he wrote a living will requesting that he must not be kept artificially alive on a solely biological plane. This, however, does not mean that Venerable Buddhadasa, or Buddhism in general, supports euthanasia, that is the taking of life either by the self or others. He only wanted to be allowed to die naturally i.e. to let nature take its course, and not to be put on artificial means to prolong the dying process.

Can Reason Dissolve Moral Conflicts?

What we encounter in this case is a conflict between two sets of values and obligations. The problem is how to decide which if these sets in this circumstance is right. Both the physicians and the disciples wanted to do what was best for Venerable Buddhadasa, their *ajarn*, spiritual teacher.[4] The physicians wanted to save his life by using whatever means were necessary, even against his expressed wish in the "living will", while the disciples wanted to respect the "will" and allow him to die naturally. The physicians believed that they were morally bound to preserve and prolong their patient's life at all costs and that such obligation accords with the Buddhist teaching of the preciousness of human life. These were the underlying reasons why they did not want to cease the life-saving treatments on the monk. In the eyes of the disciples the continuation of the futile treatment showed the lack of respect for their *ajarn* whom was treated only as a body to be mechanically controlled, and not as the embodiment of Dhamma for which he had lived.

Given the fact that sufficient ethical thinking has not been done on this issue by Buddhist ethicists nor by physicians, and given their different beliefs and values the conflicting claims of the physicians and the disciples regarding what was right could not be mediated through arguments alone. At this juncture, both parties practiced compassion, patience and tolerance as Buddhists and searched for a compromise. Finally, realizing the futility of their treatment the physicians were willing to let the hopelessly terminally patient be taken back to his temple but still on the respirator and with feeding tubes in place. Neither the physicians nor the disciples wanted to take the devices out for fear of causing the death of such a saintly monk as such action would yield grave kammic effects for the perpetrator.[5]

Living Wills: Should They Be Recognized?

The concept of a "living will" is new in Thai society. Its underlying premise is individual autonomy, namely that a competent patient has the right to select or reject medical treatments. In Thai society the concept of the autonomy of the individual to choose or refuse medical treatment has not been a focal issue.[6] How a patient is to be treated is the physician's decision alone and patients' rights are not recognized. The case of Venerable Buddhadasa has raised the issue concerning the right to refuse life-preserving treatment and the obligation of the physician to honor such right. Though a "living will" is not a usual practice in Thai society, when it was made by an 86 year old monk, who had dedicated his life to understanding, practicing and disseminating Buddhist teachings, and who was ready to let go of life, should his expressed wish be respected? Particularly his case is different from the case of the "living will" written by a person is still young, healthy and unaware of possible future medical development and cures. This young person may change his mind when he is actually facing death and, if he could, might express the desire that everything possible be done to sustain and prolong life.

By tradition it has been recognized by families, patients and physicians that a physician's role is to do any or everything to preserve and prolong his patient's life in all cases. Consequently physicians are looked upon as healers, dedicated to preserving and

prolonging life of all patients under their care. This primary image of the medical professionals should not called into question. But does this mean keeping the hopelessly terminal patients alive at any cost? Are physicians morally bound to preserve life in all cases and under all circumstances? And as the country strives towards more democratic principles and individual rights, should the patients' right to die in the nanner of their own choosing be honored? These moral issues need to be analyzed and discussed in the Thai public and among physicians to find possible solution and consensus. The traditional responses are no longer adequate. New circumstances make necessary a review of traditional ideas, attitudes and accepted practices to cope with the reality of life in contemporary Thai society.

Does Euthanasia Interfere with the Law of Kamma?

The case of Venerable Buddhadasa has also raised the issue of euthanasia in Buddhism. A Buddhist solution to the complex issue of euthanasia has to be found within the framework of the doctrine of kamma, Buddhist psychology and the teaching of compassion. According to the doctrine of kamma a patient's disease may have physical cause such as bacterial infection and/or kammic cause namely the result of his past bad kamma.[7] When the suffering has kammic cause it will have to run its course until the kammic potency is exhausted. Even if the patient seeks to end his suffering by taking his own life he is only interrupting the course of kamma, the suffering will arise again in his life until that bad kamma is completely expended. Within this framework the physician ought not to interfere with the working of kamma either by actively taking the patient's life or by withdrawing life-support systems. If the bad kamma is allowed to run its full course here and now, the patient might be reborn into a higher state when the present life has come to its end. But that could not happen if the patient's life were to be cut short while the bad kamma is still to be undergone.

The Buddhist understanding of health and disease in terms of kamma does not lead to a fatalistic attitude of not seeking any care at all or giving up treatments out of despair. Buddhism advises us that for practical purposes we have to look upon all diseases as though they are produced by mere physical causes since no ordinary person can definitely know which disease is caused by kamma. But even if the disease has a kammic cause it should be treated. As no condition is permanent and as the causal relation between deed and its correlated consequence is more conditional than deterministic, there is the possibility for the disease to be cured so long as life continues. On the other hand, we need to take advantage of whatever means of curing and treatment are available. Such treatment, even if it cannot produce the cure, is still useful because appropriate physical and psychological conditions are needed for the kammic effect to take place. The presence of the predisposition to certain disease through past kamma and the physical condition to produce the disease will provide the opportunity for the disease to arise. Medical treatments will improve the patient's physical condition and thereby prevents bad kammic results to manifest fully. At the same time the treatments do not interfere with the working of the individual's kamma but may reduce its severity. The usual advice of Buddhism given to a person with incurable disease is to be patient and to perform good deeds to mitigate the effects of the past bad kamma. For the law of kamma does not entail complete determinism. It only stresses the causal relation between the preceding "cause" and the following "effect" understood in terms

of mutually conditioning factors. The emphasis on the kammic cause of health and disease implies individual responsibility for health and disease. It, however, does not mean that Buddhism assigns personal responsibility for *all* illness. In Buddhist thinking kamma has both the individual and social dimensions. This latter component may be termed *social kamma* which, for example, refers to the environmental factors that could aggravate or mitigate an individual kamma.[8]

Is Mercy-Killing really Merciful?

In Buddhist psychology hatred or ill-will (*dosa*), delusion or spiritual ignorance (*moha*) and greed (*lobha*) are the three defilements conductive to bad kamma. With regard to mercy-killing or active euthanasia in the context of Buddhist psychology this act cannot be carried out without the ill-will or felling of repugnance on the part of the pepertrator towards patient's suffering. The motivation behind this action may be good i.e. to prevent further suffering of the patient, but as soon as such thought becomes action to terminate life it becomes an act of aversion. So when a physician performs what he believes is "mercy-killing", actually it is due to his repugnance of the patient's pain and suffering which disturb his mind. The physician experiences negative emotions toward this disturbance and projects it on the suffering of the patient. But he disguises his real feeling (i.e. repugnance) as a morally praiseworthy deed to justify to himself for "mercy-killing". If he understands this psychological process he would recognize the hidden hatred that arises in his mind at the time of performing the lethal deed, and would not deceive himself with the belief that this deed was motivated by benevolence alone. Therefore from the view of Buddhist psychology "mercy-killing" is not really a benevolent act. It is done from ill-will i.e. the felt desire to end the patient's suffering is actually derived from self-deceptionviz the physician's own repugnance in watching the patient's suffering. Actually he wants to save himself from further suffering, and not the patient. This self-deception has bad kammic consequences both for the physician and the patient.

The Buddhist ethical ideal of compassion does not complicate the issue of mercy-killing for the practice of compassion has its limits which prohibit killing of humans and animals regardless of the conditions of their lives. In the case of dying persons compassionate help is limited to giving drugs in sufficient quantities to relieve intense pain as a last resort and helping them to face the inevitable calmly and to have a "good death". Beyond this point the precept against the taking of life is violated. The Buddhist compassion cannot be associated with killing in any form.[9]

What Criteria Should Influence Euthanasia Decisions?

In Thai society the problem surrounding the euthanasia issue is complex. It involves many factors such as the use of modern medical technologies medical costs and Buddhist teachings. It is true that life-saving and life-preserving technologies could keep more of us alive for longer periods than formerly. But this success has raised questions about the worth of the life saved. Venerable Buddhadasa's "living will" represents the demand that people be allowed to die. This response to the success of modern medicine is shared by many people including medical personnel who witnessed the results of these new procedures. It is also true that medical expenditures for keeping alive weighs

differently between the rich and the poor. Because of these facts lay Thai Buddhists, who consider euthanasia a violation of the Buddhist precept of taking life, realize that there are circumstances in which euthanasia is not a clear cut case of an immoral act. Through the newspapers they have become aware of cases such as that of a 94 year old woman kept alive by artificial means for over a year at the cost of bankruptcy of her family. Another case was that of an 11 year old girl in irreversible coma for years, again at high cost to the family. In such cases questions are raised to these Buddhists whether economic factor, the age of the patient and the quality of life should make any different in their decisions on the use of life-support systems. None could give a definite Buddhist answer. Some say yes and some no, for they are not certain about the Buddhist position regarding this issue, an which there has not been ethical reflection.

The reality is that, although euthanasia is not legalized in Thai society some forms of it are being currently practiced by some physicians who sometimes make life and death decisions alone, and sometimes with families. Should physicians be deciding which patients are better off dead and thus directly act to cause their death? Should families make the decisions? What criteria should be used to make such decisions? What about the possible abuses that would arise then? All these questions need careful analysis to find resolution and consensus. The lack of public and professional consensus on these questions and regulations of these practices of euthanasia will create a general climate of suspicions and mistrust of modern medical practice in Thailand and the intent and motivation of medical personnel. At stake will be the primary social role and image of physician, who have traditionally been conceived of as "preservers of life". What would happen to the public when the physicians become "death advocates"?

Is Letting-go-of-life a form of Killing?

The practices of passive euthanasia particularly the withdrawal of life-support systems or stopping treatments that simply prolong the dying process are known to exist in Thai hospitals. The position of "passive euthanasia" is more difficult to resolve in Buddhist context. In this case the ethical waters become more muddy. Despite their belief in the law of kamma a certain number of lay Buddhists who are aware of the problems arisen from sustaining life at all costs and under all circumstances consider withdrawing life-support systems morally acceptable particularly in a case when, by the best medical wisdom and through rigid testing, there has occurred in the patient total birch death, i.e. irreversible coma and no hope for recovery. They recognize that there is a real moral distinction between "leting-go-of-life" or "allowing to die" and "directly and intentionally killing". For them, in such case letting an irreversible comatose die does not violate the precept against killing. It is not outright killing and such an act of omission is motivated by good intention e.g. for the best interests of patients, or their families, or society, given the expense of maintaining these patients and the scarcity of medical resources.[10]

In Buddhist ethics, intention is crucial in determining actions as right or wrong, and kamma is defined in terms of intention. But with regard to passive euthanasia there can be mixed motivations behind the intention to act in seemingly good ways. The intent of family members and the physician to let the patient die may be motivated by selfish as well as altruistic desires. For example, for family members there may be the desire to

relieve the suffering of a patient and the desire to inherit his fortune. The physician may desire to end the pain and suffering of one patient and at the some time desire to have a viable organ for transplantation in another patient. A hospital can have a policy accepting passive euthanasia motivated both by the desire to relieve the suffering of the patients and families and to contain medical costs. For these reasons lay Thai Buddhists are cautious about extending the grounds for "letting-go-of-life" by withdrawing medical technologies beyond the strict and narrow grounds mentioned above. It is true that sometimes "letting-go" is just as immoral as killing directly. If parents passively allowed children to die by not giving them food available we would hold it to be as horrendous an act as strangling them. Since many factors entering into decisions about withdrawing life-support treatments these Buddhists want such decisions to be made on a case to case basis. They also recognize that sometimes human choices are only between two evils. Even in this tragic life situation one still has responsibility to choose the lesser evil.

For such agonizing decisions there has been little guidance culled so far from Buddhist sources to help Buddhists and to ease their conscience. As generally known Buddhism encourages each person to face the troubles by relying on oneself alone, without expecting any divine power to intercede and help. Choosing among evils requires wisdom (*panna*) or insight arising from the regulated mind (*samadhi*), right understanding (*sammadhithi*) of the real nature of existence characterized by conditionality (*paticcasamuppda*), impermanence (*anicca*), suffering (*dukkha*) and unsubstantiality (*anatta*), and from continuing learning (*sikkha*). With *samadhi* and *sammadithi*, one is able to make a realistic evaluation of a given situation and to act thoughtfully and unselfishly. *Sikka* enriches *panna*, diminishing the number of mistakes made. Since there have been cases especially with younger people where remarkable recoveries have occurred even after doctors pronounced them terminaly ill or as being in irreversible coma, these lay Buddhists also are unwilling to see general policies adopted accepting passive euthanasia for fear of possible abuses that are detrimental to patients and existing moral norms of society. As there are always risks and uncertainties, they would incline to favor life.

Is there a Buddhist Principle for Euthanasia Decisions?

As mentioned above Buddhism upholds the preciousness of human life and is against euthanasia or mercy-killing. With regard to the debate on "the right to die" the Buddhist principle of mutual dependency and inter-relatedness (*paticcasamuppada*) may be added to the basis of ethical reflection on this issue. This concept affirms the interdependence of all beings. When all beings depend an other beings, nāme of them is primary, and concern for others, co-operation and harmony are crucial human values in social relationship. Suicide or assisted suicide as a "right to die" cannot be absolute because people do not live alone but are members of communities who might be injured by their death or by a social policy that encourages such death. With regard to life and death decisions this principle could also be applied to the case. Accordingly physicians should not decide and act by themselves but in partnership with patients, their families or surrogates. When making decisions about treatment, including the use of life-saving, life-preserving technologies. When conflicts arise, some form of structure of mediation is needed. In the case of Venerable Buddhadasa such mediation means was lacking

leaving resolution to the good will of the two parties. But such good will or possible compromise may not always be present and a law might be enacted to regulate decision-making in case of conflict. But law is a blunt instrument, unable to deal with the individual differences and nuances that mark human interactions especially in matters of life and death the public then must be more educated about what is involved in such decisions. Similarly physicians and nurses must be educated to change their roles to be more of a partner and facilitator in helping patients and surrogates make decisions. Apart from this, while keeping their primary image as healers, dedicated to preserving and prolonging the life of all patients under their care, physicians have to develop a new approach to death and dying, so that when death becomes imminent they would become graceful acceptors of the inevitable, not seeing the hopeless condition of the dying patient as the failure of their skills and knowledge. They should turn their full attention now to the compassionate care of the dying. Their main concern is to relieve the suffering of the patients and families and to ensure a "good death" for the patients.

Is Hospice Care a Buddhist Alternative?

There are grounds in Buddhism for hospice care. In Buddhist tradition death is accepted as the natural end of life and one is not encouraged to either hasten it or to save it all costs. Buddhism is also known for its holistic approach to health care, focussing on the entire person, and for its emphasis on the last stage of life as being of great importance and on the practice of compassion on the part of physicians and nurses to provide a special care for the dying. The ideal is to help them to die in a calm, conscious state, so that possible good rebirth is obtained. Hospice care provides humane treatment, comfort, consolation and companionship to the dying either in their own homes or in special units at hospitals staffed by specialists specially trained to deal with the physical, mental, emotional, moral and spiritual suffering that people and families endure at the end of life.

In Thailand this hospice-like work has been carried on by numerous monks. Out of their compassion these monks make use of their temples as refuge for full-blown AIDS sufferers, who, shunned by friends and families and rejected by society, came to the temples as the last resort. At Wat Prabat Namphu, a temple in Lopburi Province, for example, twenty AIDS sufferers are being cared for by the abbot and 5 monk-assistants without any charge. Though they are not specially trained to deal with dying persons these monks could help them to have meaningful lives in their last days. This compassionate care includes herbal treatments to relieve the patients' pain, the provision of consolation and companionship to alleviate their suffering caused by depression and lonliness, the teaching of meditation practices and the encouragement of observing the precepts and merit-making to prepare them for the last days of their lives to ensure "good death". Apart from these they are also encouraged to enjoy life through playing and working together however short it may be. The work of this temple indicates that compassionate care for the dying is a Buddhist alternative to euthanasia. We can only hope that such care will continue in the days to come, especially when people are touched by the selfless work of the monks and by the manifested fruits of their work.

Conclusion

Euthanasia is an agonizing problem in Thai society as more and more hi-tech treatments are being used by physicians to save the lives of their patients. It has raised many unresolved ethical problems as witnessed by the case of Venerable Buddhadasa.

It is clear that active euthanasia including assisted suicide is morally unacceptable in Buddhism. But passive euthanasia presents a complex ethical challenge to Buddhist morality. Physicians cannot prolong the use of life-support systems indefinitely because of many complicated factors involved such as medical cost for family members, scarce medical resources, medical uncertainty, and the resulting quality of patients' lives saved or sustained. While some lay Buddhists draw a moral distinction between "directly killing" and "allowing to die" or "letting-go-of-life" to avoid the breach of the Buddhist precept against the taking of life, the majority do not share the view. Passive euthanasia therefore remains problematic for the general public. It is even more problematic for the physicians who strongly believe that sustaining the lives of their patients is their primary duty and obligation. The question of to save or "let-go-of-life" is therefore a continuing ethical issue for the majority of Thai Buddhists as they grapple with the reality of existence in the modern world and the need to be faithful to Buddhist teachings. Like Venerable Buddhadasa more and more elderly Buddhists, monks and lay people alike, express their wishes to be allowed to die in case of irreversible coma accepting death as a natural end as taught by Buddhism. But whether the physicians and the families will help to fulfill their wish is still a mooted point.

Note

1. There are various meanings of *nibbana* (or Nirvana in Sanskrit) found in different contexts in Buddhist texts. In the paper the term is used to mean the unconditioned state of consciousness in which there is the ceasing of the "I" (Ego), lust, hatred and delusion, the three principal forms of evil in Buddhism. This state is not caused, not originated. It simply makes itself known when all that is opposite (ego-absorption, lust, hatred and delusion) is removed. There are two kinds of *nibbana*; i.e. *sa-upatisesa nibbana-nibbana* without the disintegration of all the five aggregates of existence, and *anu-patisesanibbana-nibbana* without any element of life remaining. It is believed that with this state of consciousness completely void of any defilement a person is released from the round of existence.

2. In this endless cycle the whole range of sentient beings, from the tiniest insect to man, is believed to exist. Only the human being, however, has the potential to terminate this cycle. The term sansara is usually presented in Buddhist art as the to Wheel of Life (*bhavacakra*). For a detailed discussion of this concept, see The Three Jewels by Sangharakskita (London: Ryder 8 Company, 1967), pp. 68-82.

3. Many of his work were translated into English, French, and German. Some of English/French books and articles on his life and work are Donald Swearer, Thai Buddhism: Two Responses. Leiden: E.J. Brill, 1973; Louis Gabaude, Une Hermeneutique Buddhique Contemporaine de Thailande: Buddhadasa Bikkhu. Paris: Ecole Francaise d'Extreme Orient, 1988; Peter A. Jackson, Buddhadasa: A Buddhist Thinker for the Modern World. Bangkok: Siam Society, 1988; Grant A. Alson, "From Buddhadasa Bhikkhu to Phra Debvedi: Two Monks of Wisdom, and Donald Swearer, "Buddha, Buddhism and Bhikkhu Buddhadasa", in S. Sivaraksa (ed), Radical Conservatism: Buddhism in the Contemporary World. Bangkok: Thai Inter-Religious Commission for Development, 1990.

4. Data concerning the last days of Venerable Buddhadasa at Siriraj Hospital was compiled from the author's interviews with some attending doctors and his disciples.

5. In Buddhism, *kamma* (or *karma*) means volitional actions, good or bad, has consequences (*vipāka*) according to its nature. One reaps what one sow. In regard to killing a human the gravity of the action depends on the quality of the one killed. To kill a virtuous person such as a saintly monk is worse than killing others.

6. I have discussed the concept of individual autonomy in thai culture in an article entitled "Community and Compassion: A Theravada Buddhist Look at Principlism" in Edwin R. Du Bose et al (eds), A Matter of Principles: Ferments in U.S. Bioethics (Pennsylvania: Trinity Press International, 1994), pp. 121-130.

7. In Buddhist perspectives, life and death are an integral part of samsara existence, and each rebird is conditioned by the nature of the previous lives. In samsara existence each person weaves his own web of fate through his deeds (*kamma*). The individual is both the *cause* and the *effect*, the entries deed on the one hand, and, on the other hand, the effect of the deed. As an *effect* of his past deeds he is the product of the past. But as a *cause* he is a field of possibilities i.e. he has the ability to gradually free himself from the past to become whatever he wants to be.

8. For further discussion on this issue, see Pinit Ratanakul and Kyaw Than (eds), Health, Healing and Religion (Bangkok; Mahidol University, 1997), pp. 29-33.

9. For a discussion on different Buddhist perspectives on euthanasia, see Damien Keown, Buddhism & Bioethics, (London: St. Martin's Press, Inc.), pp. 168-173.

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Equity and Resource Allocation in Health: The Islamic Perspective

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Introduction

This paper will begin with explaining a working definition of equity and its relationship to health resource allocation. Following this is an exploration of the Islamic perspective of populations and their welfare with specific reference to health and health care. The meaning of equity within such an Islamic state would then be defined together with implications for resource allocation decisions. Throughout the paper the stress would be to attempt to link Islamic literature, jurisprudence and sources with the issues in the distribution of benefits - in this case health benefits. At the end is a summary of those features that may help define such an "Islamic perspective".

Part I: Equity and Health

The Meaning of Equity in Health

The search for equity in health is essentially a struggle to reduce inequities in health status between people. The reduction of inequities requires the capacity to recognize and label such inequities. The definition of these inequities rests on the identification of inequalities in health, which can be measured by some qualitative or quantitative parameter. The presence of an inequality in health status between two persons or group of people (howsoever defined) does not necessarily mean the presence of an inequity. Rather an inequality is a necessary but not sufficient criteria for defining inequity.

The mere presence of "unequal age" or "unequal physical strength" is an inequality that may not be avoidable or necessarily harmful. However, if the inequality has attributes that can define it as avoidable and harmful (Bryant et al 1997) then it can be considered an inequity. The latter would include groups of people with unequal infant mortality rates or individuals with different access to health care. Thus an avoidable and harmful (to health) inequality is an inequity.

The concept of being avoidable and harmful though seemingly easy to fathom is also complex. Traits that affect health and are controlled by genetic factors are in general currently unavoidable (though medical technology may change that premise); while poor access to health care is certainly avoidable. For example, the color of hair may be unavoidable but not harmful to health; while poor access to health care is avoidable and harmful to health.

Equity and Resource Allocation in Health

Inequalities in health are often influenced by individual and societal responses to health issues. One of the main features of such a response, especially in organized societies, is the distribution of resources to improve health and the health status of people. Historically speaking, such responses unfortunately have also been responsible for the creation of inequities. Unequal, targeted and unjust distribution of benefits such that some gain and others do not, has allowed the creation inequalities. It is therefore quite logical, that an attempt at *redistribution* of current financial and economic resources would be attempted to redress some of these issues.

Resources denote a wide spectrum of societal goods and services that can be redistributed. These funds and in addition those controlled through money such as manpower, infrastructure and technology. At the same time, an analysis of the status quo in most developing countries will show that current distributions are not helping reduce inequities - rather the redistribution of funds needs to be augmented and focused. Thus there are several ways of reallocating resources, all of which will not help reduce inequity. It therefore becomes imperative to be able to identify the specific pattern of resource flows that is most likely to help with health equity in a population.

There have been several developments in health policy and planning that aim to assist in the identification of resource flow patterns that maximize output for the investment. Such criteria of cost effectiveness (greatest bang for the buck) will stress the total output compared to the total input for any potential resource allocation. It is a useful and pragmatic criteria but for equity purposes, it is necessary though not sufficient since it is essential to know *how* and *to whom* benefits will be distributed. An equity analysis will therefore carry cost effectiveness analysis further to map the location of benefits received and their subsequent impact on health status differentials.

The Moral Argument for Equity

The moral argument for equity in health is a derivative of the overall moral case for egalitarian distribution of benefits. Justice or fairness is the basic moral premise within which elements of both social and distributive justice are embedded. This moral premise seeks that *to each is his or her due* and *like be treated as like*. Equity then becomes an operational element for this principle of justice to implement a sense of fairness in distribution of benefits.

Part II: Islamic References

Defining the Sources

There are well recognized sources of information within Islamic knowledge:
-the Quran
-the life and teachings of the prophet (sunnah).

In addition two other means of decision making have been allowed:
-consensus (ijmaa)
-analogy (qiyas).

Together the above comprise the Shariah and have lead to the formation of two major sects within Islam: Sunni and Shia. And within the Sunni sect there are four schools of thought (jurisprudence).

The Quran (Koran) is the book of God, the last of the revealed books, delivered through His chosen messenger Prophet Muhammad (PBUH).

The teaching and sayings of the prophet represent another source of information. There exists a complex science of tracing the alleged sayings to the sources and references and verifying them. The most verified of sayings (hadith qudsi) are highly valued for their guidance.

The Welfare Society in Islam

The attributes of an Islamic society are ensconced by the following principles of Justice (adal or insaaf), brother hood (unity) and a dynamic equilibrium of rights and obligations. Justice has been quoted in the Quran more within the context of just decision-making and fair judgements for differences amongst people. Brotherhood is used to promote the concept of inter-dependency between each person within an Islamic society. Such that either by being a relative, dependent, neighbor, poor or other each individual has some linkage with each other. Thus the Islamic society is to be seen as unitary entity comprising individual parts, rather than the reverse. It is important to note that this concept of the Islamic society does not have geographical boundaries and may be used to illustrate local, regional, national or supra-national entities.

The interplay of rights and obligations in an Islamic society is what maintains a live link within the concept of an organic whole. Each individual has rights which define their expectations within the social dynamics of the family and society. At the same time there are distinct responsibilities that come with each role that have to be carried out. In addition there are obligations towards God that each individual and the society as a whole needs to fulfill.

Islam and the Distribution of Benefits

An exploration of the distribution of benefits in Islam is important for defining conditions that will assist thinking through the concept of health distribution. Material goods and wealth are one form of "benefits" that may be obtained and distributed under rules that have been clearly defined.

Distribution of property taken from the enemy has been mentioned explicitly in the Quran. If it has been obtained in battle then:

"And know that out of all the booty that ye may acquire (in war) a fifth share is assigned to God - and to the Apostle, and to near relatives, orphans, the needy, and the wayfarer,-"
(S. VIII, 41)[1]

In conditions where property and wealth is obtained without battle, then:

"What God has bestowed on His Apostle (and taken away) from the people of the townships, - belongs to God, - to His Apostle and to kindred and orphans, the needy and the wayfarer; in order that it may not (merely) make a circuit between the wealthy among you.....(some part is due) to the indigent muhajirs (immigrants), those who were expelled from their homes and their property....."
(S. LIX, 7-8)

In both the situations above the rights of the disadvantaged parts of the population have been protected. In the case of newly acquired wealth through war a specific amount (20%) has been specifically set aside for this group. It is also important to note the use of the phrase "...that it may not (merely) make a circuit between the wealthy among you..." which is specific indication of the circulation of wealth between a limited few in a society. This danger of wealth being restricted to a small proportion of people is disliked and by analogy, any benefit (such as health) that would augment human life should therefore not be restricted to a few in any society.

Another form of benefits is that which is given away by people for others. Thus the injunctions for the distribution of charity are similar:

"To spend of your subsistence , out of love for Him, for your kin, for orphans, for the needy, for the wayfarer, for those who ask, and for the ransom of slaves"
(S.II, 177)

This verse stresses the active re-allocation of personally owned wealth and property to others less advantaged for the love of God. The descriptions of the disadvantaged are common to other scriptures.

Islam and the Value of Health

Islam respects the value and humanity of man; it's outlook is holistic and comprehensive. This needs to be emphasized and the role of religion in the protection of human life and health all over the world needs to be promoted.

In verified teachings of the prophet Muhammad it is said that God would ask <My servant, why have you not visited Me?>. The person would reply: <How can I visit You, and You are the Lord of all mankind>. God would say: <Did you not know that so and so

[1] These are references to the Holy Quran in the following order: S=Surah or Chapter number; #=verse number.

has fallen ill, and that if you were to visit him you would have found Me there?>. Thus God is to be found with the sick and helping them is being close to Him. This consideration of the sick must be viewed as a serious injunction of not only helping the sick cope with sickness but also making them less sick. Thus the healer is always with the sick, always with those who are close to God and making them healthier makes the healer special in the eyes of God.

Part III: Islam, Health and Equity

Implications of Islamic Perspectives on Equity

Islam does not recognize any differences between individuals to be of substance to their destiny except for their closeness to God. All other differentials are for worldly purposes, and the only one that matters is how pious (taqwa) is the individual. Therefore, for all intents and purposes all are equal.

Differences of gender, age, color and others are seen as a tribute to the powers of creation of God, such that no one individual is exactly similar to the other. They are to be considered as morally irrelevant. Therefore the distribution of benefits based on these features should also be egalitarian unless it is for the benefit of the under privileged. This is the one category of persons that has been grouped separately on the basis of the challenges that God has put them in - for which they will emerge successful. This group of people may have different types of worldly disadvantage (not moral) such as lack of money, power and social status. Moreover they can be in such a state for a long time (mimicking permanence) or for a temporary period of time. These are the poor, the orphans, the wayfarers and the needy. A difference in their health status is therefore unacceptable based on these attributes. This is therefore a case for the active reduction of inequities between groups of people.

Though the word equity does not appear in the Quran, words denoting egalitarian society, universal brotherhood and inter-dependence of people have been clearly expressed. These concepts denote an active movement for the recognition and demonstration of unity within the larger Islamic community (ummah). Thus a case for the active search for equity is also made.

Implications of Islamic Perspectives on Resource Allocations

The active notions of seeking equity and reducing inequity in health in Islam have to be operationalized within the context of provision of resources and opportunities. These principles mandate the distribution of resources to the advantage of the poor and other vulnerable groups.

However, allocations of state funds are not the only means of reliance on achieving such equity. Social and financial safety nets have been actively promoted in Islam as defined by functions of the Islamic state and the individual. Zakat or income-based charity is

mandatory on those individuals who qualify (based on annual wealth holdings). This represents 2.5% of the annual wealth and is to be either given directly to the poor in the absence of state mechanisms or through a state controlled means.

There is an integral and interactive relationship between poverty and health. Poor people are much more likely to be unhealthy, and when they fall ill are more likely to stay ill and recover to less than optimal levels. Unhealthy people are also more likely (in the long run) to face economic consequences, especially if they are living on subsistence levels, as happens in most developing countries. This relationship is difficult to tease out and is complex even in the interventions taken to-date. However, if people are prevented from falling into poverty, assisted in improving their incomes and helped with catastrophic life events then there is a higher chance that they will not fall in the poverty-ill-health crisis. A true re-distribution of funds in an Islamic society will therefore achieve this purpose thus favoring a better health status for all and specifically those who are more unwell.

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Equity and Resource Allocation in Health - The Christian Perspective

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I. Current inequities in health

When we look at the status of global health at the beginning of a new millenium we can see unprecedented opportunities and challenges. But even a cursory investigation of health indicators shows us that there are dramatic variations between the different regions of the world. There are good reasons to conclude that the current inequities in the allocation of resources for health are the most devastating problem in global health requiring our urgent attention. Millions of deaths could be prevented each year if people had affordable access to basic quality health services and preventive measures. Therefore ethically it is one of the most important tasks to analyze the current inequities and to consider ways how these might be overcome. The religious communities can provide valuable insights for these considerations.

There is no universal agreement about a working definition of the term equity and the methods to achieve equity. Of course, the term equity has to be differentiated from the term equality. It is impossible to achieve complete equality in terms of health status or allocated health care resources because people have very different needs and are living under very different conditions. Equity can be understood in relation to different variables: one could measure the resources spent on health per capita (input), the coverage of or access to health services (output) or the outcome in terms of levels of morbidity and mortality. In this paper the main concern is equity in terms of allocated resources on national and international levels keeping in mind that the reduction of inequity will lead to measurable differences in health outcome. The following definition will be used: equity is fairness in the distribution of resources enabling people to achieve the highest attainable level of health and reducing disparities in health status as far as possible. Equity has to be achieved independ from the wealth of the individual or the country of birth and residence and irrespective of criteria such as gender, ethnic origin, religion or social class.

The national level

There are striking inequalities in health in many countries. The inequalities can be demonstrated in terms of health expenditure per capita for different parts of a population as well as in terms of health indicators for different ethnic and social groups in a given society. These difference exist in countries with a strong private sector like the USA (Andrulis 1998) and the Republic of South Africa (Bloom 1998) as well as in countries with a more socialized national health system like the UK (Townsend 1982) and Sri Lanka (Jayasinghe 1998).

The international level

Just considering the most commonly used indicators for the status of health we can discern enormous differences between the most affluent and the poorest nations.
Life expectancy is a very crude measurement not only for the quality of available health services but also for the general living conditions influencing health. There is a gap of 35 years in life expectancy at birth between the least developed countries (43 years) and the most developed countries (78 years). (WHO 1995, p.1)
A very sensitive marker for health and development is child mortality. In some highly developed countries infant mortality is as low as 4.8 per 1000 live births whereas it may be as high as 161 per 1000 live births in some least developed countries. There is a strikingly high 33-fold difference between these countries. (WHO 1995, p.5)
One of the most tragic and yet largely preventable event is the death of a young woman during childbirth. Here the gap is even more drastic. Although this problem has become very rare in countries with a good infrastructure in health (1:1400), more than 580.000 women die from the complications of childbirth in low-income countries every year (1:16). The mortality rate is more than 50 times higher in those poorest countries than in high-income countries (WHO 1999, p.97).

Unfortunate and unjust inequalities

Some inequalities in health might be unavoidable. There are conditions affecting human health like genetic disorders, disabilities, natural disasters etc. that are unfortunate but not unjust events. Neither individuals nor societies can be held responsible for them. Therefore there might be a moral claim to help persons affected by these unfortunate events as much as possible but it is not necessarily a demand of justice.

Other events affecting health like infection with a pathogen at a given point in time might be called unfortunate as well. But there is overwhelming empirical evidence that infectious and other diseases are to a large extend determined by social factors like housing conditions, access to clean water, access to information and education, access to health care etc. These factors are influenced by individuals and societies so that inequities in these regards might be called not only unfortunate but unjust.

This differentiation between unfortunate and unjust events has consequences for the conclusions we draw about what has to be done to change unjust conditions.

II. What can be done to overcome these inequities

The methods to prevent premature and avoidable deaths are commonly available in the more affluent parts of the world but are not sufficiently available in low-income countries because of the extremely uneven distribution of resources on this globe.
It is impossible to outline a complete strategy of how to reduce current inequities in health in this short paper. There is a wealth of knowledge and concepts about this question and the author wishes to refer to a practical evaluative framework for decision makers that has been developed to implement the concept of equity once its basic assumptions and philosophical justification have been accepted (Benn, Hyder 1999).

III. The christian understanding of justice

1. The Old Testament

The basis of any consideration of justice in the Holy Scriptures is the equality of status before God which is shared by all men and women. Every human being has been created in the image of God (Bible: Genesis 1,27) and this quality belongs to all, independent of any other differences.

The Hebrew word for justice sdq describes good and harmonious relationships between God and man and between different human beings. God is the one who is just. He has given mankind his good order and a just man is the one who follows this order. The main source for the good order can be found in the law of Moses (tora).

The word sdq describes in a positive way all the actions that are preserving harmonious relationships within a community, be it between family members, the working relationship between a landowner and his servants or the relationship between the king and his subjects. But obviously the term was used for the relations as they were established in the ancient society of Israel. It was not a tool to critisize or change the social order of that time. Therefore we have to be careful with a translation of sdq into the modern word justice because it might cause false associations and implications. Some scholars prefer to translate sdq with loyal or faithful relationships rather than the perhaps misleading term justice for which there is no exact equivalent in the Old Testament (Koch 1976).

However, sdq requires people to pay particular attention to the weak, the poor and the vulnerable who were under the special protection of God's law. In particular the orphans, widows and strangers were regarded as being socially disadvantaged. Doing justice meant to protect them. And doing justice in this sense was certainly one of the most important and noble things man was expected to do.

"He has showed you, O man, what is good. And what does the Lord require of you? To act justly and to love mercy and to walk humbly with your God." (Bible: Micah 6:8)

However, the Old Testament is quite realistic about man's ability to fulfill the requirements of justice. The prophets remind the people of Israel again and again that they have failed to do justice and that the true service of God is the pursuit of justice.

2. The New Testament

The book the christians call the New Testament (NT) is a collection of writings of different authors reporting about the life of Jesus and his teachings as well as giving theological interpretations of it.
The Greek term used most frequently for justice is δικαιοσυνη (dikaiosyne). It means justice as well as justification. Overall the term justice appears relatively frequently in the NT and different greek words are being used for the term we call justice or righteousness apart from dikaiosyne. Given the structure of the NT it is not surprising that experts agree that in the NT there is no uniform understanding of the term justice (Hagglund 1984, p. 419).

Rather there are different concepts that need to be interpreted:

a. Justice as an attribute of God

Justice is primarily related to God. It is not an abstract principle relating to the political or social order but a religious term describing what is demanded for man to do. Human justice is a response to God's justice that human beings can experience.

b. Justice as justification

God's justice is evident in the undeserved justification of man. The justification provided for man by God himself as a gift out of grace. The freedom from sin and guilt achieved through justification by God leads not so much to justice but to a responding love.

c. Justice and the law

Justice as understood in the New Testament does not replace the law of Moses. Jesus was a Jew. He acknowledged the validity of the Jewish law and ordered his disciples to practice strict adherence to this law. However, in several of his sermons he asked his disciples to go beyond the strict requirement of the law. This is sometimes called the "new justice" in the New Testament (Luz 1989).

Justice is not denied as an important value but love goes beyond justice demanded by law.

"Do not think that I have come to abolish the Law or the Prophets; I have not come to abolish them but to fulfill them." (Bible: Matthew 5:17)

d. Justice in relationships

Justice in relationships is understood as the actual deeds of one person toward the other. Justice is something you do and not so much the abstract order regulating the relationship of an individual toward the community in which he or she lives. An example is the story of the Good samaritan who helps a person who was wounded by robbers. He shows compassion and mercy although it is not his duty and although he is from a different ethnic background than

the victim (Bible: Luke 10, 25-37). This story is the answer to the question: Who is my neighbour? The answer is that anybody is your neighbour who is in need of your help. The requirement to do justice is certainly not confined to the own religious or ethnic group. God's love is extended to all human beings who are created by him and those following his commandments are required to offer all fellow human beings their love and concern. Jesus was dealing very often and, one could even argue in a special way, with persons not belonging to the Jewish community. When taking examples of outstanding faith and exemplary behaviour he pointed at people of different ethnic or religious origin like the Good Samaritan, Roman soldiers or women from neighbouring ethnic groups. Therefore ethical demands transcent national and religious boundaries.

IV. The christian understanding of distributive justice or equity

Distributive justice or equity is even less a theoretical concept in the Bible than justice as such and there is no specific term for equity (Bowlby 1983). But certain aspects of the law of Moses, of the sermons of the prophets as well as of the parables and teaching of Jesus can provide us with valuable insights.

The law of Moses contains regulations about the distribution of goods and wealth. One example is the so called Sabbath Year (Bible: Leviticus 25). It demands that after seven times seven years the Israelites should take a rest for themselves, their animals and their land. It is a time to recreate, to forgive all debts, to release captives, to make a fresh start. This law is certainly about the redistribution of wealth and property rights. The purpose is to provide everybody with a new and fair chance in life recognizing that in the usual pursuit of human work, of power, greed and war inequalities and inequities will grow and perpetuate themselves if there is no mechanism of redistribution.

The concept of the Sabbath year has been used extensively in the worldwide campaign of debt cancellation for highly indebted poor countries. It is questionable whether historically this concept has ever been put into practice but it certainly reminds Jews and Christians of the kind of order God intended for man to live in. It is an order that tries to provide human beings with a fair chance in life, not allowing inequities to rise to unacceptably high levels.

The call for a Sabbath or Jubilee year was reconfirmed by the great prophets like Isaiah (Bible: Isaiah 61, 1-2) and directly referred to by Jesus when he announced his understanding of the Kingdom of God in a synagogue at the beginning of his public ministry.

"He [the Lord] has sent me to proclaim freedom for the prisoners and recovery of sight for the blind, to release the oppressed, and to proclaim the year of the Lord's favor." (Bible: Luke 4, 18-19)

Throughout his ministry Jesus taught about love to one's neighbor which was for him closely related to the love of God. He warned about the dangers of accumulating material wealth and asked people to give up their riches in favour of the poor. The motivation for this demand was not so much social change and an egalitarian society but the drive for spiritual perfection. Therefore Jesus was certainly not a social reformer fighting for justice in a modern sense of this term but a religious reformer who expected radical change in the personal lives of his disciples. In general Jesus' teaching was more about love and compassion than about equity.

Love is about face-to-face relations between different persons. Love involves not only a particular action but the whole person. It goes beyond what might be rationally expected of a benevolent person. Love never contradicts or obstructs justice but goes beyond the demands of justice. After justice has been fulfilled love will do even more.

"True love is always more than justice; love fulfills first the law of objective justice. There can be no love at the cost of justice or circumventing justice, but always beyond justice and working through justice." (Brunner 1981)

The question is: what is the relationship between love and justice? The influential 20th century American theologian and ethicist Reinhold Niebuhr puts it very well:

"A rational ethic aims at justice, and a religious ethic makes love the ideal. A rational ethic seeks to bring the needs of others into equal consideration with those of the self. The religious ethic, ... insists that the needs of the neighbor shall be met, without a careful computation of relative needs...(Since it [the principle of love] is more difficult to apply to a complex society it need not for that reason be socially more valuable than the rational principle of justice.)" (Niebuhr 1960, p.57)

Niebuhr captures the essential difference between the principles of love and justice. The principle of justice is more limited. It gives a person its due, it tries to calculate carefully claims and gratifications to come to a just solution. But love goes beyond that. It does not go against the principle of justice, it rather presupposes its implimentation. But it will allocate to a particular person more than what pure justice demands. It gives out of true love and compassion not calculating the cost and not comparing the consequences of a certain action to persons who are not directly involved. Therefore love is not necessarily the best advisor for policy decisions. On the other hand love prevents the development of justice into a mechanical dehumanizing tool. Forrester is right in his warning that "without love justice always degenerates into something less than justice." (Forrester 1997, p. 218)

There are certain stories and parables in the New Testament that illustrate Jesus' attitude toward distributive justice and its relation to love.
When Jesus was annointed with a very precious oil by a woman his disciples criticized this behaviour saying that the money should have been spent for the poor. But Jesus objects to this saying: "The poor you will always have with you, and you can help them any time you want. But you will not always have me." (Bible: Mark 14, 7) He acknowledged the apparent waste of the oil as an act of love that had a value in itself. This value was higher than a strict application of a principle of justice demanding redistribution of any available resources for the poor.

In a parable Jesus tells the story of the owner of a vineyard who hires workers for a day. Some are hired in the morning, some at lunchtime and some one hour before dawn. At the end of the day they all receive the same wages. Of course, those who were hired in the morning complain about unfair treatment, but the landowner asks them: "Are you envious because I am generous?" (Bible: Matthew 20, 1-16) Jesus compares this situation to the kingdom of God indicating that we do not receive our dues because of our own efforts and work but we receive what we need. Translated into modern ethics we might conclude that Jesus favours distribution according to need and not distribution according to merit or status.

Again we should not take these stories and parables as ethical principles and theories because this would lead to misinterpretations. They are fragments and indicators in our search for the meaning of distributive justice.

In the New Testament we find another illustration in one of the earliest form of donations for international aid. St. Paul asks the richer congregations in the Greek town of Corinth to collect money for the poorer congregations in Jerusalem (Bible: 1. Corinthians 16). It is to be transferred to Israel to help their brothers who are in severe material need. But there is no question of achieving equity or redistributing income from a richer nation to a poorer one. It is to be done out of love and charity to satisfy an immediate demand.

But there are also good arguments to state that love and compassion can be less than justice. If somebody shows compassion toward his/her neighbour and offers temporary help without paying any interest in the social condition leading to the situation causing this particular need, this kind of love is lacking an essential component. Justice but also love understood in a comprehensive way demands that help is offered that has the potential to change the conditions leading to need. These conditions can be caused by social, economic, physical, or spiritual factors. Certainly any kind of cheap compassion is far from the concept of love in the New Testament. When Jesus was demonstrating the meaning of love in concrete deeds he was not only addressing the particular need of a person but the whole life including the physical, mental and spiritual dimension. The aim was not to give alms but to help the person to experience the fullness of life. This attitude is illustrated in the many stories presenting Jesus as a healer. He is healing the whole person helping him or her not only to overcome physical illness but also social isolation and spiritual exclusion.

Further considerations by christian philosophers/theologians

Christian theology and ethics has not only reflected on the understanding of justice in the Holy Scriptures but has also been influenced extensively by philosophy and secular thinking. In particular Greek philosophy as the dominating school of thought in the mediterranian culture of that time provided crucial insights to christian theologians throughout the centuries. The most influential school of thought for christian theology was that of Aristotle. He regards justice as the most complete virtue and taught that justice means to give everybody one's due. Equals should be treated equally and unequals unequally in proportion to the relevant inequalities. In Aristotle's sense justice means fair or proportionate treatment (Gillon 1985, p.87). This is the basis for the just distribution of goods, rights and other things in society. It is also called arithmetic justice as the correct measure of distributed goods can be calculated almost mathematically. One of the problems with Aristotle's ethics was that equality was not a

principle applied to all human beings. In ancient Greece only free male citizens were regarded as full human beings and slaves, women and foreigners were certainly not included in the rule that goods and rights should be distributed equally.

Many christian theologians throughout the centuries have written about justice and interpretated its consequences for moral behaviour. The formulation of their theories was always done in close dialogue with the dominant philosophers of their time who presented their particular views. The most influencial theories apart from Aristotle were those of Kant, Hegel, Mill, Marx and in this century Rawls, Nozick, McIntyre and others. It is impossible to review all these theories here. In recent years most theologians writing about justice/equity would refer to the major schools of thought such as libertarian ethics, utilitarian ethics, Rawls' justice as fairness or Marxist interpretations in a theology of liberation.

Summary

In summary we have to conclude that there is no commonly accepted christian theory of justice. There are a number of concepts often leading to totally different conclusions. The Scottish theologian Duncan Forrester in his book "Christian Justice and Social Policy" published only two years ago came to the discouraging conclusion that "nobody knows what justice is" (Forrester 1997, p.2). What we do have are insights and fragments. These are based on central texts in the Holy Scriptures indicating how justice was understood in the context of the Old and New Testament. Therefore the lack of agreement among ethicists does not mean that the exercise to search for the meaning of justice in health is futile. Even thoughful insights can be convincing not only for scientists but also for policy makers who put ideas into practice.

Keeping in mind these limitations the following insights can be derived from a careful study of christian and biblical ethics:

1. All human beings have an equal status before God and deserve fair opportunities in life.
2. In the Holy Scriptures there is a special concern for the poor, the sick, and those needing special protection.
3. Measures have to be taken to counterbalance the effects of human greed and the misuse of power.

4. The main criterium for assistance is need.
5. The rules of justice are defined in the law of God revealed to man. The law has to be fulfilled.
6. Love goes beyond justice in doing more than is required by law.
7. Justice and love apply to everybody irrespective of national boundaries or ethnic backgrounds.

V. What are the consequences of our understanding of equity and resource allocation?

The following conclusions are a possible interpretation of the aforementioned christian understanding of distributive justice. They are by no means statements of any kind of authoritative body of christian churches or theological schools. There are probably as many variants of practical conclusions for the distribution of resources in health care as there are theories of justice and political systems. Basically the question of resource allocation is a political one and can only be resolved by political means. But religion and morality are part of a process leading to widely supported opinions and political decision making. The following remarks can only be an attempt to explore the potential of ethical thinking based on religious values.

Consequences for resource allocation on a national level

The principles would lead the author to conclude that christian ethics would support the allocation of resources in health so that equal access to health care for all people according to need would be achieved. Justice would demand that conditions are established enabling people to live healthy lifes and develop their full human potential. The primary responsibility to ensure access to health and healthy living conditions falls upon governments as the elected bodies looking after the well being of all people.
Of course, it has to be realized that resources are by necessity limited and any amount of resources for health is competing with other vital concerns. Therefore christian ethics would not necessarily support equal access to maximum health care. Justice would demand fairness in the distribution meaning that people with equal needs have equal claims on public resources to provide them with the quality health care covering the most essential needs.

Beyond this optimum care the principle of love would oblige christians to make additional resources available out of compassion and concern for the sick to provide the highest level of available health care. But this level does not necessarily have to be funded by public means.

Consequences for resource allocation on the international level

Resources are required to reduce the most glaring inequities in global health. Due to the present global economic system many countries cannot mobilise sufficient resources to enable its citizens to achieve a decent level of health. The international community and citizens of wealthy nations in particular have to supplement the locally available resources. There are basically two ways to argue for this kind of international development aid. It can be done out of charity or compassion. Rich nations or individuals might feel that morality demands to help people in desperate situations. These poor people have no legitimate claim on the resources of the rich. They can only hope for voluntary contributions out of abundance others comand. Some might come to the conclusion that no more is required out of the christian understanding of love and compassion.
The other alternative is to say that most differences in health status are avoidable and therefore unjust. It would be first and foremost a matter of justice to correct these inequities. Poor people need not wait for generous donations but they have a moral claim for assistance. This concept is certainly supported by the Human Rights Declarations stating that health and health care is a basic human right (Jamar 1994). Therefore providing necessary resources to achieve this goal is not only a charitable action but a legally required policy. As we are talking about Universal Human Rights all people commanding sufficient resources either privately or through their governments are obliged to make the resources available to implement the basic human rights if the respective governments in poor countries are not in a position to do it. Justice and human rights do not respect national boundaries but extend to all human beings wherever they live.

What might be the appropriate christian response to these two different lines of arguments? Looking at the concepts of justice and love it seems to me that first the fulfilment of the law of justice is required. Justice in this case means that all human beings should have access to resources in health permitting them to lead healthy and productive lives facilitated by a defined level of basic quality health services. Beyond that christians according to their

understanding of love should feel obliged to do even more than that and share resources freely so that more than a basic level of health and health care can be provided.

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Buddhist Sexual Ethics and AIDS

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Sex and AIDS are issues widely discussed today. Buddhism has been known for its spirit of renunciation and its ideal of compassion. There are many people who are puzzled to know what the Buddhist attitude towards sex, the basic fact of life, is, and what kind of response Buddhist monks make to the issues AIDS epidemic. The purpose of the paper is to discuss the Buddhist view on the nature of sexuality, love and marriage, its attitude towards AIDS sufferers and the compassionate work of some Buddhist monks in Thailand to alleviate the suffering of these people.

Sex and Sin

Buddhism recognizes the power of sexual desire in man and realizes that this primal force can create problems unless it is properly managed. Many people are proned to much suffering because of the lack of knowledge and understanding of the nature of their sexuality and the way to be related to the opposite sex. In keeping with its "middle way" philosophy Buddhism does not advocate the two extreme position of rigid puritanism and total permissiveness with regard to sex. In Buddhist understanding sex in neither "sinful" nor "virtuous". Sexual act becomes good or bad only when it is benefitial or harmful to all the parties involved.

Buddhism accepts that sexual pleasure is very much part of the worldly life, but it considers the craving for or the attachment to sexual pleasure as unconductive to ultimate peace and purity of the mind. In this respect the observance of celibacy is neccassary if one wants to gain spiritual development and perfection at the highest level. Though Buddhism advocates celibacy for Buddhist monks it does not urge the average lay people for total abstinence. To these people it teaches them how to regulate and control sex to solve their personal problems and particularly not to act irresponsibly and recklessly to make the other suffer.

Love and Marriage.

In Buddhist sexual ethics love between a man and women should not be based entirely on carnality. Love is an expression of human concern for another being. This, however, does not mean that Buddhism does not recognize the physical aspect of love which is expressed in sexual union between a man and a woman. Buddhism wants this physical side of love to contribute to the well-being of the couples and be consummated selflessly and with compassion.

Marriage is viewed as important part in the strong web of relationships of giving support and protection. It is a partnership of two individuals based on trust, sharing, equality, generosity and dedication. In such relationship duties and obligations the two parties have to each other and to the children born through the pleasure of sex are emphasized. These duties and obligations are self-imposed because marriage, in Buddhist view, is a matter of personal choice and is a civil affair, not a "sacrament". There is no specific Buddhist marriage ceremony. Buddhist monks usually attend the wedding ceremonies as guests to give blessings to the married couples and not to saeri the wedding. Since marriage is a secular affair the married

couples are free to choose the kind of life they want to have. It they want to practice contraception it is entirely their own business and Buddhist monks have no part in it. Abortion is a different matter it because involves the taking of life and thus violates the Buddhist precept against killing. This, however, in the view of the majority of lay Buddhists, can be condoned in cases of serious health hazards where it may represent the lesser evil.

As in the case of contraception Buddhism does not lay down any religious rules with regard to the number of wives a man should have or should not which people are forced to follow. Marriage to more than one person is an option for Buddhists. However, monogamous marriage seems to be the most benefitial to the two parties than polygamy which may be more an expression of mon's lust.

Post marriage blues and Divorce

As mentioned before, in Buddhist view, marriage is a secular affair and the bond is not insolvable. If the husband and the wife cannot live together, instead of leading a miserable life with anger and hatred, they should have the liberty to separate and live peacefully. However, the separation must be done in an atmosphere of understanding by adopting reasonable solution and not by creating more hated. If they have children, they should try to make the divorce less traumatic for the children and help them to adjust to the new situation. It is unacceptable in Buddhism to neglect the children and made them suffer as the consequence of divorce.

Sexual Misconduct and Adultery

With its emphasis on sex with responsibility Buddhism prohibits sexual misconduct. Adultery or extra-marital sexual relation is a form of sexual misconduct because it undermines the stability of marriage, based on trust and loyalty, by the selfishness of one or the other party. Thus adultery is something to be avoided. It is an inauspicious action which will bring harmful consequence to all people involved.

Pre-marital Sex and Homosexuality

Buddhism does not regard sex before marriage between consenting heterosexual adult couples as sexual misconduct if there is love and agreement between them. However, since the mind is always in constant change any illicit action or indiscretion may cause undue harm to either party if legal marriage does not happen as expected. Buddhism, therefore, urges young couples to exercise self-restraint on sexual desire or to get married. Though early marriage may "work" or may not "work" it is preferable.

Unlike pre-marital sex homosexuality is not a clear cut case. For the Buddhist monks complete abstinence is essential for spiritual envelopment. Sexual intercourse whether of hereosettual or homosexual nature is considered a *parajike* (offence) that involves irrevocable expulsion from the Order. But for lay people there is no Buddhist discourse on homosexuality. Whether on not this sexual activity is a form of sexual misconduct needs careful investigation. However, it is clear that neither sexual indulgence nor sex without love is acceptable in Buddhist sexual ethics.

Buddhist Method of Sexual Control

The importance and the power of sexual drive in man is well recognized in Buddhism. In order to prevent problems caused by sexual indulgence Buddhism urges people to behave themselves sexually to the best of their ability. Instead of emphasizing rigid suppression of this primal force Buddhism recommends the practice of mindfulness as an important means of gaining control of human sexuality by avoiding repressed sex. This practice involves the four foundations of mindfulness i.e. the body, feelings, mental states and mind-contents, Mindfulness of the mental states will enable us to know, for example, how lust arises and how it ceases, and therefore, how to bring about its cessation. Knowing is therefore victory. Thus there is no forcing. It may take time and need much perseverance, but it does not do violence to one's nature.

Sexuality and AIDS

As mentioned before, in Buddhist view, there is nothing "sinful" about sex. Since people have both strengths and weakness it is easy for the average lay people to make mistakes in their lives partially in regard to sexuality. With such realization Buddhism does not want those who made such mistakes to develop a guilty-complex. Instead it encourages them to avoid repeating these mistakes, and to look forwards to the future. A the same time Buddhism wants us to exercise compassion towards these people who are less fortunate by being sympathetic to them and by alleviating their sufferpeopleing.

It is this compassionate attitude that is the basis of the Buddhist monks' work for AIDS sufferers in Thailand. AIDS has been a deadly disease in the countries since the eighties. In 1998 the Ministry of Public Health estimated that the number of Thai infected with the HIV virus were between 700,000 – 900,000. The main problem AIDS patients have been facing in the country is lack of adequate care provided by the govemment. At present there are 204 non-gonvermnent organizations, which are helping these sufferers in various ways ranging from consultation to treatment and care. Among these there are 44 organizations that provide AIDS sufferers with lodging and care. There are also 10 organizations specifically geared to children born from HIV positive mothers. Besides these organizations there are some Buddhist monks who acting on their own initiatives turn the temples into lodging for AIDS sufferers who usually turn to the temples as the last resort.

AIDS Sufferers and Buddhist Monks

One of these monks is Phra Pcecha of Wat Tem Sriwilai in Saraburi nears Bangkok who uses special herbal concoctions to boost up the patient's immune system to resist the virus. The herbs—numbering thirty and used in these concoctions—cannot be bought from the indigenous drug stores but have to be collected in the deep jungle. Along with herbal treatments, the monk prescribes a vegetarian diet, merit-making (such as helping others and boservace of the precepts), and the practice of meditation. Merit-making and meditation are components of the healing process because the monk believes that healing has something to do with the spirit. Through merit-making the patient develops an ability to "give" while

meditation enables him/her to develop self-control and to let go of stresses caused by anger and anxiety. Though this particular treatment is still experimental there are at least two specific cases out of one hundred AIDS patients in the earlier stages who have been declared by hospital physicians to be completely cured. Other patients remain a symptomatic and ethics stabilize or increase their T-cells. Consequently, a large number of patients have come to the temple to seek help from the monk who, in the absence of any government support, is quite over-burdened (particularly when the resources of the temple are very limited). The monk has only two assistants and he himself has not enough time to rest, having to teat the patients from dawn to dusk. This raises the question of the limits of compassion. *"I am very tired,"* he said, *"and my health is in deterioration." At times while treating patients I have to rush to my lodging to throw up because of over-work and exhaustion. But have grest sympathy for these sufferers who have no other place to go. Of course I treat them free of charge. But some of their relatives like to donate money to the temple. This enables me to buy one herbs from villagers and to help more patients. The temple has very limited space. I like to advise people to take the medicine home and to come back only if there is no improvement. If they follow my advice on diet, merit-making and meditation while taking the prescribed herbal concoctions, I expect the cure to be effected in one year and a half. Apart from treatment I encourage all patients to have hipe instead of despair, otherwise their conditions will become worse. It is not important for me at all to know how they got AIDS and whether they are good people or not. All I know is that they are in great suffering and I have to help to relieve their suffering."*

Wat Tam Sriwilai treats only AIDS patients in the earlier, curable, stages. There is another temple which takes care of those in the full blown stages where no cure is possible. This temple is Wat Prabat Namphu in Lopvuri, another province near Bangkok, and the monk is Phra Alogkul. Moved by compassion for those AIDS sufferers, who have nowhere to go for needed care, the monk has transformed his small temple into a hospice. Without professional knowledge about AIDS, he wears no protective clothes when treating these patients. When AIDS patients were initially accepted into the temple, other monks fled and villagers threatened to stop supporting the temple because of their fear of AIDS. Lacking proper knowledge about this deadly disease the villagers believed (wrongly) that the disease could be spread easily (e.g. though mosquito bites), and, as a preventive measure, dernanded the monk to keep the patients under mosquito nets at all times. Buring this period, Phra Alongkot had to deal with the hostile attitudes of the villagers as well as procure adequated resources in order to provide proper health care for the AIDS patients. After three years of hard work hemanged to persuade the villagers to develop compassion for these patients and to support the temple's humanitarian work. Gradually the villagers began to follow him even visiting the patients and helping to treat them. The treatment consisted mostly of traditional herbs, diet, and meditation. Apart from the medical treatment, patients are encouraged to form a support group and to enjoy life (however short it may be). At present the temple has five volunteers from the villages. The monk is now receiving, increa-sing assistance, including financial support from NGO's and the general public. Govemment agendee are also encouraging other temples to follow the example of Wat Phrabat Namphu. Even though they cannot cure the patients, the temple is a refuge for patients in their final days. At the temple they are with supported and cared for (without any charge), and often livelonger. When they do pass away they let go of their lives peacefully. The provision of free health care adds

a burden for the temple however. Few relatives visit the temple and when the patients die their bodies are cremated and their bones kept at the temple because relatives will not receive them for fear of contracting the HIV virus. The Ministry of Public Health and some NGO's are assisting the temple to initiate a home care project for AIDS sufferers which will have a supportive community for them. To implement this project, Phra Alongkat has to work harder to persuade people in different villages to take care of AIDS patients in their own areas and not to bring them to the temple. It is not important whether he succeeds or not, for the has already set an example of translating the high ideal of Buddhism into practice, and has contributed, though in a limited way, towards the alleviation of suffering in contemporary Thai society. When divorced from action this moral ideal of compassion is nothing at all.

These two monks are examples of Buddhist monks who have been working to provide proper care to AIDS sufferers. This is a way of translating compassion into action to alleviate human suffering and to help these suffering people to lead meaningful lives to the end. Through this means AIDS sufferers are not neglected and left to their own destiny by themselves.

Conclusion

Buddhist sexual ethics does not regard sex "holy" nor "unholy" it is an expression of craving which sparks life but is not conductive to spiritual development. Thus celibacy is an option for those who want to attain perfection and purity of the mind. For the average lay person Buddhist sexual ethics affirms the importance of love and marriage and particularly monogamy. At the same time it discourages sexual misconduct such as adultery or extra marital sexual relations. Though pre-marital sex between two consenting adult couples is acceptable it is less preferable to marriage. As a means of gaining control of human sexuality Buddhism recommends the practice of mindfulness which will enable us to know our sexual desire and the way to bring it to cessation. This practice is not any form of suppression nor does it lead to repressed sex with harmful physical and emotional consequences.

Equally emphasized in Buddhist sexual ethics is compassion. It is incumbent on us at all time to act responsible with regard to our sexual behavior so that the sexual act will not bring suffering to people involved. This compassion is also called upon us particularly in cases of sexual lapses. While it is possible to restraint or to transcend the sexual impulse not many people are able to reach this stage. In such case we should not condemn those who violated the precepts but should be sympathic and help to alleviate their suffering as much as we can. This compassionate attitude is witnessed in the selfless work of Buddhist monks for the well-being of AIDS sufferers in Thailand.

The Jewish Approach to Living and Dying

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When presenting "Jewish attitudes" to any subject it is appropriate to specify in advance what specific position is represented within the spectrum of extant Jewish positions. Israeli governments have fallen over the definition of "Who is a Jew". Various Israeli supreme court justices have, in their published decisions, defined Judaism's core values in diametrically opposing ways. Jews everywhere today live in pluralistic societies, and many different voices claim to speak for Judaism.

The "Jewish attitude" in the present paper does not refer to the results of a poll among bagel-eating individuals with a name identifiable as being of middle European Jewish origin. Rather it refers to those individuals who consciously govern their lives by the tenets of their faith and who actively seek out Jewish values to guide their actions. These individuals, while clearly a minority among ethnic Jews, to my mind compose the group whose voice can be appropriately said to represent the "Jewish attitude".

The majority of these Jews are what are commonly referred to as Orthodox, and therefore I feel no need to apologize, or be defensive, about using these values as representative of Judaism. Furthermore even those who do not identify as Orthodox, if they are serious about using Judaism's values to guide their decisions, must ultimately fall back on the classic Jewish sources, no matter how differently they are interpreted - and there is certainly room for various interpretations. These sources represent probably the longest unbroken tradition in bioethics which is still followed by its adherents. Former Israeli supreme court justice and talmudic scholar Menahem Elon estimates that there are over 300,000 halakhic responsa, a veritable treasure of casuistic literature on which all Jewish scholars of whatever their persuasion are dependent.

But before referring to actual Jewish texts I want to comment about Jewish culture, with regard to attitudes towards life and death.

The task of defining Jewish culture is no less difficult. Russian Jewish culture differs from Moroccan Jewish culture, which in turn differs from American or Yemenite Jewish culture. But each of these, in turn, differs from the specific non-Jewish culture that surrounds it. In Israel we have a blend of multiple Jewish cultures - mixed, but not homogenized, into a unique Israeli blend of Jewish culture, which includes, perhaps very importantly for bioethics, the post-Holocaust impact. There is I believe a commonality - a Jewish ethos that can be extracted from these diverse Jewish cultural expressions.

I remember distinctly a visit of mine as a lecturer at the University of Manitoba School of Medicine in the 1960's when the chairman of the department of medicine there asked me whether I had an explanation for an his observation among the physicians in his department. He had noted that the Jewish physicians tried much harder in treating their patients and gave up much later in the struggle for saving lives than did their Christian counterparts. At that time I had no answer for him, nor

could I confirm the validity of his observation. But I now believe that this perceptive clinician and educator did identify correctly an essential element of the Jewish ethos - a strong emphasis on life. This life ethos is reflected also in a number of other manifestations, including perhaps the impressive overrepresentation of Jews in the medical profession in almost all societies and eras. Other expressions of this culture include the relatively high percentage of Israeli patients on dialysis as compared to wealthier countries, the Israeli policy of placing physicians virtually on the front line in the battle field in order to enhance the chances of saving the lives of wounded soldiers, and the overrepresentation of Israeli patients in transplantation centers around the world. Finally there is a myriad of jokes confirming the perhaps exaggerated emphasis on life in the Jewish value system.

The Jewish culture is strongly pro-life, probably more so than its daughter religions, Christianity and Islam. This culture, even among avowedly secular Jews, is rooted in several thousand years of Jewish tradition, and is religious in origin.

It is best expressed by the Mishnah in Sanhedrin (1): "Therefore was Adam created as a single individual - to teach us that one who destroys a single life is as if he destroys an entire world. And he who saves a single life is as if he saved an entire world. And so that one man should not say to his fellow man 'My father is greater than yours'".

This statement in the Mishnah is responsible for what I call the "mythology" of the infinite value of human life; that is that every life is of equal and infinite value, that even a moment of life is equivalent to longer periods of life, and that no value whatever is placed on the quality of life.

I do not use the word "mythology" in a pejorative sense, nor do I wish to denigrate this principle which does bear a powerful and important message. But clearly no recognized halakhic authority prescribes a course of action in <u>full</u> accord with that phrase. Otherwise we would not permit anyone to die without an attempt at resuscitation and without attachment to a respirator, even if only for a few minutes. But the message, nevertheless, is clear and unequivocal. Life is of enormous significance. We dare not deliberatly extinguish even a brief moment of life, even if this life is of poor quality. This is a valid and valuable myth which characterizes Jewish tradition.

But there is a dialectic here. On the one hand life has intrinsic value, independent of what can be accomplished, and we are cautioned not to trifle with even tiny quanta of life, even if to our mortal perception this life serves no obvious purpose. Life is a precious divine gift of great <u>intrinsic</u> value - but it is also of <u>instrumental</u> value. Man is placed on Earth to serve his Creator. The Jewish religion is one in which deeds are emphasized more so than merely beliefs. In the words of the Talmud (2) "One Hour of good deeds is worth more than all of the world to come."

One may exploit even the shortest life opportunity to utter another amen, to say a prayer, to give a coin to a poor man, or to say a kind word to a distressed neighbor. Thus even in the area of the duty to save another's life, on the one hand some sages give a pragmatic rationale for the mandate to violate the Sabbath (3). "Violate a single sabbath so that he may be enabled to keep many subsequent Sabbaths." But on the other hand the duty to violate the Sabbath takes precedence even if the patient is comatose and does not stand a chance to live beyond the moment, and certainly he will not be able to keep subsequent Sabbaths.

Yet in spite of this unequivocal premium placed on human life, it is important to emphasize that life itself is not an absolute, nor even the ultimate highest value in Jewish tradition. The Torah commands us at times to sacrifice our own lives for higher values. For example, when one is faced with the forced violation of one of three cardinal sins (idol worship, murder, forbidden sexual relations) or at times when sacrifice of one's life is a matter of kiddush hashem (sanctification of God's name). The Torah also mandates the taking of human life, capital punishment, although only under ceratin clearly specified conditions. The command „lo tirzahk" in the Ten Commandments is not generally translated in Jewish sources as „do not murder". There are times when taking a life is not just permitted, but even required.

There are several other aspects of the Jewish tradition that bear on the subject which should be mentioned. The Jewish physician-patient relationship, unlike that in the United States and some other Western countries, is not what Baruch Brody calls the contract type (4) – i.e. a totally voluntary relationship under which the physician agrees to undertake the care of a patient and the patient may or may not seek medical attention. The physician has a duty to help any patient who needs his assistance. This obligation is derived variously from several Biblical ordinances, such as „Do not stand idly by your friend's blood" (5) - and – „You shall return it to him" (6), the latter referring to the obligation to return a person's lost object, and extended to include lost health.

The characteristic American slogan „mind your own business" expressing a laissez-faire, individualistic attitude towards ones neighbour is not part of the Jewish tradition. The Jewish attitude may justifiably be termed paternalism, if you will, but in its positive, rather than in its commonly used, pejorative, connotation. Just as I would care deeply if one of my own children were sick and was headed for a disasterous decision, so too am I concerned about my patient, and I am obligated to help him/her in distress. Autonomy, the virtually unlimited right of a person to dispose of one's body as he/she sees fit, with no restrictions, is foreign to our tradition. Man is a but a custodian of his body – bound by the ground rules imposed upon him by the Creator and ultimate owner of the body – the Almighty. In the West the last few decades have

witnessed the rise of autonomy to the top of the list of ethical values, to the point that it often takes precedence over almost all other values. In our tradition, while there is more recognition of autonomy than is commonly believed, it certainly is far more limited than in the secular West. There is relative unanimity in the recent Jewish tradition that it is mandatory for a person to seek medical attention for any major illness, and that is equally mandatory to follow expert medical advice – particularly if a potential danger to life exists.

Suicide is unequivocally condemned in the Jewish halakhic literature, and the strictures prescribed in the halakha about the burial, the treatment of the bodies, and the rules of mourning for those who have committed suicide are quite harsh and even seemingly cruel – particularly when one takes into account that those who suffer from this stance are the surviving family, who obviously have already suffered severely.

Yet side by side with the unequivocal condemnation of those who commit suicide, one can find another thread throughout history, from the Tanach to our own day. There are repeated attempts to find extenuating circumstances to mitigate the harsh attitudes towards suicide. In contrast with the strict uncompromising theory, the practice, as guided by the rabbis in dealing with individual cases in their community, was usually much more understanding and forgiving. Rabbis went out of their way to unearth the most tenuous extenuating circumstances to permit the suicide's body to be treated respectfully and not ostracized. This is a fascinating and illuminating insight into the nuanced application of rabbinic law to meet the needs of the individual and of the circumstances. Interestingly enough with the dramatic increase in societal approval of suicide and the rise in the rate of suicide in the West, Rabbi Ovadiah Yoseph, the former Sefaradic Chief Rabbi of Israel, has suggested that, in reaction to this shift in societal norms, rabbis might once again revert to treating suicides according to the strict letter of the law.

I would now like to turn our attention to euthanasia itself. It is important to point out that the definition of the term and the aim of the practice is a „good death", and only one person is dying – the patient. In this discussion the focus should be primarily on the individual, not on the family, not on the physician, not on the hospital administrator, not on the minister of health, nor on the budget director.

In this sensitive and difficult area there are significant differences of opinion, even among accepted Orthodox halakhic authorities, because the interpretation of the basic texts and their degree of relevance to modern dilemmas is not easy, and rarely straightforward. Therefore indivicuals of great erudition, scholarship, and conscience may interpret the same texts differently.

The spectrum of possibilities for euthanasia begins with active euthanasia, (which, of course, may be involuntary, i.e. against the wishes of the patient, non-voluntary, or voluntary). None of these are sanctioned by the Torah, no matter how difficult the circumstances. The command not to take human life continues to be valid, and there is unanimity on this point. With respect to active euthanasia it makes little difference whether the patient has only a few minutes or a few years to live – active, purposeful, taking of life is a capital crime in Judaism.

The Shulkhan Arukh goes so far as to forbid the mofing, or even the touching, of the person who is in the death throes, for fear of hastening his death, even by a few moments. The picturesque example given compares the dying person to a flickering candle – any movement may extinguish the flame. Similarly and untoward movement of the patient may be the final push from life over to death – a forbidden act.

Is our tradition callous to the suffering of the patient? Do our rabbis really feel that there are no situations perhaps even worse than death? No, indeed we do recognize that in certain situations continued suffering may be a fate worse than death. There is little glorification of suffering in the Jewish tradition. And there are several sources which may be interpreted to permit, and even perhaps encourage, prayer to the Almighty for the death of a suffering patient.

One of the most moving and dramatic stories describes the terminal illness and death of Rabbi Yehudah the Prince (7). His rabbinic colleagues and students decreed a public fast and prayed for his recovery, as did his maid, known for her wisdom. But when she observed the degree of her master's suffering and the indignity to which he was subjected by his unrelenting diarrhea, she decided that it was more appropriate to pray for his death. But her prayers stood no chance against those of the great rabbis, who continued in their pleas for his recovery.

The Talmud describes graphically and movingly a dramatic heavenly struggle between those on earth who wanted Rabbi Judah's recovery and the angels in Heaven who were beckoning him to heaven. In desperation, and with great ingenuity, it is told that Rabbi Judah's maid threw a jar from the roof. The noise distracted the rabbis from their prayer and, with this impediment to death removed, the tide turned in favor of the maid's prayers, and Rabbi Judah's soul departed in peace.

The Talmud seems to have approved of this simple woman's act, although some authorities note that the rabbinical contemporaries of Rabbi Judah acted differently than the maid, and perhaps it is their view that should prevail. There are several other references in Jewish sources which seem to legitimize the prayer for death.

But the permission to pray for the death of a suffering patient was limited by an extraordinarily perceptive, and currently most relevant, insight by a

19th century Turkish rabbi, Haim Palache (8). He was approached by a pious member of his community who was in a serious ethical quandary. His wife had been seriously ill and suffering for many years with an incurable illness. Her suffering had now reached a point where she no longer could tolerate her distress. Euthanasia was clearly out of the question for this pious Jew and his wife. But he asked the rabbi whether or not he was permitted to pray for his wife's death, since recovery was essentially impossible.

Rabbi Palache, in a sensitive and meticulous review of the relevant Jewish sources, concluded that indeed there were grounds to permit such prayer when suffering is so great that death may properly be seen as a deliverance much to be desired. But he added a critical limitation, that only those who have no involvement in the care of the patient may pray for the patient's death, because only they can do so objectively. But family members, or members of the health-care team, who are burdened in any way by the responsibility of the care of the patient, may not pray for the patient's death, since their prayer may be tainted with a degree of self-interest. The Jewish tradition is extraordinarily sensitive to the subtle biases that may influence life and death decisions, even in the best-motivated and pious individuals. The relevance of this insight in our era of managed care and „bottom line" considerations is obvious.
What about what has been referred to as passive euthanasia, i.e. witholding theapy which may be life prolonging in order to shorten life? There are philosophers who contend that there is no ethical difference between passive and active euthanasia. In general, these philosophers are not contending that just as one forbids active euthanasia so too one should forbid passive euthanasia. On the contrary almost invariably they are trying to convince those who do not treat everyone maximally, that by the same logic they should not hesitate to perform active euthanasia.
I find it fascinating to note that physicians, nurses and other individuals who personally deliver care for the patients, and who are the ones whose actions determine whether a patient shall live or die, as well as when and how the individual will die, often reject the philosopher's equation of active and passive euthanasia. Their intuitive response is that there is a difference between active killing and merely witholding a therapeutic act. And I believe that ethicists and philosophers would do well not to reject such intuitive responses out of hand. The halakhah too backs this intuitive response and posits an unequivocal difference between an act of omission and one of commission, with respect to culpability.
Having made this point, I prefer to avoid altogether the use of the term passive euthanasia, even for those acts of omission which the halakhah might sanction. The goal should not be the death of the patient. The goal should be the avoidance of suffering and the elimination of barriers to the

natural process of death; not the hastening of death. One may argue that this represents quibbling ofer semantics, but I believe that terminology is important medically, philosophically and emotionally.

The Jewish tradition recognizes the permissibility of removing a factor that prevents the death of a dying patient. There are two unusual examples cited in the Shulkhan Arukh which describe a patient in the throes of death (goses) whose imminent death seems delayed by one of two stimuli; one was noise created by a woodchopper near the patient, or salt on the tongue of the patient. Either of these phenomena, perceived as impediments to the death of the patient, may be removed, because such removal is not considered active termination of life, but merely removal of obstacles to the departure of the soul.

Another example cited in support of the permissibility of removal of impediments to death, is the moving description of the martyrology of Rabbi Hanina ben Tradyon (9). When he was immolated by the Romans they placed layers of wet wool on his chest to prolong his suffering. When the rabbi's students witnessed the suffering of their rabbi, they suggested that he inhale the flames to hasten his death, to which he replied: „Better that the Lord who gave me my life take it from me rather than that I should contribute to my demise". While the Roman executioner witnessed the scene, he too apparently was moved, and he asked the rabbi whether he might attain a place in Heaven if he hastened the rabbi's death. The rabbi replied in the affirmative, whereupon the executioner raised the flames, removed the wool, and then in a final act of personal repentance leaped into the flames and perished together with Rabbi Hanina. At this point, a heavenly voice proclaimed that both Rabbi Hanina and the executioner entered Heaven.
It is not easy to translate any of these examples into modern idiom. What are the modern analogies of the woodchopper, the salt or the removal of the wet wool? There are significant differences of opinion between established halakhic experts on each of these points.
Individual, seemingly similar, cases may be different enough in subtle, but important ways, so as to yield different condlusions. It is therefore not easy to derive generalizable rules. For example: How does one define a dying patient, a goses? The classic definition is that of a patient expected to die within 72 hours, but there is considerable controversy as to the exact definition. Some experts have even stated that we simply do not know. Prediction of death is at best a very inexact science, even by the experts in intensive care whose professional life is spent treating critically ill patients, as Dr. Joann Lynn and her colleagues have so convincingly shown over the past few years (10).

When dealing with a patient who has been judged to be incurable, that is the basic illness is no longer amenable to specific treatment and who is suffering, most Jewish authorities agree that the patient may refuse obtrusive, complex, and distressing treatments, which may be regarded not as life-saving, but rather as merely prolonging the death process.
Those treatments, which many feel that may be refused, include dialysis, attachment to a respirator, resuscitation, surgery, chemotherapy and the like. On the other hand straightforward, safe, simple treatments, such as antibiotics for an intercurrent infection or a blood transfusion for severe anemia, should be given. Feeding and fluids by mouth should certainly not be witheld, nor should simple intravenous fluids to prevent dehydration. Most authorities would also not permit withdrawal of tube feeding, although if a patient would have to be restrained in order to insert a feeding tube, such force-feeding would not be mandated by all authorities.
It cannot be overemphasized that pain relief muts be offered in quantities sufficient to relieve suffering, even if such treatment shortens life. Actually more and more data are accumulating suggesting that adequate and humane pain relief may not only not shorten life, but may prolong life. The treatment of pain, even in 1996, still leaves much to be desired in even the best Western hospitals, because of ignorance and/or callousness.
What roles do the patient's wishes have in these decisions? Here indeed there seems to be a clear acceptance of, and respect for, the patients' desires by most halakhic authoroties. While theoretically a Jewish court (bet din) may compel therapy on an unwilling patient, in the real world today no such authority exists. In practice most authorities do not favor actual physical coercion to treatment. When one is dealing with a dying patient who is suffering, one should accept the patient's refusal of those treatments which he/she regards as without adequate benefit/cost ratio for himself/herself.
Most halakhic authorities do differentiate between withdrawal of therapy already begun and withholding of therapy, although many philosophers and physicians regard the two processes as ethically identical. The halakha is particularly strict when withdrawal of a therapy, such as disconnection of a respirator, is followed immediately by death. But there are valid halakhic ways in special circumstances for terminating therapy without a direct causation of death.
I would caution again that it is difficult to give precise guidelines for individual cases. There are often subtle differences between seemingly identical cases which may result in opposite halakhic rulings.
There is also as yet no unanimity of opinion in each situation. The field is dynamic; new and difficult dilemmas are being posed daily, and new

specific decisions often carve out new ground and new precedents. We are, after all, dealing with life and death matters.

It is critical to emphasize that a great deal of objectivity is essential in these decisions. The only concern of the halakha is the welfare of the patient under discussion. it is clear when one reads much of the general literature on the subject that all too often it is the interests of the family, the staff, and/or the society that may influence the decision, usually in a direction of terminating the patient's life. These considerations are totally unacceptable by our tradition.

One of the unfortunate effects of the almost universal transfer of the locale of death to the hospital and even more so into the intensive care unit is the conversion of a natural process into a battlefield environment. And just like modern warfare is dominated by technology, so too is today's dying scene. Some of the undesirable consequences of this change are:

1) the fostering of the illusion that death is conquerable – if but we make the effort,
2) the loss of the critical emotional and social support by family and friends in the death process, and
3) the deprivation of the ultimate equanimity and resolution of life issues on the part of the patient.

In times gone by the confession (vidui) by the dying person was an integral part of the Jewish dying process. While not a sine qua non for status in the world to come, as last rites may be for the Roman Catholic, the confession nevertheless was an important, and standard procedure, for a seriously ill person. With what I call the Americanization of the death process even among pious Jews, there has been a marked reduction in the undertaking of this religiously and psychologically therapeutic step of squaring accounts with one's maker and one's family before death, and then being able to accept death's inevitability as a natural finale to a life well lived.

I would like to close with a bit of a digression from the Jewish view on life and death, to the Jewish view on another subject which bears on the present discussion.

A few months ago, I received a letter from a prominent secular philosopher ethicist who is doing some research on the slippery slope concept; and he asked me whether there are traditional Jewish sources that address the issue. Indeed there are. There is a clear acknowledgement of human nature in its ability to rationalize and to blur distinctions, if it so suits the individual and the society's purpose. I believe that in the field of treatment of the terminally ill and euthanasia the rapidly changing societal attitudinal changes that have taken place over the past two decades are clear evidence that the slopes are indeed

slippery. While unquestionally the overuse of life sustaining technologies and the arrogant paternalism of physicians have contributed in a major way to changing attitudes, it is hard to escape the condlusion that these objective realities do not explain fully the or of events.
The Dutch experience is particularly troubling. Although only a few short years ago we were repeatedly and emphatically assured that the safeguards, as originally proposed, would prevent any abuses, the reality has proven otherwise. Thousands of cases of non-voluntary euthanasia of adults and children have taken place, and further erosions are on the horizon. As one Dutch physician told me recently when he was asked how it felt to actively kill a patient. „The first time was difficult". Subsequent cases were much easier for him. So too, it seems that each step along the path towards societally encouraged active euthanasia is a natural progression from the previous one.
I believe firmly that it would be a tragic mistake to join the stampede toward changing our Jewish medical tradition, which has been a beacon of humanity and sensitivity towards human life and human suffering.

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THE VALUE OF HUMAN LIFE IN THE JEWISH TRADITION
Implications for the DALY approach

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Judaism is appropriately regarded as a religion and a culture, in which life in general, and human life in particular, is granted an extraordinarily high value probably well beyond that in most other cultures . The Lord Rabbi Immanuel Jakobovits, the creator of the term "Jewish medical ethics" has popularized the view that the value of human life in Judaism is "infinite and beyond measure". This concept has been repeatedly quoted subsequently and it carries with it important practical consequences, as pointed out in the original text (1) by Jakobovits "a hundred years and a single second are equally precious: one may not normally deliberately take a single life even to save multiple lives".

I have since pointed out on multiple occasions that the infinity concept is a myth, albeit a most useful one. In the real world, while Judaism assigns comparatively great importance to human life, it does not act invariably in consonance with the infinity concept. Otherwise, for example, we would attach every dying patient to a respirator, even if we could thereby add just a few minutes of additional "life". There is no responsible Jewish authority who suggests such a policy.

The importance of human life in the Jewish tradition is divinely ordained. It is not because of life's instrumental value, but is intrinsic. Man is a creation of God in his "image". Man's body and soul are not his exclusive possession to dispose of them at will, but are the creation and possession of the divine Creator who has given them over to man as a caretaker, to use, but not to abuse, in the service of the Creator and of fellow man.

Thus not only is murder prohibited as a cardinal sin, as it is in many other religions, but suicide is regarded as no less serious an offense. In fact some regard suicide as a more serious offense.

A twentieth century scholar Rabbi Tukachinsky, in a classic work on end of life guidance, (2) writes:

> "The sin of one who murders himself is greater than that of one who murders someone else for several reasons: First, through this murder he has left no possibility for any remorse and repentance. Second, death (according to Babylonian Talmud Yoma 86, etc.) is the greatest form of

repentance, but he, on the contrary, has committed through his death the greatest sin, namely, murder. Third, through his act he has made clear his repudiation of his Creator's ownership of his life, his body, and his soul; he has denied the simple idea that he did not participate in his creation at all, but rather [maintains that] his entire identity is exclusively [within] his power to sustain, to reproduce his existence, or to destroy it. He is like one who actively [and intentionally] burns a scroll of the Torah, for our Sages, may their memory be blessed, compared the creation of the soul to a scroll of the Torah that [now] has been burned and he must therefore face judgment in the future for this as well.

He is also among the unequivocal deniers of the continued existence of the soul and of the existence of the Creator, may His name be blessed, and of the future judgment after the departure of the soul [from the body]...."

While this comment may represent perhaps an extreme exposition of the traditional view of suicide it does reflect a generally unequivocally negative view towards suicide.

Indeed the strictures prescribed in the halakhah about the burial, the treatment of the bodies, and the rules of mourning for those who have committed suicide are quite harsh and even seemingly cruel - particularly when one takes into account that those who suffer from this stance are the surviving family, who obviously have already been traumatized severely.

Yet, side by side with the seemingly unquivocal condemnation of those who commit suicide, one can find another thread throughout history, from the Bible to our own day. Baruch Brody, (3) and more recently Noam Zohar, (4) have attempted to present a more balanced view of suicide, pointing out the particular incidents in traditional texts in which suicide under unique situations was apparently at least understood, and even condoned. Furthermore, in contrast with the strict uncompromising theory, the practice, as guided by the rabbis in dealing with individual cases in their

communities was often much more understanding and forgiving. Rabbis went out of their way to unearth the most tenuous extenuating circumstances to permit the suicide's body to be treated respectfully and not ostracized. This is a fascinating and illuminating insight into the nuanced application of rabbinic law to meet the needs of the individual and of the circumstances. Interestingly enough with the recent dramatic increase in societal approval of suicide and the rise in the rate of suicide in the West, Rabbi Ovadiah Yoseph, the former Sefardic Chief Rabbi of Israel, has suggested that, in reaction to this shift in societal norms, rabbis might once again revert to treating suicides according to the strict letter of the law.

The deliberate taking of a human life is one of the worst possible offenses in Judaism. Witnesses in capital cases are forewarned to exert every effort to be absolutely truthful because human life is at stake. The Talmud (5) prescribes the formula for this instruction:

> "For this reason Adam was created as a single person, to teach you that anyone who destroys a single soul is regarded by Scripture as if he destroyed an entire world, and anyone who rescues a single soul is regarded by Scripture as if he saved an entire world; and so a man may not say to his fellow man "my father is greater than yours".

Virtually all of the precepts and commands of the Jewish faith are waived if there is even a question of risk to human life. Such suspension is invoked even if the life to be saved is fleeting, even if the life is of poor quality and even if the chance for saving life is minimal. Similarly the taking of a human life, no matter how close to death, or however compromised, is nevertheless a capital offense. Perhaps the most dramatic example given is that of child falling to a certain death from great heights; if someone kills him by a sword while falling, the perpetrator is guilty and punishable for shortening life even by seconds. So too one who kills a dying person is guilty of a capital offense.

Capital punishment is clearly mandated in the Jewish tradition, and one cannot help but get the impression from reading the biblical text itself that

such punishment seemed to have been meted out with relative ease. But the halakhah and codes of Jewish law which regulated practice throughout history made the meting out of capital punishment. a difficult, if not almost impossible, task. The requirements of evidence for conviction are so stringent , circumstantial evidence is ruled out; so that capital punishment was rendered almost impossible in practice. Indeed one Talmudic comment referred to a court that handed down a death sentence once in seventy years as a "murderous court".

But it is fair to point out that there is also a dialectic here. On the one hand life has intrinsic value, independent of what can be accomplished, and we are cautioned not to trifle with even tiny quanta of life, even if to our mortal perception this life serves no obvious purpose. Life is a precious divine gift of great intrinsic value - but it is also of instrumental value. Man is placed on Earth to serve his Creator. The Jewish religion is one in which deeds are emphasized more so than merely beliefs. In the words of the Talmud "One hour of good deeds is worth more than all of the world to come". One may exploit even the shortest life opportunity to utter another amen, to to say a prayer, to give a coin to a poor man, or to say a kind word to a distressed neighbor. Thus even in the area of the duty to save another's life, on the one hand some sages give a pragmatic rationale for the mandate to violate the Sabbath. "Violate a single sabbath so that he may be enabled to keep many subsequent Sabbaths". But on the other hand the duty to violate the Sabbath takes precedence even if the patient is comatose and does not stand a chance to live beyond the moment, and certainly he will not be able to keep subsequent Sabbaths.

The life orientation of the Jewish faith is expressed also in other ways. Ascetism has been frowned upon by mainstream Judaism throughout the ages. Man's role is to enjoy the world in which he lives, to exploit it, to be a partner in creativity, all within fairly carefully prescribed civilized limits, all in the service of the Creator.

Holiness in Judaism is not the withdrawal from the world but the injection of holiness into the mundane daily activities of eating, drinking, working and sexual activity. One is bidden to marry, to have children, as a

partner with God in creation, within the boundaries prescribed for a holy nation. Celibacy is not an acceptable option, no matter what the circumstance. Indeed the scholars and rabbis, the intellectual and religious elite, were most likely to marry early and have many children, in contrast to a number of other religions. The demographic and eugenic consequences of this practice are of considerable interest and impact.

Because of the importance attached to life in this tradition, the role of a physician assumes major proportions. It is no accident that Jews have been attracted to the healing professions for centuries, that the proportion of Jewish physicians in almost every culture was extraordinarily high and that many leading rabbis in the Middle Ages were also physicians. Healing was regarded as part of imitatio dei - for God said "I am the Lord your healer". In addition, the permission, and indeed the obligation, to heal another is derived variously from several verses in the Torah:

1) The verse regarding the obligation of an assailant to ensure that the victim is "thoroughly healed" (Exodus 21: 19-20).
2) "Love your neighbor as yourself (Leviticus 19:18).
3) "Do not stand idly by the blood of your neighbor" (Leviticus 19:16).

The value attached to human life, the concept that the body is not ones own possession to do with it as one pleases, the obligation not to stand by idly while another's life is in danger, create a milieu quite different from the classic American "mind your own business", laissez faire, attitude towards one neighbor and his/her illness. A positive kind of communitarian paternalism is engendered and encouraged, even at times to the point of imposing treatment on an unwilling patient - an idea anathema to the current Western ideology which emphases autonomy. This paternalistic involvement is incumbent on the individual and on the community.

The Talmud advises scholars not to take up residence in a city without physicians, safe water and sewage services as part of ones religious obligations. The community is obliged to provide health care for its citizens as one of the basic services rendered.

Judaism respects not only human life, but all life, and indeed all of creation, living or not. But there is, in the Jewish tradition, a clear hierarchy in nature, rising progressively from the inanimate through the plant and animal, to the human and the divine. In a purposeful universe, those in the lower category serve the higher forms. Thus, unlike some modern philosophers who decry the discrimination between man and animal as "speciesism , a concept akin to "racism", our tradition regards such blurring of the boundary between animal and man as more likely to lower man to the level of the animal than the reverse.

The Jewish legal and aggadic traditions are replete with references to the importance of kindness and sensitivity to the suffering and needs of animals. Moses was chosen to lead his nation in part because of the kindness he showed to the lambs while a shepherd; Rabbi Judah the Prince was punished with years of illness and suffering merely because of a callous remark about an animal being led to slaughter; we are obliged to feed our domestic animals before sitting down to our own meals; etc.

But whereas Judaism pioneered legislation against any cruelty to animals, long before such concepts were accepted in the West, it unhesitatingly gives man the right to dominion over animals, to kill them for any nonfrivolous human use. This privilege was given to man, for man was created in "God's image", a concept subject to multiple interpretations, but with important implications. This permission carries with it a clear responsibility for man to act at a moral and ethical level higher than the animal - otherwise there is little rationale for his priority over the animal. The use of animals for medical research is regarded as laudable and mandatory, when indicated, provided such activity is carried out with sensitivity and minimalization of animal suffering. But, the license to exploit animals specifically excludes killing and paining of animals for trivial purposes such as hunting, cockfighting and the like which have traditionally been totally alien to Jewish culture. Indeed, Albert Einstein is quoted as once defining a Jew as one who derives no pleasure from hunting.

While the dichotomy between body and soul is perhaps not as clearly marked as in Christianity, and the body-soul unit is regarded more as an

integrated unit than as conglomerate of the holy and the base, death reduces the body to a source of ritual "uncleanness". Yet the body must be treated with utmost respect, as the former repository of the soul, and it must be buried rapidly.

The life ethos of Judaism and the strong emphasis on the individual has pervaded Jewish culture, even the secular variants thereof, to this day. In modern Israel one can find such manifestations in the relatively high rates of dialysis, in the sending of physicians to the front-lines of the battle field, and in the innumerable Israelis for whom money is raised to send them to leading transplant centers the world over.

Even much of Jewish humor reflects the strong emphasis on human life that pervades the culture.

The reverence for life, both for its instrumental value, but also for its intrinsic worth, affect the attitude towards equitable distribution of health care services.

Learned discussions about equity in distribution of health care services and the various formulas that are proposed have invariably lead me to serious uneasiness. The comparative advantages of various economic and ethical theories for the most equitable division of the resources are dealt with in a commendably scholarly manner, but one which seems to ignore the most glaring existing injustices inherent in our world.

The almost axiomatic thesis of inadequate resources for health care and "tragic choices" that must be made, while indisputable on the whole, nevertheless has hypocritical and misleading aspects, when one compares the expenditures on health care to those on military purposes. It was once estimated that for the money the world spends just on several <u>hours</u> of military expenditures, one could completely eliminate eight infectious diseases throughout the world by immunization. The Western world also spends absolutely incredible sums of money on gambling, smoking, alcoholic beverages, pets and entertainment. The diversion of even a small fraction of these expenditures towards properly chosen health care outlays could make a dramatic contribution to world health.

If one looks within the health care field itself the disparities between

nations often dwarf those within countries. According the World Bank figures for 1990 (6) the high income countries spent 90% of the world's annual total of 1,700 billion dollars of health expenditures, about 1,500 dollars per person. The developing countries spent about 10% of the world's total for an average of $41 per person. The pathophysiology of a such glaring discrepancies, their ethical implications and the steps to rectify the inequities are unfortunately discussed all too rarely, for obvious reasons.

Another basic point that merits reemphasizing in any discussion of distribution of health care resources is the Inverse Care Law. (7)

This law, which is probably no less powerful than some of nature's laws of thermodynamics, was described by Dr Julian Tudor-Hart. Tudor-Hart is an anachronism, a Marxist true believer, in the best idealistic sense of the term; a family physician who has devoted his professional life to caring for underprivileged and improverished Welsh miners. He stated that even in societies that are allegedly egalitarian, the best health care is generally given to those individuals who need it least, and the worst to those who need it most. Enormous gaps remain between "the haves" and the "have nots" even in relatively egalitarian societies. While the existence of these gaps is an almost inevitable consequence of the human condition, awareness of this "law" and conscious efforts to redress these unfair situations can help to narrow them.

A closely related and most relevant point is that perhaps the major contributory factor to ill health, even if we define it in a purely biomedical sense, is poverty. This is neither the time not the place to examine the pathophysiology of this relationship, but it is universal in all societies in which it has been examined. The morbidity and mortality in the poor sectors of towns and countries is much greater than that among the well-to-do. Of course, poor health, in turn, is a major contributing factor to poverty, and the poor sick are often trapped into a vicious reciprocal cycle. The consequences of this relationship are most relevant to health policy issues. The poor have much less free money to spend on healthcare after the non-optional expenses for food, housing, clothing and education have been taken

care of.

Overrepresented among the poor in most societies are the aged and the disabled, the groups that would be most affected by a blanket application of DALY (disability adjusted life year) or QALY (quality adjusted life year) calculation to the determination of the manner of distribution of health care resources.

The discussions on the ethics of distribution of health care are a relatively recent phenomenon, for several reasons. It is only modern medicine that has provided us with effective treatments, and therefore with choices. It was not until almost the mid-twentieth century that specific treatments for many medical illnesses become available at all, that selection of options became relevant. Shortly thereafter, with technologic advancement the costs of medical care began to rise incessantly. Now the choices became more and more painful and the experts were called in to assist in these decisions.

Economists, of course, quite appropriately were consulted since fiscal responsibility in decision-making falls into their area of expertise. And quite in keeping with their experiences and outlook they analyzed the choices through their perspectives - how to get the most for the dollar spent - a logical, rational and seemingly non-disputable thesis.

Simultaneously with these developments, another evolution, or perhaps a revolution, was occurring in Western medicine. Medicine was changing from being strictly physician-centered to becoming more and more patient-centered.

This meant that individual health care decisions were being made not just according to the <u>needs</u> of the patients, but now also taking into account the patient's <u>desires</u>. While the former might possibly be best assessed by the physician, the relevant desires are purely the patient's.

The weight now appropriably being assigned to the patients' desires creates a much greater variability in health care decisions as compared to when the physician decided unilaterally on choice of therapy.

When a patient is faced with a personal decision in which he/she has to choose between two alternate treatments in a rational way, economists

have suggested a helpful conceptual tool, the QALY or DALY. (8) If we can accurately assess and factor in the patient's preferences, we can, by this analysis, help the patient choose intelligently between two alternate forms of therapy. We can ascertain and calculate the degree of tolerance a patient has for a particular disability, and the ultimate choice can then be individualized for that patient. One would hope that in practice physicians might actually take the trouble to learn about the unique preferences and foibles of their specific patients, that they would expend the effort to determine as best they could the risks and benefits of each form of treatment available, that they would present all the data to the patient, and together they would arrive at a reasoned, balanced decisions. This process would permit autonomous patient choices that would reflect and grant status to the unique individuality of each human being, his/her tolerance of suffering, and the values that are of greater and lesser importance for him or her.

But DALY's and QUALY's, while perhaps ideally suited for such individual decision-making have not achieved their fame (or notoriety) for individual decision-making. They have been proposed for the most part to help societies which have limited resources for their "infinite" health needs, in their decision-making as to which services to finance, and to whom to provide care. (8)

The assumptions behind such use are several: (9)

1. The "quality" of life can be quantified reliably - and should be factored in to the decision making process. I believe that while the quantitation will inevitably be difficult, there is general agreement that the effort to evaluate and quantify quality is a useful exercise. The thought processes inherent in the exercise probably improve the quality of care.
2. The ethical theory best suited for the societal decision making is a form of utilitarianism, "the greatest benefit for the most people". This superficially attractive slogan is quite problematic, even if society had a way of determining what is the "greatest good" for each member of society. Unfortunately the present century has experienced the distorted and criminal application of pure utilitarianism by the Nazi regime.

Elementary school books in Nazi Germany presented children with mathematics exercises such as: "How many apartments for young couples could be constructed with the money that it costs to maintain a mentally retarded person in an institution for a year?" The consequences are well known, and could and should be reflected in our decision-making.

The application of utilitarian ethic clearly gives priority to community preferences over those of the individual patients in apportioning resources.

This kind of reasoning can also readily lead to a deprivation of care for a less numerical and usually weaker segment of a community irrespective of the magnitude of its needs.

3. By definition, older patients, those with multiple illnesses and the disabled will inevitably and invariably receive a lower priority than the young and the otherwise healthy individuals afflicted with identical illnesses. A 70 year old with pneumococcal pneumonia stands no chance in the competition with a 30 year old suffering from the identical disease even if the prgnosis for cure is identical. It is no wonder that the major public opposition to the use of QALYs and DALYs comes from the elderly and the disabled. While it is true that both these groups have traditionally been discriminated against in treatment, the application of DALYs has given this discrimination a legal and ethical force, and a respectability, against which it is difficult to argue.

The Jewish tradition cannot accept the DALY concept as <u>the</u> overriding guiding principle in societal health care decisions, for several reasons. The emphasis on the uniqueness and importance of each individual does not permit us to deny care to an individual on the basis of an arbitrary assessement that saving that person's life or reducing his suffering is less important than that of another.

Research data have shown repeatedly that discrimination against the aged is already widespread in the Western world. The elderly person even when his/her physiologic state is identical with a younger person, is likely to receive less ideal care. (10) This discrimination is probably rooted in part in the current societal emphasis in on instant gratification, youth and

achievement, but this approach is not compatible with the Jewish tradition.

When discussing priorities for scarce organs with medical students, I often ask the students whether they would accept age as a criterion. There are usually two groups in each class, those who are opposed to age discrimination and those who are willing to accept such discrimination. But the assumption is invariably whether or not to favor the younger person. Just to be devil's advocate I often shock the group by vocally and deliberately advocating discrimination against the young, arguing that the older person who has contributed so much to society deserves his/her reward whereas the younger person has not yet proved himself nor has he merited a reward from society.

Aside from the importance of the individual and the unwillingness of our Jewish value system to begin rating one person's life over that of another, there are several other considerations in rejecting the DALY approach to societal decision making about health care priorities between individuals. The older person is venerated in the Jewish tradition, is granted respect by both family and society. Society, and particularly offspring, acknowledge a debt of gratitude to parents and elders for their years of contributions in raising, and sustaining and educating them. This in itself mitigates against overt discrimination because of increased age.

But there is another factor that militates against discrimination against the aged and the disabled. The Jewish tradition, in many ways, expects of its adherents to give special attention to the needs of the underprivileged and disadvantaged members of society. Again the idea of imitatio dei is invoked. The Almighty is described as healer of the sick, clother of the naked, liberator of the captive, raiser of the fallen, paragon of hesed, (giving loving-kindness). Particularly are we admonished to give special attention to the underprivileged, the disadvantaged in society. Specifically mentioned repeatedly in our sources are the stranger, the orphan, the widow and the poor. The admonitions about mistreatment of the stranger are mentioned 35 times in the Bible, with the reminder "you too were stangers in Egypt". The specific groups mentioned in the Torah are paradigmatically the weakest elements in society, those in greatest need

of succor. While the elderly and the disabled are not specifically cited as such among those singled out for special attention, all the previously invoked principles apply to them in today's society, for they are today's vulnerable. Thus it is inconceivable that an already disabled person, or an elderly person who has serious existential problems, and who is already devalued in an achievement-oriented society should be doubly discriminated against by going the bottom of the priority list in obtaining health care by a DALY system.

Does this mean that health care rationing should be done haphazardly emotionally, irrationally and without careful evaluation of the costs and benefits? On the contrary, since there are in all societies resources which are significantly less than needed to meet the reasonable health needs of each society, rational calculations must be made. These calculations are not just optional but are an inherent part of the responsibility of community leadership. Community leaders have an obligation to take into consideration all community needs, and they must divide the resources equitably and wisely, balancing immediate needs with future investments. While a premium is placed on human life in Jewish thinking and therefore life-saving will have a relatively high status, it is recognized that it would be foolhardy and irresponsible to spend all of the community's resources only, or largely, on health merely because "life is of infinite value". In a classic Talmudic case discussion, a legal precedent of sorts with obvious ramifications for health care rationing, communities are forbidden to ransom captives at exorbitant rates - for fear of "impoverishing the community" and in order to discourage even more exorbitant demands in the future. Thus while failure to ransom a captive would probably lead to almost certain death, it is recognized that saving lives cannot be done regardless of cost, because communities have other needs as well. And rational decision making does not permit a community to budget its limited resources irresponsibly. An individual on the other hand is generally granted full authority (if he has the means) to ransom a family member of his at any expense.

Thus a calculation of what the particular yield in life and health for

each dollar is a legitimate, and even mandatory, exercise for any community. Quality of life, and not merely existence, is also a legitimate community concern on the macro level. It is here that DALYs and QUALYs provide excellent means of calculation of the burden of disease versus the benefits from its prevention and treatment. QALYs provide useful data on the return for an investment. But even the most ardent advocates of QALYs have not proposed them as exclusive determinants for spending. Indeed in the World Bank's discussion of DALY's they state explicitly that "an important source of guidance for achieving value for money in health spending, is a measure of the cost-effectiveness of different health interventions and medical procedures". They point out explicitly however that "just because a particular intervention is cost-effective does not mean that public funds should be spent on it". And the reverse is equally true, in that at times for a variety of reasons, funds may need to be spent for a non-cost-effective intervention, which may provide other values.

In considering DALY's or any quantitative measure of cost effectiveness we must, in a system based on a Jewish tradition, build in particular safeguards to protect the underprivileged, the relatively voiceless, the disenfranchised, if we are to preserve our humanity - even at the expense of greater cost.

There is one way of utilizing cost-effectiveness calculations and yet avoid discrimination against the elderly or disabled. The key to all rational decision making using formulas are the specific values attached to the various outcomes. If one decides to place a very high value on the preservation and enhancement of a society's ethical level, it may assign an added premium to the life of the weak and the disadvantaged - a sort of reverse Darwinism. Then the treatment of such individuals may yield a high enough priority to merit their receiving treatment, even in a purely cost-effectiveness calculation..

It has been said that the ethical level of a society is best assessed by the humane way it treats its elderly, its weak and vulnerable populations. There is much to be said for specifically factoring in such values in any health care system.

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International Consultation on
Inter-religious Dialogue on Bioethics
October 5-8, 1999

Purpose, goals and objectives

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"Tell me what your God is like and I'll tell you what your society looks like."
[T. Sundermeier, The Meaning of Tribal Religions for the History of Religion]

Part I: The Rationale for Discourse

This world is defined in specific though related ways by the many religions existing today. It is only through an interactive process of communication that a common vision of a just world can be developed by all peoples from all religions. The basic principles which define such an inter-religious dialogue include:

- a pressing need to aid those people in distress, globally
- a commitment to inter-religious discourse for humankind
- a common engagement to alleviate ill health
- promotion of deeper understanding of each religion.

The Challenge

The need for such a dialogue is based on the fact that there are a set of challenges that face each religion.

- We are of a religion, and as such we live with a mission for change; how do we live out this mission in the 21st century?
- We live in a multireligous and multicultural society as a global reality; how does each religion respond to this reality?
- Everybody wants to live in peace and yet religions have been abused and used to incite tensions and war; how can we make religion contribute to peace and tolerance?
- How can this inter-religious dialogue contribute to such efforts (as described above)?

The Response

Responses to these challenges can vary though we argue that there is only one response which will be mutually fulfilling.

One form of response to the global reality has been defined as the "patchwork". Individually we each create our own "patchwork faith" that has elements of our choice from each religion. This response expresses freedom of choice to mix and match; and yet

denies the essential notion of the claim to the truth as expressed by each religion. It therefore indicates that there are many religious truths and the individual is accepting many at the same time.

Another response is to dialogue with faiths - to gain more knowledge of our own religion and to gain more knowledge of other religions. This assumes that we have a conviction that our religion is the truth but we also affirm that other religions have the right to exist and prosper. This response generates tolerance and promotes healthy communication.

In fact, dialogue is a part of the "mission" of each religion. It can be defined as an interaction where *people speak with humility and listen with respect.*

The Action:

Opportunities for inter-religious dialogue today are manifold and occur in many different places and formats. Direct face-to-face discussions, exchanges via traditional media such as phones and faxes, and interactions through the Internet and email are all available and need to be seen as an opportunity. In addition, the opportunities for discourse are pressing for world peace.

Such interactions need to be held accountable to some "guidelines" for a dialogue such as an exploration of the following issues.

- What is the nature of the relationship between the religions?
- What is the religious tradition on each side?
- What are the perceived obstacles to common ground?
- What are the areas for engagement?
- Suggestions and recommendations for practical application.

Finally we all need to make sure that we conduct a reality test of a global perspective. This entails recognition that:

- all religions will continue to exist;
- they all seek the common good of humanity; and
- they all need to take each other seriously.

This will help and facilitate meaningful inter-religious exchange.

Part II: International Dialogue in Tubingen

We are privileged that the Inter-religious Dialogue on Bioethics in Tubingen will contribute to efforts for world peace. We are honored that people, such as yourselves, have taken time out of your busy scheduled to come and share your thoughts and listen to others. We are thankful to the people who facilitated this event and have made it possible for us to meet in this wonderful town of Tubingen.

The overarching goal of this meeting is to demonstrate the intrinsic beauty and need for a deeper understanding between religions and their positions on important health issues. The next two days are meant for open discussion - this is the central theme of this dialogue. We all have an interest and a stake in these issues, and yet we need time and opportunity to explore the possibilities. Each session of this meeting will do exactly that - define a set of possibilities, which will open intellectual, and we hope, practical prospects for a better understanding between religions.

The specific objectives of this meeting are therefore to:

- pursue an inter-religious dialogue on specific issues of bioethics
- produce documentation to demonstrate the intersection of religious thoughts on thise issues
- identify areas where further dialogue is required for a common understanding
- recognize that such explorations need to be encouraged and stimulated more frequently
- emerge with a set of practical recommendations for further research and action.

The conduct of this meeting is simple. Each session has a central topic, which will be introduced by 1 or 2 speakers that come from specific religious backgrounds. This will lead into a general and interactive session where we can all join to explore the specific health issue from an ethical and religious perspective. There is no fixed, standard format for any session - you are free to innovate to the advantage of the whole group. The meeting will cover the following themes:

- Value of life
- Status of unborn life and family planning
- Sexual ethics and HIV/AIDS
- Patient autonomy and euthanasia
- Equity and resource allocation

The final session will discuss the result of the meeting and future steps to be taken. It is important to note that this meeting is not a one-time, stand-alone event. Rather it is the beginning of a process where dialogue, research and action will merge for a common goal. It must be seen as the predecessor of a set of activities, such as:

- More dialogues with different stake holders
- More research on the attitudes and opinions of people on Bioethics
- More case studies on inter-religious action in health

This stream will require your support and continuing efforts, and the support of others who are not present here today.

We hope that these common objectives, together with your own personal objectives will be fulfilled over the next 48 hours.

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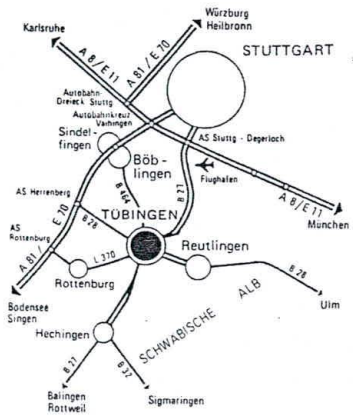
DIFÄM - „Health in a sick world“

→ How to get there...

... by railway and bus:
Rail connection Stuttgart-Tübingen. From the bus terminal 'Europaplatz' (next to the railway station) take bus no. 4 (direction 'Waldhäuser-Ost') and get off at the bus stop 'Corrensstraße/Tropenklinik'. Then follow the sign 'Tropenklinik'.

... by car:
Coming from Stuttgart on B27, take the exit 'Kliniken/Kunsthalle'. From here (as from any other direction) continue in direction Tübingen-Zentrum and follow the signs 'Tropenklinik'.



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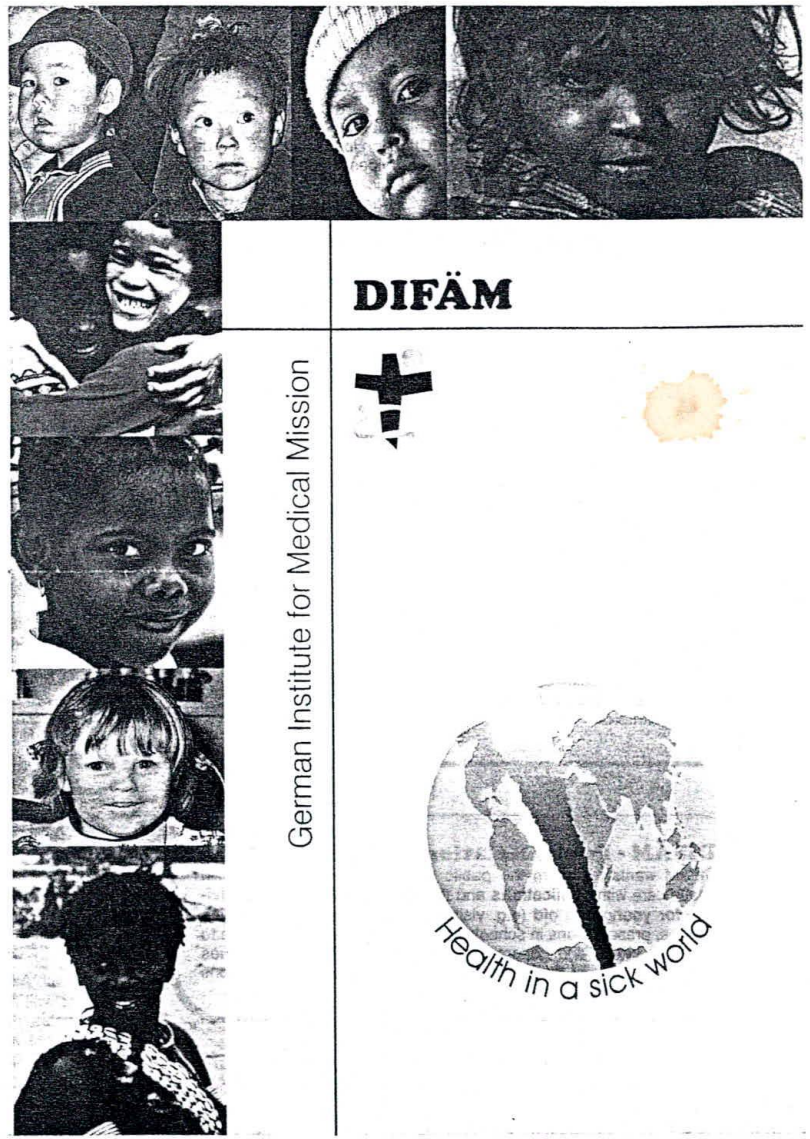

German Institute for Medical Mission

DIFÄM

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DIFÄM

DIFÄM - Consultancy:

DIFÄM, **a national church office for health care**, advises and supports churches, mission societies, church-related development agencies and other Christian institutions worldwide.
It offers professional services and practical assistance to nurses, physicians and other medical staff working in health care services overseas. The DIFÄM Pharmaceutical Department advises health care institutions overseas in the selection of essential drugs and in questions relating to appropriate technology.

DIFÄM - Pharmaceutical Department:

The DIFÄM Pharmaceutical Department supports Christian hospitals and health care institutions in more than 80 countries with **essential drugs** as recommended by the World Health Organization (WHO), and with **medical equipment**. It is an **official purchasing office** for the EKD Social Service Agency (Diakonisches Werk) and other organizations.

DIFÄM - Seminars:

DIFÄM regulary offers courses and seminars on **'Community Based Health Care'** and **'Tropical Medicine'**.
Furthermore, it organizes **interdisciplinary seminars** for theologians as well as for people working in social or health care services. Important issues are the exchange of experiences, the training in practical skills and the discussion on the Christian healing ministry.

DIFÄM - Study Department:

In close cooperation with the CMC - Churches' Action for Health of the World Council of Churches, the DIFÄM Study Department works on the **Christian understanding of health, healing and disease** and on principles of health care.

DIFÄM worldwide

The German Institute for Medical Mission - **tasks and objectives:**

DIFÄM, a national church office for health care activities, promotes Christian health care programmes worldwide and helps people to help themselves.

DIFÄM - Library:

The DIFÄM Library offers a wide range of **international publications** on health care (books, periodicals, teaching materials, posters etc.) with a special emphasis on the tropics and subtropics.

DIFÄM - Hospital:

The hospital **'Tropenklinik Paul-Lechler-Krankenhaus' in Tübingen** offers medical care to patients with tropical diseases, examinations before and after a stay in the tropics and vaccinations as well as general health care counselling for people who plan to travel to the tropics. Another important scope of work of the hospital is the medical care and treatment of elderly and chronically sick patients from Tübingen region.

DIFÄM - Public Relations:

DIFÄM wants to inform the public about ist various activities in health care with **publications** and the organization of many **activities for young and old** (e.g. visits in congregations, confirmation classes, presentations in schools, exhibitions, fairs, contributions to church services and congregational festivities). Important issues are the activities of the Pharmaceutical Department and questions concerning the global HIV/AIDS pandemic.

DIFÄM - Campaign:

The special campaign 'All people: Children of God!' wants to support people with **AIDS, leprosy** or **tuberculosis** as well as the **differently abled**. It promotes the integration of these programmes into general health care services overseas.

DIFÄM - Tübingen Project:

The Tübingen Project aims to provide **home care services for seriously ill and dying persons** in the Tübingen region. In cooperation with local health and social services centres, the project tries to provide nursing care and adequate pain control so that long admissions to hospitals can be avoided.

DIFÄM - German Institute for Medical Mission:

The ecumenically based German Institute for Medical Mission (DIFÄM) in Tübingen was founded in 1906 and is the institution **responsible for the hospital 'Tropenklinik Paul-Lechler-Krankenhaus'**.

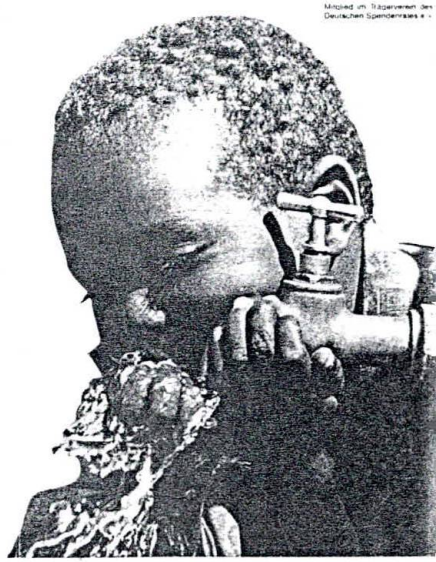
It is a **member** of the Association of Protestant Churches and Missions in Germany and of the Baden-Württemberg Diaconical Service (Diakonisches Werk).

DIFÄM cooperates with Protestant and Catholic missions and German church-related development agencies as consultants for the realization and support of health care programmes worldwide. DIFÄM is in close contact with churches overseas and with CMC - Churches' Action for Health of the World Council of Churches (WCC).

DIFÄM activities are mainly financed by donations.

Deutscher Spendenrat

Mitglied im Trägerverein des Deutschen Spendenrates e. V.



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A Muslim - Christian Dialogue on Equity and Resource Allocation in Health

Adnan A. Hyder and Christoph Benn

1. Define the specific position of one's faith concerning the topic in question

The Christian Position

- All human beings have an equal status before God and deserve fair opportunities in life.
- In the Holy Scriptures there is a special concern for the poor, the sick, and those needing special protection.
- Measures have to be taken to counterbalance the effects of human greed and the misuse of power.
- The main criterium for assistance is need.
- The rules of justice are defined in the law of God revealed to man. The law has to be fulfilled.
- Love goes beyond justice in doing more than is required by law.
- Justice and love apply to everybody irrespective of national boundaries or ethnic backgrounds.

The Islamic Position

- The only morally relevant difference between people is "closeness to God".
- The vulnerable defined in any way - the poor, the sick, the aged, the infirm - have special status such that their needs need to be looked after
- The distribution of benefits - of any type - needs to be monitored both by the individual and the society
- This distribution needs to be towards the favor of the disadvantaged and for the reduction of morally irrelevant inequalities.
- The application of this justice is for the Muslim ummah globally, and to include the non-Muslim people of the world.

2. Explore the main ethical/philosophical arguments for this position

The Christian Arguments

The consideration of the Christian meaning of justice and equity has been based mainly on the Holy Scriptures consisting of the Old Testament and the New Testament. It is a search for insights gained from the most accepted texts of Christianity. However, no attempt was made to do an analysis of how these concepts were applied historically by Christians nor were the differences in interpretation between different christian denominations or churches taken into consideration. These differences do exist and to put principles into practice they have to be applied to concrete political and socioeconomic contexts. Although desirable this kind of comprehensive analysis was beyond the scope of this background paper. It was also decided by the authors that a comparison of the foundations and ideals of a particular religion is more appropriate for a first step in interreligious dialogue than the more divisive issues of the historical context including cultural, ethnic and political aspects.

The basis of any consideration of justice in the Holy Scriptures is the equality of status before God which is shared by all men and women. Every human being has been created in the image of God (Bible: Genesis 1,27) and this quality belongs to all, independent of any other differences.

The Hebrew word for justice sdq describes good and harmonious relationships between God and man and between different human beings. God is the one who is just. He has given mankind his good order and a just man is the one who follows this order. The main source for the good order can be found in the law of Moses (tora).

In the New Testament we find four different concepts of justice:

a. Justice as an attribute of God

Justice is primarily related to God. It is not an abstract principle relating to the political or social order but a religious term describing what is demanded for man to do. Human justice is a response to God's justice that human beings can experience.

b. Justice as justification

God's justice is evident in the undeserved justification of man. The justification provided for man by God himself as a gift out of grace. The freedom from sin and guilt achieved through justification by God leads not so much to justice but to a responding love.

c. Justice and the law

Justice as understood in the New Testament does not replace the law of Moses. Jesus was a Jew. He acknowledged the validity of the Jewish law and ordered his disciples to practice strict adherence to this law. However, in several of his sermons he asked his disciples to go beyond the strict requirement of the law. This is sometimes called the "new justice" in the New Testament (Luz 1989).

Justice is not denied as an important value but love goes beyond justice demanded by law.

d. Justice in relationships

Justice in relationships is understood as the actual deeds of one person toward the other. Justice is something you do and not so much the abstract order regulating the relationship of an individual toward the community in which he or she lives. An example is the story of the Good Samaritan who helps a person who was wounded by robbers. He shows compassion and mercy although it is not his duty and although he is from a different ethnic background than the victim (Bible: Luke 10, 25-37). This story is the answer to the question: Who is my neighbour? The answer is that anybody is your neighbour who is in need of your help.

Distributive justice or equity is even less a theoretical concept in the Bible than justice as such and there is no specific term for equity. But certain aspects of the law of Moses, of the sermons of the prophets as well as of the parables and teaching of Jesus can provide us with valuable insights.

Throughout his ministry Jesus taught about love to one's neighbor which was for him closely related to the love of God. He warned about the dangers of accumulating material wealth and asked people to give up their riches in favour of the poor. The motivation for this demand was

not so much social change and an egalitarian society but the drive for spiritual perfection. Therefore Jesus was certainly not a social reformer fighting for justice in a modern sense of this term but a religious reformer who expected radical change in the personal lives of his disciples. In general Jesus' teaching was more about love and compassion than about equity.

Love is about face-to-face relations between different persons. Love involves not only a particular action but the whole person. It goes beyond what might be rationally expected of a benevolent person. Love never contradicts or obstructs justice but goes beyond the demands of justice. After justice has been fulfilled love will do even more.

Christian theology and ethics has not only reflected on the understanding of justice in the Holy Scriptures but has also been influenced extensively by philosophy and secular thinking. In particular Greek philosophy as the dominating school of thought in the mediterranian culture of that time provided crucial insights to christian theologians throughout the centuries. The most influential school of thought for christian theology was that of Aristotle. He regards justice as the most complete virtue and taught that justice means to give everybody one's due. Equals should be treated equally and unequals unequally in proportion to the relevant inequalities.

The Islamic Perspective

The attributes of an Islamic society are ensconced by following the principles of Justice (adal or insaaf), brother hood (unity) and a dynamic equilibrium of rights and obligations. Justice has been quoted in the Quran more within the context of just decision-making and fair judgements for differences amongst people. Brotherhood is used to promote the concept of inter-dependency between each person within an Islamic society. Such that either by being a relative, dependent, neighbor, poor or other, each individual has some linkage with others. Thus the Islamic society is to be seen as unitary entity comprising individual parts, rather than the reverse. It is important to note that this concept of the Islamic society does not have geographical boundaries and may be used to illustrate local, regional, national or supra-national entities.

The interplay of rights and obligations in an Islamic society is what maintains a live link within the concept of an organic whole. Each individual has rights which define their

expectations within the social dynamics of the family and society. At the same time there are distinct responsibilities that come with each role that have to be carried out. In addition there are obligations towards God that each individual and the society as a whole needs to fulfill.

Islam does not recognize any differences between individuals to be of substance to their destiny except for their closeness to God. All other differentials are for worldly purposes, and the only one that matters is how pious (taqwa) is the individual. Therefore, for all intents and purposes, all are equal. Differences of gender, age, color and others are seen as a tribute to the powers of creation of God, such that no one individual is exactly similar to the other. Therefore, the distribution of benefits based on these features should also be egalitarian unless it is for the benefit of the under privileged. This is the one category of persons that has been grouped separately on the basis of the challenges that God has put them in - for which they will emerge successful. This group of people may have different types of worldly disadvantage (not moral) such as lack of money, power and social status. Moreover they can be in such a state for a long time (mimicking permanence) or for a temporary period of time. These are the poor, the orphans, the wayfarers and the needy. A difference in their health status is therefore unacceptable based on these attributes. This is therefore a case for the active reduction of inequities between groups of people.

Though the word equity does not appear in the Quran, words denoting egalitarian society, universal brotherhood and inter-dependence of people have been clearly expressed. These concepts denote an active movement for the recognition and demonstration of unity within the larger Islamic community (ummah). Thus a case for the active search for equity is also made and the active notions of seeking equity and reducing inequity in health in Islam have to be operationalized within the context of provision of resources and opportunities. These principles mandate the distribution of resources to the advantage of the poor and other vulnerable groups.

However, allocations of state funds are not the only means of reliance on achieving such equity. Social and financial safety nets have been actively promoted in Islam as defined by functions of the Islamic state and the individual. Zakat or income-based charity is mandatory on those individuals who qualify (based on annual wealth holdings). This represents 2.5% of the annual wealth and is to be either given directly to the poor in the absence of state mechanisms or through a state controlled means.

There is an integral and interactive relationship between poverty and health. Poor people are much more likely to be unhealthy, and when they fall ill are more likely to stay ill and recover to less than optimal levels. Unhealthy people are also more likely (in the long run) to face economic consequences, especially if they are living on subsistence levels, as happens in most developing countries. This relationship is difficult to tease out and is complex even in the interventions taken to-date. However, if people are prevented from falling into poverty, assisted in improving their incomes and helped with catastrophic life events then there is a higher chance that they will not fall in the poverty-ill-health crisis. A true re-distribution of funds in an Islamic society will therefore achieve this purpose thus favoring a better health status for all and specifically those who are more unwell.

3. Specify the areas of agreement with the discussion partner from a different faith

There is broad agreement on the understanding of equity and the need for a more just global allocation of resources in health. There is also agreement that Islam and Christianity share some important roots, e.g. both are based on Holy Scriptures and have originated in closely related geographical and cultural contexts. Both religions recognize the teachings of Moses and Jesus is recognized by Muslims as an important prophet. These historical connections need to be strengthened in the real discourse between peoples of both religions.

Statements agreed upon by Muslims and Christians:

- Man is created by God
- All human beings share the same value and status which constitutes the basis for an egalitarian distribution of rights and benefits
- There is a special provision for the orphans, needy and wayfarer
- We meet God by caring for the sick
- The modern term equity is not a specific concept in our Holy Scriptures
- We can however get insights and inferences from stories and teachings
- We both refer to arithmetic justice "to each his or her due" although it is a philsophical concept not directly derived from the Holy Scriptures but from philosophical interpretations

4. Specify the areas of disagreement with the discussion partner

It is challenging to identify any areas of clear disagreements but there are some concepts which require further clarification.

The concept of individual and community.

In the early Christian tradition there has been a strong emphasis on the person that is in relation to others - in particular the extended family system and the membership in the Jewish faith community. Later on through the reformation and the period of enlightenment there was a stronger emphasis on the individual in his/her direct relationship with God. A person is justified by God through his or her individual faith in Jesus Christ. Community in the form of a Christian congregation is still important but the individual is a sufficient entity with rights and responsibilities. This more individualistic approach has helped to come to terms with the concept of human rights which is not a Christian idea but presupposes an understanding of a person having intrinsic rights over against governmental and religious authorities.

Two important points for the Islamic position. The individual has distinct roles and responsibilities that define the equilibrium between that individual and the society. There is a dynamic interface between the responsibilities towards others and the rights that define each person. The latter lead to the expectation that others have obligations towards the individual as well. These "rights" have been as explicitly defined to make each interaction a bilateral give and take situation.

The relationship of the individual with God is direct - in some ways more than in Christianity as there is no interceding by Christ even in prayers. Rather, man is directly responsible to God and must take individual responsibility for all actions irrespective of the role of society. This is true for most of the roles that are defined by personal action. In addition there are some specific roles which are societal in nature and are directed to the group rather than the individual. For example, funeral prayers in a neighborhood (for a resident) may be attended by some people to fulfill the obligations of all the people in a neighborhood. Thus, there are two different kinds of spheres of human existence in Islam - one which can only be defined by individual human action, and the other where collective action defines the roles.

People outside the "brotherhood": are there obligations towards those?

The responsibility of those in the religion towards those of other faiths is emphasized in Islam in many ways. Protection and provision of civil services for those living in the community (irrespective of faith) is mandatory. In an Islamic state, the state must protect all while those of other faith may or may not contribute (indicating that it is not necessary for them to contribute to the protection). Similarly, helping those in need is not related to their faith - it is defined by need.

The Christian teaching emphasizes that God's love extends to all people irrespective of their own religious or ethnic background. There are even quite a lot of stories in the New Testament showing that people from a different background are in many ways closer to the "Kingdom of God" and are portrayed as good examples for Jesus' disciples, e.g. The Good Samaritan, the Roman soldier, the Syrophoenician woman. Therefore the ideal is that the Christian should respond to God's universal love and extend his love and concern to all fellow human beings and help those in need irrespective of their background.
To pursue a hypothetical case where resources are very scarce (such that you can help only one person of two) and there are two people to help - one of your faith and the other not. Would preference be give to the one of one's faith over the other, or would there be a case for seeing who is more "needy" and then helping that person irrespective of faith? Such an exploration would be worthwhile.

5. Identify the common ground for further discussion and continued dialogue

To explore further the understanding of love and justice and the relationship of love going beyond the demands of the law (of justice).

Three related points pursuing the Islamic perspective:

- Laws in Islam are only to be enforced within the presence of an Islamic welfare state. Scholars (Fazal-ur-Rahman) have indicated that punishments can only be applied if all persons can eat and live at an acceptable minimum. A starving persons cannot be held responsible for stealing food - it is the fault of the state to have conditions such that persons are starving.

- Islamic injunctions define the minimum standard that either must be done or is acceptable. The maximum is never defined but always stated as being left to the state and actions of people. Thus the minimum requirement for giving charity and alms have been clearly defined while love of those in suffering and love for God will define how much more a person or people will do. Examples from the behavior of the companions of the prophet indicate that the desire to help, to love God and love the prophet made it easy for these persons to give away their entire households in the way of God.
- The concept of love in Islam extends to all humans and to all forms of life in earth. They are to be regarded as the creation of God and man is the "highest form" of this creation. Thus animals and insects should not be destroyed unless there is need for human survival or danger to mankind. Glimpses into the life of the prophet indicate his concern for the welfare of animals and active efforts to ensure that they are treated with love and kindness. Similarly, the main characteristic of his dealings with all mankind (those in the faith and those not) was kindness and compassion. It is these types of behaviors that defined the universality of mankind in the eyes of God.

How does the concept of giving alms relate to the principle of doing justice and changing the conditions leading to poverty and ill health?

Islam and Christianity would agree to such a case. In addition, poverty and ill-health can be the main weave that can help us see the common purpose of all religions on this earth. We need the love of God as expressed through the love of all mankind to help suffering people.

6. Highlight areas that need further research and/or reflection

We need further reflections on the consequences of our religious convictions for the distribution of resources in health. Could we find a religious consensus, with other religions, to demand a more egalitarian distribution of resources in national and international health leading to more equity?

Looking at the concepts of justice and love in Islam and Christianity advocate an allocation of resources at community, national, and international level that provide an adequate level of health care and reduce current inequities at all these levels. This can only be achieved by giving preferential treatment to the most disadvanteged groups in any given society. All

human beings should have access to resources in health permitting them to lead healthy and productive lives facilitated by a defined level of basic quality health services. On an international level resources have to be shared according to ability to help and to need. The obligations of people and nations commanding a aufficient level of resources extend beyond their own ethnic, religious or political communities.

Christianity and Islam share great truths - they need to be shared more effectively.

New forms of engagement are required to break historical suspicions between religions. Health is an avenue where this can be attempted.

In the Muslim tradition there is an impetus for believers to set aside theological disputes and meet on the common grounds of ethics:

> "If God had willed, He would have made you one single community, but He wanted to test you. So vie one with another in good deeds. To God you will return, and He will decide wherein you differed".
> (S V:48)

In view of current global reality, it is most important to identify and reaffirm the set of "common goods" of priority. These include integrity and the dignity of humankind and thus any act against this is to be seen by both as an act against God. Therefore, this can define the common struggle for human rights, against poverty and for justice.

Human rights

Our discussion of equity and justice in health is closely related to the discussion of human rights. Nowadays we are talking about three generations of human rights. The first, are the civil or political rights as embodied in the universal declaration of 1948. They are aiming at the protection of the individual over against the state and its executing authorities. It is defending the liberty of the individual person to exercise his or her right to freedom and right to non-interference by the state.

The second generation are the social and economic rights as embodied in the International Covenant on Economic, Social and Cultural Rights of 1966. It includes rights to certain services and condition as e.g. the right to health in a broad sense and to health services in particular.

The third generation are usually interpreted as the rights of communities or societies e.g. the right to development. These are collective rights extending not to individuals but to societies or nations.

Could there be a consensus among major world religions concerning the justification and implementation of these rights? Can we come closer to a common understanding of a definition of the right to health? Can we agree on the rights of disadvantaged communities or nations to a broad definition of social and economic development? Do only societies have a legal claim to developmental progress or can individuals hold their governments and authorities responsible for failed developmental progress and violations of social human rights?

Reality and practice

Despite the theological perspectives a review of current reality will demonstrate that countries that have one or the other faiths as dominant have different practices.

Interreligious Dialogue on Bioethics 5. – 8. Oktober 1999
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THE ROLE OF THE CHURCH IN DELIVERY OF SUSTAINABLE HEALTH CARE: REFLECTION ON BASIC THEOLOGY AND ETHICAL PRINCIPLES

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Paper presented to Workshop on Sustainable Health Care
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[DRAFT]

THE ROLE OF THE CHURCH IN DELIVERY OF SUSTAINABLE HEALTH CARE: REFLECTION ON BASIC THEOLOGY AND ETHICAL PRINCIPLES

Health care has long been associated with the mission of the church to evangelise, to bring the Good News to all nations. In Mark's account of the missioning of the first disciples after the Resurrection, Jesus promises that believers would "place their hands on sick people, who will get well." (Mark 16:18) This ministry of healing is a continuation of Jesus' healing activity. Throughout the Gospels, we have examples of the cure of the sick as a integral part of the preaching of the coming of the Kingdom of God (e.g., Luke 10:9). In its missionary activity worldwide, the church has always had a role in the delivery of health care.

Will that delivery of health care be sustainable? This question that we struggle with during this workshop takes on a particularly urgent character when we reflect on the reality confronting the countries that serve as the focus of our attention, the "countries with limited resources." (Is this the *politically-correct* language for the "poor countries"?)

My own reflections come from the stance neither of a theologian nor a health-care professional. My training is in the political economy of development and my immediate experience is in a very poor African country. Therefore in preparing the topic assigned to me, I was particularly touched by the message of the World Health Organisation's publication earlier this year, *The World Health Report 1995: Bridging the Gaps.* I am sure that many of you also have read this and have equally been touched by the power of its opening paragraphs:

> The world's most ruthless killer and the greatest cause of suffering on earth is ... extreme poverty.
>
> Poverty is the main reason why babies are not vaccinated, clean water and sanitation not provided, and curative drugs and other treatments are unavailable and why mothers die in childbirth. Poverty is the main cause of reduced life expectancy, of handicap and disability, and of starvation. Poverty is a major contributor to mental illness, stress, suicide, family disintegration and substance abuse.
>
> Poverty wields its destructive influence at every stage of human life from the moment of conception to the grave. It conspires with the most deadly and painful diseases to bring a wretched existence to all who suffer from it. During the second half of the 1980s, the number of people in the world living in extreme poverty increased, and was estimated at over 1.1 billion in 1990 -- more than one-fifth of humanity.[1]

Our discussions here go on in the face of this recognition that poverty is the number one health problem in today's world. What we say about the church's role in the delivery of sustainable health care must of course address that sad fact. My contribution in this presentation is to provide some contextual theology and macro-ethical principles for us to reflect on as we look at this topic.

A CHANGING CONTEXT

Today the delivery of health care by church-related institutions and organisations continues to go on around the world as it has for many centuries. But within many of the countries with limited resources, there is a new context for the church's role. This new context is marked by two significant movements, two important transitions. These are the movements toward (1) *political democratisation* and (2) *economic liberalisation.*[2] The first provides a new

context for church-state relations, and the second a new context for meeting the economics of health care. Because this topic is so broad, let me narrow it to the continent of my own experience, Africa, and be very specific with examples from the country of my own mission, Zambia.

Political democratisation is the transition from authoritarian regimes to forms of government that allow greater popular participation under a constitutional rule of law that respects basic human rights. The 1960's in Africa was the period of "First Independence," when freedom from colonial rule was achieved and national identity secured. Hopes were high, as majority rule governments took control and parliaments with multi-party organisation were put in place. But the experience of full freedom and dignity was short-lived in many if not most of the new African states. For a variety of reasons, internal and external, the hopes of the First Independence gave way to the rise of one-person and one-party totalitarian rule, and, in many instances, the oppression of military dictatorship. By the end of the 1980's, out of the 44 sub-Saharan African states, some 38 were governed by authoritarian regimes.

Then a new experience of "Second Independence" began in the 1990's throughout Africa. Again for a variety of internal and external reasons, there has occurred a move toward political democracy, the rise of or return to a system of multi-party competition, the respect for a free press, and the hope of protection and promotion of basic human rights. In Zambia, for example, we ended a period of 27 years of one-person, one-party rule with a peaceful transition in 1991 to multi-party democracy. Other African countries have experienced similar transitions. South Africa, of course, is the most dramatic instance of transition to democratic majority rule and offers the greatest hope even amidst extremely difficult circumstances.

But the political democratisation movement is still too young to make evaluations of its success or predictions of its sustainability. In many parts of Africa there have been setbacks -- most notably in Nigeria with the retention in power of a cruel military dictatorship. But what is important for our discussions here is that the movement for political democratisation provides a new context for the church's mission of health care. Another paper of this Workshop will specifically address church and state relations. Here it is sufficient to point to two questions that arise: (1) is a democratic context more conducive to the orientation of health care under church sponsorship? and (2) does sustainable health care itself require today a more democratic style?

Economic liberalisation is the transition from a centrally-planned, state-controlled economy (socialism) to a free-market, privatised economy (capitalism). For a variety of reasons, internal and external, African economies declined in the period after Independence. Deteriorating terms of trade, increasing debt burdens, mistakes and misplaced priorities meant a fall in production and a decline in standards of living. Basic services and infrastructures deteriorated. Social indicators of health and education that had risen after Independence took a turn downward. By the end of the 1980's, of the poorest forty nations in the world, 27 were in sub-Saharan Africa.

In an effort to turn around the economic decline of Africa and address the serious problems of widespread poverty, the international donors began pressuring governments to change significantly the direction of their economies. The model of change adopted was that formulated by Northern economists associated with the International Monetary Fund and the World Bank. The "Structural Adjustment Programme" (SAP) is an effort to bring short-term *stabilisation* (e.g., through devaluation, budget constraints, credit restrictions, etc.) and long-term *restructuring* (e.g., through removal of price controls, privatisation, trade liberalisation,

etc.). Faithful adherence to this economic liberalisation is now a condition for any further aid and assistance.[3]

The experience of a country like Zambia is illustrative of the problems created by SAP. First, there is widespread suffering of the people. The elements of SAP such as the withdrawal of subsidies, imposition of fees in health and education, and retrenchment of workers impose especially hash burdens on those who are already suffering. This is a point strongly made by the Zambian Bishops in their 1993 Pastoral Letter, *Hear the Cry of the Poor*. Second, there is serious questioning of the long-term development consequences of SAP, since it does not address questions such as employment generation, agricultural production to feed the nation, the informal sector, regional cooperation, and the environment.

This is not the place to go into detailed analysis of the economic liberalisation movement. Other workshop papers will take up questions of resources, financial aspects, etc. But it is possible to point to two questions arising in this new context for the church's health care mission: (1) What is the impact of increased poverty and suffering of the people on demands made on the church's health mission? and (2) Will governments make increased efforts to put health care back into private hands of groups like the church?

The context for the church's health care mission is of course affected by other important events on the continent of Africa, all deserving much more analysis than is possible here. These events include:

- The rise in internal conflicts such as that experienced in Somalia, Liberia, Rwanda and Burundi, and the danger of regionalisation of these conflicts
- Increased numbers of refugees and internally displaced people, caused by these conflicts and also by natural disasters such as droughts and pestilence
- The HIV/AIDS pandemic with consequences not only for health care but for economic development and political stability

THEOLOGICAL REFLECTION

Theological reflection is necessarily *contextual*. For this reason, this paper has begun with an analysis of the changing context. To discuss the role of the church in the delivery of sustainable health care it can help to provide a theological model that addresses the challenge posed by the two movements of political democratisation and economic liberalisation. Such a model will by no means provide specific answers for the difficult practical questions of day-to-day health care but can provide a framework for evaluation of what is currently going on and for stimulation for our thinking and planning about new directions for the future.

I want to suggest as a theological model the three-fold action of the *Good Samaritan* that we find in the well-known Lucan parable (Luke 10:30-37). The Samaritan's response to the health care needs of the person beaten by robbers and left for dead along the Jerusalem-Jericho road included these elements:

- *compassionate awareness*: not ignoring the needs despite pressures to do so
- *effective immediate response*: providing personal care even at great expense

- *long-term structural response*: providing institutionalised care in cooperation with others

To begin with, the church's sustainable health care must be *compassionate*. One writer describes compassion as "that divine quality which, when present in human beings, enables them to share deeply in the sufferings and needs of others and enables them to move from one world to the other; from the world of helper to the one needing help; from the world of the innocent to that of sinner."[4] Jesus in his ministry is certainly the model of compassion, as again and again we are told in the Gospels that he is moved with compassion to take some healing, comforting, uplifting action (e.g., raising the widow's son, Luke 7:13; feeding the 5000, Mark 8:2; teaching the crowds, Mark 6:34) ; healing the sick, Matthew 14:14).

Coming along the road to Jericho after the priest and Levite, the Samaritan sees what they also had seen: a man lying badly injured in the road. But the Samaritan sees with the eyes of compassion and enters into the suffering man's world. His awareness is not blocked by the pressures of going off for other important business, of fearing what involvement might bring, of revulsion toward such pain and anguish. He does not ignore the needs of the man precisely because he has been moved by compassion; his is a compassionate awareness, much deeper and much more compelling than the superficial and selfish awareness of priest and Levite.

In today's context of economic reductionism, there is little place in government and business policy circles for compassion. The neo-liberal economics that guides structural adjustment programmes creates pressures to ignore and marginalise the poor and the suffering. Compassionate awareness is blocked by systemic emphases on budgetary constrains, competition, efficiencies, bottom-line exigencies, etc. Furthermore, the sheer magnitude of human suffering in much of the world has given rise to the frightening phenomenon described as "compassion fatigue": people are simply exhausted, worn-out and wearied by stories of and contact with those who are suffering. "Don't tell us any more! We've done our part!" (Who knows, possibly the priest and the Levite had just come from tending to the needs of many others who had been beaten up on the road to Jericho?!)

This theological model tells us, therefore, that sustainable health care in today's context must be motivated by a compassionate awareness that may be pressured and may be wearied but is never blinded.

The second thing to note in the Good Samaritan model is the *immediate personal response*. The Samaritan takes time to become personally involved, providing what help he can at the moment: "he poured oil and wine on his wounds and bandaged them; then he put the man on his own animal and took him to an inn, where he took care of him." (Luke 10:34) Throughout the Gospels, we have stories of how Jesus reached out and touched someone in need, a sign of his personal involvement (e.g., curing a leper, Luke 5:13; straightening a crippled women, Luke 12:13; healing a deaf-mute, Mark 7:33; comforting Peter's mother-in-law, Matthew 8:15; feeding his own disciples, John 21:13). His was not a distant, aloof, detached ministry. He became personally involved and shared whatever he could, most especially his loving presence and personal touch.

What does this personal involvement shown in the Good Samaritan model say to our efforts for sustainable health care in today's context? As I will explain in greater detail later in this paper, there is a serious tension in health care in the industrialised world between two competing models of health care: health care *ministry* and health care *industry*. In the former

model, there is more personal, hands-on emphasis; in the latter, a technical, specialised approach means greater de-personalisation. But as you know so very well, personal involvement, the personal touch, is a medicine that no amount of technological sophistication can replace.

Our theological model thus points to the fact that sustainable health care must emphasise personal involvement of health-care givers.

Finally, we need to take note of the *long-term structural response* present in the Good Samaritan model. Not only was the Samaritan compassionately aware and immediately involved; he was also committed to further assistance through arrangements that involved planning, financing, and cooperative efforts. "The next day he took out two silver coins and gave them to the innkeeper. 'Take care of him,' he told the innkeeper, 'and when I come back this way, I will pay you whatever else you spend on him.'" (Luke 10:35) The Samaritan took steps to institutionalise the care given so that it would be effective. As important as his own immediate and personal care was for the injured person, it was not enough.

This "institutionalisation" of loving care has been a mark of church-related health care over the years, in the best sense of the word. Hospitals, clinics, hospices, homes, etc., are all ways of assuring that the loving care can go on. Indeed, the establishment of these institutions by the church was a significant step toward "sustainability" of health care before that phrase ever became popular. In the tight economic situations of today in countries with limited resources, commitments to institutions may be more difficult but also more necessary. The control over these institutions -- not simply in financial terms but also, and more importantly, in terms of values -- is also a serious challenge in the new political environment.

Thus, sustainable health care in today's context must, according to our theological model of the Good Samaritan, find ways of effective institutionalisation of the compassionate and personal response of the church.

ETHICAL PRINCIPLES

In looking at ethical principles that would guide the church in the delivery of sustainable health care, I want to make an initial distinction between the *macro*-ethical and the *micro*-ethical.

- *Macro-ethical* principles guide societal and institutional response and refer to topics in social policy areas such as access of the poor to facilities, priorities for the future, etc.

- *Micro-ethical* principles guide individual response and refer to topics in personal choice areas such as contraception, maintenance of life-support systems, etc.

Because my own training and experience is in the field of the political economy of development, my focus here will necessarily be on the macro-ethical principles. Someone with more specialised medical ethic background would have to address the micro-ethical principles. But I will say this. From my involvement in consultancy with church-related health care systems in the United States in the 1980's, my impression is that considerably more attention has been spent on the micro-ethical issues that on the macro-ethical issues. That has meant in practice that some very significant points regarding institutional practices have not been subjected to as critical an ethical evaluation process as have been individual

practices of medical personnel. An obvious point is that the ethical demand of concern for the poor -- the implementation of the church's mandatory "option of the poor" -- has significant consequences that should affect institutional decisions and policies.[5]

For provoke our discussion here this morning, to stimulate questions in our discussion groups today, and to focus our potential resolutions in the days ahead, let me suggest a set of four macro-ethical principles that should guide the role of the church in the delivery of sustainable health care. These principles are related and all can be rooted in the theological model of the Good Samaritan that I have presented. As you hear the principles, I ask you to apply them to your own specific experiences and test their validity and relevancy.

Sustainable health care in today's context should be primarily:

1. Ministerial (not industrial)

"Sustainable health care should follow a ministerial model and not an industrial model."

This first and indeed foundational principle states very simply that providing health care is a form of service in and for the community before it is a form of economic activity, a commodity exchanged for profit. Care is to be provided for whoever needs it. Who pays for that care is an important consideration, but it definitely is a secondary consideration. This at least has been the traditional ethic guiding health care over the years.

Now this principle may be simple to state, but it is increasingly difficult to implement. Of late, particularly in the rich countries, health care has followed more of an *industrial* model than a *ministerial* model.[6] This is understandable given the pressures arising when health care assumes the economic proportion it does. For example, in the Untied States of America health care currently accounts for more than 14% of the annual GNP. The fastest-growing sector of health care activity is the for-profit sector.

The *ministerial* model of health care emphasises:

- the service of persons with respect for equal dignity of all
- a holistic approach relating to the whole person in the whole community
- a focus on the spiritual dimension of the person
- a preference for the poor, the so-called "option for the poor"

The *industrial* model of health care emphasises:

- the pursuit of profit for a return on investment
- specialisation for efficiency with attention to individual parts
- technological effectiveness
- competition in order to survive economically

Although these models can be complementary -- one must survive in order to serve! -- they also can be conflicting in the values, directions, standards and ethos of an institution. For example, the option for the poor may be pressured to give way in the face of stiff competition and budgetary constraints. Sustainable health care in a church-related institution in today's political and economic context must be guided by this macro-ethical principle of ministerial service if it is to maintain the religious character, the link to Jesus' ministry of evangelisation, that was the mark of its founding.

2. Holistic (not isolationist)

"Sustainable health care treats the whole person in the whole community, not isolating personal parts from the rest of the body or individuals from the rest of the community."

This ethical principle recognises that a human person is not a unique organism with isolated problems, but a whole. Not just a whole individual person either, but a part of that whole that is the web of relationships to the wider community, to the person's family, to their work, to their social situation.

Sustainable health care is guided by this principle when it avoids a hyper-specialised approach to taking care of a sick person or to preventing illness. I am more than my inflamed appendix, more than my malaria-caused fever. There is a spiritual dimension to my existence, in the sense of my beliefs, my hopes, my loves. This dimension too must be taken into account when I am seeking health care. For example, other professionals in society must be recognised besides simply the physician or the nurse. Religious personnel are not simply for offering "spiritual consolation" but have a significant role in the preventive and curative processes.

Moreover, I am not alone, a *lone* individual. There is a *societal* dimension to my existence, a dimension that cannot be ignored in diagnosing needs and in prescribing remedies. Families, support groups, work places, all come into consideration in an holistic approach. And the cultural aspects of my existence are likewise seen as important. This is especially true where explicit cultural emphases are significant factors in holding a society together and in giving it its identity.

One consequence for sustainable health care guided by this holistic principle: the role of the traditional healer and of traditional medicine assumes a much more important role. This is certainly true in Africa. Recently I was speaking with some African friends who told me of the significance of advice from traditional healers and of the use of herbs, special diets, etc., that followed traditional patterns. They were not speaking of consulting the *ng'anga* (witch doctor) for medicines to seek revenge or enhance domination. Rather, they sought to be in touch with the wisdom of a community that knew health remedies before the chemistry, technology and "scientific rationalism" of Western medicine came to control so much of health care activities. There is greater interest today in this traditional wisdom. It is certainly in line with the holistic ethical principle we have been speaking of here.

3. Structural (not symptomatic)

"Sustainable health care should take account of the structural causes of sicknesses and not deal only with the symptoms."

It is certainly clear from our earlier discussion of the changing political and economic context that sustainable health care is profoundly affected by what is occurring today in countries with limited resources, such as African countries. The structures of political participation and of economic distribution touch the life and the livelihood of every individual. Institutions and services of health care are themselves involved in the transitions taking place around them.

It is for this reason that church-related sustainable health care must be guided by an ethical principle that recognises the deeper causes of sickness in society, especially sicknesses that affect the poor. Dr. Paul Farmer, a physician and anthropologist at Harvard Medical School who has worked in rural Haiti, has argued that health care is ineffective in poor societies unless it addresses the deeper, poverty-related forces that are the root causes of many of the serious diseases on the increase, such as tuberculosis.[7] If TB, for example, is viewed as an exclusively biological phenomenon, then available resources will be devoted to pharmaceutical and immunological research. If the problem is viewed primarily as one of patient compliance (e.g., whether or not medicine is taken, diet is followed, etc.), then plans will be made to change the patient's behaviour. But if a more serious structural analysis is done, and the poverty-related forces are identified (e.g., overcrowding, hunger, lack of education, inability to pay for drugs, etc.), then effective sustainable health care must also necessarily address these forces.

What strikes me about Dr. Farmer's analysis is that it is remarkably substantiated by the *World Health Report 1995* that I referred to at the opening of my remarks. According to WHO, "The world's biggest killer and the greatest cause of ill-health and suffering across the globe is ... extreme poverty." And this poverty affects people in a variety of ways. Let me give an example that I know of from personal experience in Zambia. The UNICEF efforts to promote universal immunisation have been very successful in our country -- a rate of 88% for tuberculosis, for instance. But this rate has been falling off in the past year or two, as very poor parents have stayed away from clinics that now are charging user fees (because of SAP). Although the immunisations are free, they are associated in people's minds with clinics that charge fees for other services -- and are avoided!

Health care cannot, of course, solve problems of poverty. The point I am making is that sustainable health care must be guided by a macro-ethical principle that recognises that sicknesses and ill health are in many instances caused by the deeper societal structures of poverty, inequity and injustice. It does not help to address only the symptoms; the structures must also be addressed.

4. Liberative (not dependency-building)

"Sustainable health care should be liberating to all those involved, health-care givers as well as receivers, and not build dependencies."

In countries with limited resources, one of the most serious challenges in the development process today is to avoid building bonds of dependency. A major critique offered in recent decades of "developmentalism" -- the political-economic ideology espoused by many Northern countries and donor institutions -- has been that it ignored the structural dependency existing in North-South relationships. Structures of trade, aid, investments, and monetary arrangements have all maintained the dominant influence of the rich countries.

These dependency relationships can, of course, also go on within and between organisations and between individuals. It is thus a challenge to design and implement relationships that are liberative and not dependency-building. This is true in the efforts of sustainable health care. On the level of individual interactions, it is important that the style of exchange between the health-care giver and receiver be such that people are empowered to build on their own ideas, to make new discoveries for themselves. The people must become actively responsible for their own and the community's health. To use the expression of Paulo

Freire, people become *subjects* of their own development, not *objects* of someone else's efforts to develop them.

In Zambia, we make use of a popular development education approach called "Training for Transformation" that is based on Freirean methodology.[8] (It is also used in several other countries in eastern, southern and western Africa.) I myself have participated in programmes with health care workers in which the emphasis has been in the liberative direction. Local communities build their own clinics; local health workers involve people in education, nutrition, sanitation, and environmental programmes. The well-known handbook for village health care, *Where There Is No Doctor,* is another excellent example of promotion of a liberative health care approach.[9]

There is also the sensitive issue of the dependency on outside funding of church-related health care efforts in countries of limited resources. This is surely an issue of importance for the members of this audience and for the CIDSE/Caritas Internationalis sponsors. The dilemma is that without some outside assistance, much health care would be curtailed. Yet the question arises: does outside assistance build dependencies and also absolve local governments, groups and individuals from their political and personal responsibilities? (This is not an academic question for me in Zambia, since I personally arrange for donations of much-needed medicines to be shipped from the United States to our mission hospitals that experience the constraints of severe national poverty.) The African Synod message of last year made the point in general terms in a paragraph significantly entitled, "Examination of Conscience of the Churches in Africa," when it stated: "Our dignity demands that we do everything to bring about our financial self-reliance."[10]

CONCLUSION

What "sustainable health care" demands in the situation of countries with limited resources will become more clear over the remaining days of this workshop. What I have attempted to do in this presentation is to provide an analysis of the context of political and economic transition; to offer a model of contextual theology based upon the compassion, personal involvement and institutional commitment shown by the Good Samaritan; and to suggest a set of macro-ethical guiding principles that emphasise a ministerial, holistic, structural and liberative approach.

I close where I opened, by repeating the message of the World Health Organisation: "The world's most ruthless killer and the greatest cause of suffering on earth is ... extreme poverty." Can we of the church find a role in the delivery of sustainable health care in such a world? Faithful to following the way of Jesus who said, "I have come that they may have life and have that life more abundantly" (John 10:10), we must seek our role humbly, wisely, courageously.

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ENDNOTES

[1]World Health Organisation, *The World Health Report 1995: Bridging the Gaps (Geneva: World Health Organisation, 1995), p. 1.*

[2]For a more complete treatment of these topics, see Peter J. Henriot, S.J., "The Social Context of the AMECEA Countries on the Eve of the African Synod," *AFER (African Ecclesial Review)*, Vol 34, No. 6, December 1992, pp. 340-363.

[3]For further explanation of SAP, see Peter J. Henriot, S.J., "Effect of Structural Adjustment Programmes on African Families, in *African Christian Studies* (Journal of the Catholic University of Eastern Africa), forthcoming 1995.

[4]From a privately circulated paper by Howard Gray, S.J., "Moving Ahead."

[5]See Peter J. Henriot, S.J., "Service of the Poor: The Foundation of Judeo-Christian Response," in James E. Hug, S.J., ed., *Dimensions of the Healing Ministry* (St. Louis: Catholic Health Association, 1989), Pp. 66-85.

[6]See Peter J. Henriot, S.J., "Catholic Healthcare: Competing and Complementary Models," in Hug, *op. cit.*, pp. 19-19-35.

[7]Paul Farmer, "Medicine and Social Justice", *America*, July 15 1995, pp. 13-17.

[8]Anne Hope and Sally Timmel, *Training for Transformation: A Handbook for Community Workers*, 3 vols. (Harare, Zimbabwe: Mambo Press, 1984).

[9]David Werner, *Where There Is No Doctor: A Village Health Care Handbook for Africa* (London: Macmillan Publishers, 1987).

[10]"Message of the Synod," #44, in *The African Synod* (Nairobi: Paulines Publications Africa, 1994), p. 26