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THE CHURCH AND HEALTH:
REFLECTIONS AND POSSIBILITIES

Editorial Note

When a thoughtful man reflects upon the basis of his life's work, others in his field benefit from his shared experiences, doubts and hopes—the wisdom accumulated by long endeavour. The main article in this issue of CONTACT offers such an exploration by James McGilvray, giving readers interested in the churches' role in health care an opportunity to pause and consider the meaning of health and the directions they are taking to promote it.

Mr. McGilvray served as first Director of CMC from its founding in 1968 until his retirement in 1976. His thoughtful article, "The Church and Health: Reflections and Possibilities", makes stimulating reading, particularly in its insistence that the most valuable thing we have learned as Christians involved in health care—and the thing still to be absorbed and acted upon in many cases—is the vision of health as a total concept. While striving to cure the ills of the body, this vision reaffirms that a healthy person has healthy relations with his community, family, his own personality, and with God.

CMC photo

James McGilvray

In 1968 James McGilvray began the work of the CMC with the conviction that the time for hard choices had come, a time to evaluate the activities of the churches in health care. The obvious injustices in the distribution of health care services, the financial crisis that existed in many church hospitals, and the need for new priorities required a broad perspective. The churches were asking for help in setting priorities and making choices. At the same time, he was well aware of the need for study of the theological basis of the churches' concern for health, a problem addressed by the 1964 and 1967 Tübingen Conferences on the "Healing Ministry of the Church". It is the combination of these two areas of need—the medical and spiritual—which forms the foundation of the CMC and which Mr. McGilvray explores in his "Reflections".

James C. McGilvray, fondly called "Mac" by his colleagues, was born in Great Britain and took most of his education there. He attended universities in Manchester, Oxford and Bonn, and was trained as a hospital administrator. In 1935 he began a fourteen-year missionary service in India. For the last nine years of this time he served as Secretary of the Governing Council and Superintendent of the Vellore Christian Medical College. It was here that he met and married Eva Tysse, MD, who was teaching at the same institution. They moved to the United States in 1950, and for the next seven years Mac served as hospital administrator and consultant in health planning.

In 1957 the McGilvrays went to the Philippines, where Mac organized the first ecumenical health agency, linking all church-related institutions and programmes for coordination and joint planning. This post was followed by a return to the United States in 1962, and Mac served until 1965 as Associate Medical Director of the United Presbyterian Church in the USA. This was followed by his appointment as Director of the Christian Medical Council of the National Council of Churches of Christ in the USA (1965-68). During this period he served as Consultant to the World Council of Churches on medical programmes and participated in discussions which led to the formation of the Christian Medical Commission. In 1968 he was appointed Director of the CMC as its offices opened in Geneva. His tenure at the CMC was marked by his courageous promotion of the comprehensive approach to community health

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Cover photo courtesy Amy Dozier

care, by the founding of this publication, CONTACT, and by constant concern that the churches play a relevant part in promoting health.

The McGilvrays now live in Cumbria, England, where Mac enjoys an active retirement, still consulting and writing on the Christian view of health care.

An appropriate companion for the "Reflections" of James McGilvray is the essay on the work of Bob Lambourne written by Peter Bellamy. As a student of Lambourne's, Peter Bellamy, whose life is devoted to intertwined service of the Church and medicine, seems especially qualified to appraise Lambourne's pioneering work in the theology of healing. The Reverend Peter Bellamy, has his Ph.D. in Child Psychology, an MA and BD in Theology with a diploma in Pastoral Studies. He has been a counsellor in family care in long-term and terminal illness; unemployment and health; and support systems for young parents. At present he is Lecturer in the Department of Theology and the Medical School of Birmingham and Chaplain/Lecturer at the Queen Elizabeth Medical Centre, Birmingham.

The issue of "Healing and Sharing" was one of the eight major foci of study and discussion during the WCC VIth Assembly in Vancouver in 1983 where CMC's on-going mandate was also confirmed. These choices indicated a growing interest in the whole area of the healing ministry which the CMC has explored and promoted since its inception. Therefore, the CMC has further intensified its study in its continuing series of regional consultations on "Christian Understanding of Health, Healing and Wholeness". As we move into a new seven-year period with the appointment of a new Central Committee, new Executive, new General Secretary, and new Commissioners, we feel it is appropriate to share with our readers these provocative and challenging thoughts on the Christian view of health and healing.

THE CHURCH AND HEALTH:
REFLECTIONS AND POSSIBILITIES

By James McGilvray, former Director, Christian Medical Commission

What's in a name?

When the idea of creating a Christian Medical Commission was first proposed to the World Council of Churches there was considerable discussion as to whether it should be called a "Medical" or a "Health" Commission. It was surely more appropriate that the Church be concerned with health rather than medicine! The difficulty in finding an adequate title pointed up the semantic and conceptual problems surrounding the word "Health". By common usage the word is associated with medical care and one of the more persistent beliefs is that the availability of more medical care will ensure a greater measure of health.

Western societies have increased enormously their expenditure on "Health" service. In the United States, for instance, the costs of these have been galloping upward for the past two decades and a tenth of the nation's wealth is now spent on them, though it would be difficult to substantiate a comparable growth in healthy living.

It is in support of this belief that Western societies have increased enormously their expenditure on "Health" services. In the United States, for instance, the costs of these have been galloping upward for the past two decades and a tenth of the nation's wealth is now spent on them, though it would be difficult to substantiate a comparable growth in healthy living. On the other hand, the poorer countries of the so-called Third World vainly try to copy the medical models of the West to the extent of their meagre resources with the result that the large majority of the populations have no access to the few facilities which the underdeveloped economy can afford.

However, for the churches, there was a further problem. When it became known that the World Council of Churches was considering the creation of such a commission, it attracted an immediate response from various spiritual and divine healing groups which felt that, at long last, they were to be officially recognised and provided with a forum within a world-wide ecumenical body. This situation resulted from the Church's inability to understand and agree upon its appropriate response to its Lord's mandate that it should heal. The other mandates—to preach, teach and baptise—had caused no comparable difficulty, but there was no agreement about a unique methodology of healing which could be called Christian.

In fact, the Church had usually responded to this mandate by providing Western style medical services wherever there was a significant lack of them. So, since recent surveys of these medical services had pointed up several problems common to all of them, it was decided that it would be more appropriate to designate the new Commission as primarily concerned with these "Medical" services. However, it was always hoped that this would not, in any sense, preclude an interest in non-scientific forms of healing; nor has it done so.

Since health was seen to be so very much more comprehensive than medical care alone, the Commission was granted a mandate which made its activities the focus of two converging interests—one functional and related to the churches' medical programmes as such, and the second, theological, aimed toward discovering and proclaiming the Christian understanding of health and wholeness. It was hoped that the findings and recommendations of two prior consultations which had been held in Tübingen, Federal Republic of Germany, might supply the criteria for judging the appropriateness of these programme activities. (By appropriateness was meant: (1) how far did they express Christian values, and (2) how far did they answer the essential health needs of those they were intended to serve?) For most of its life the Commission has been engaged in sorting out its relationship to these two interests, the functional and the theological, and trying to discover where they converge and how.

The initial priorities

For the first eight years of its life, the Commission gave priority to reviewing and seeking solutions for the problems of the churches actually engaged in medical care programmes, most of which were located in the lesser

developed countries. The national surveys which took place between 1963 and 1967 had shown that 95% of these programmes were in the form of curative, institutional care and that they were increasingly costly to operate. They were a direct result of a transfer of a Western-type medical system to countries which could not afford it. While these programmes had been promoted and received with the very best of intentions, they had, in fact, leap-frogged over the basic need to provide a sanitary environment, potable water, adequate nutritious food and the other necessary steps towards a healthy environment which the Western countries had painfully learned but now took for granted.

Furthermore, the rapid advance of medical technology had led to an ever-increasing cost in institutional care which soon depleted the resources which were available and, so, the gap between those who could be served and those who were deprived, which was in the ratio of one to four, seemed unlikely to change. One embarrassing consequence for the churches was their inability to minister to the poor commensurate with their needs. It became necessary to explore a more egalitarian approach which would better serve those who were now deprived. This led to an initial emphasis on the development of community health programmes to provide primary health care in an attempt to balance the overwhelming commitment to secondary and tertiary care facilities.

The initial and natural response to physical need is to offer immediate care and, hopefully, cure. The Good Samaritan did not sit down and wrestle with the economics of medical care distribution. If he had, it is likely that he would have concluded that it would have been a more effective solution to get rid of the robbers. Meanwhile, the traveller might well have died!

One must recognize that there is a good deal of hindsight involved in the conclusions reached in the preceding paragraphs! The initial and natural response to physical need is to offer immediate care and, hopefully, cure. The Good Samaritan did not sit down and wrestle with the economics of medical care distribution. If he had, it is likely that he would have concluded that it would have been a more effective solution to get rid of the robbers who molested lonely travellers on the road from Jerusalem to Jericho. But, meanwhile, the traveller he encountered might well have died! Like most human problems there is no easy solution to this dilemma. Moreover, the economics of medical care distribution are further complicated by the fact that, unlike the distribution and selling of other goods and services from which one gains a tangible asset, nobody *wants* to buy what medicine has to sell except in dire situations.

So, if one cannot meet all human need for health services, one must surely seek the most effective balance of services to meet the bulk of that need within the limit of resources. An "effective" balance would weigh the consequences of spreading those resources too thin. To do less and less for more and more can end up in doing nothing for anybody! The emphasis on *community* health services involved a further complication for the churches which had, for so long, proclaimed the concept of the *individual's* dignity and worth in the sight of God. Medicine, too, treasured the individual patient-doctor relationship. Both these attitudes made the entry into community health more difficult until it became evident that each individual is part of a network of human relationships. No individual can be seen whole outside a community context. Moreover, it is these interpersonal relationships and not "things" or "techniques" that heal.

The benefits and joys of cooperation

There were two factors which were of special significance in enabling the Commission to pursue its objectives. The first was the willingness of Roman Catholics to share in its programmes and contribute to the search for appropriate priorities. Doctrinal difficulties would remain, but even these appeared to be less important when compared with the "quantum leap" in enhanced possibilities of jointly serving the poor for whom, Jesus tells us, God has a special affection.

This cooperation more than doubled the number of existing programmes to which the Commission could relate and enabled a rapid growth in the formation of national agencies for the coordination of church-related medical work. These promoted both the development of integrated health services and joint planning with governments. Both resulted in more effective service to those in need. Thus clinics could be related to hospitals for supervision; and, even though the identity of each institution re-

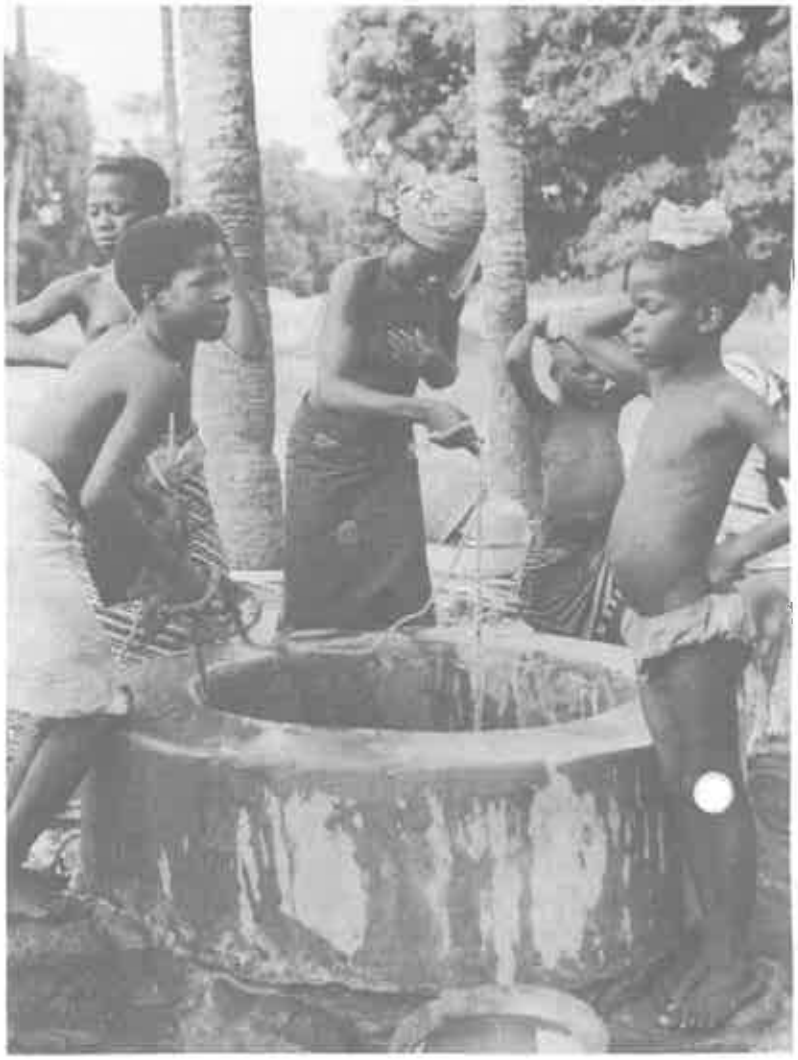
mained distinct, health services could now be based on convenience, geographical factors and population densities.

Of special significance has been the sharing of training facilities and the ability of agencies to engage in joint planning with government health services. This degree of cooperation (among all the churches working in a particular country and their collective cooperation with government) inevitably led to a more responsible awareness of national health needs, reaching beyond the preoccupation with individual institutional problems. The obvious advantages of cooperation at the national level led to the exploration of such cooperation at the international level with the result that the Secretariat for Unity within the Vatican was empowered to nominate "Consultant Observers" to the Commission, and a Roman Catholic Sister Doctor was appointed to the staff. The particular joy which resulted from this cooperation came from the dispelling of suspicions and prejudice and the discovery that each had so much to give to the other.

The second factor was the inauguration of this publication, CONTACT, in November 1970. It was launched as an "occasional paper" through which the Commission hoped to communicate with its constituency and share its own emerging understanding of its task. Since the Commission "operated" no programmes of its own, it tried to give wide publicity to the innovative programmes of others who were motivated by a similar desire to make medical care facilities available and accessible to as many as possible.

Through this kind of cooperation with others in the field the claims for community health moved out of the theoretical realm. By sharing of practical examples it became possible to demonstrate the effectiveness of a community approach. From this sharing experience, one learned that the acceptance of alternative models of medical services depended largely on discoveries about human relationships. For instance, it became apparent that no matter how imaginative and economically viable a medical care project might be in the eyes of its designer, it would not take root if it were designed *for* people rather than with them.

While community participation in the design of and decision making about a medical care programme was imperative, it could also be very frustrating because health was seldom a priority in the community's hierarchy of wants. Agriculture, water supplies and housing frequently came before health.



WFP photo by Banoun/Caracciolo

The priority may be water

Again, while community participation in the design of and decision making about a medical care programme was imperative, it could also be very frustrating because health was seldom a priority in the community's hierarchy of wants. Agriculture, water supplies and housing frequently came before health. It was embarrassing to discover that there was often a considerable difference between what a medical professional "knew" people needed and what, in fact, they actually wanted. So it became necessary to match wants and needs and balance them against resources. Also, it became apparent that the closer to a bare subsistence level a family was living, the less were its expectations that assistance, such as medical interventions, would be of benefit.

One also discovered that a cultural gap existed between city-educated health workers and illiterate rural folk, even where both are nationals or even belong to the same tribe. An illiterate person identifies him or herself with

another illiterate and feels closer to him or her than to the educated professional. In this situation, the best way to serve the community and to teach people to accept new methods and to change attitudes is to enlist the help of women (or men) from within the community itself, even if they are illiterate. So each community does have a special resource within itself, namely its own members who can be encouraged to promote better health.

In retrospect it seems strange that the search for a more equitable distribution of medical services should have led to new "discoveries" about the need for sensitivities in human relationships. It became clear that one needed not only modesty but also humility in the exercise of the health care planning which was so much in vogue during the 1970's. Everyone accepted that systems analysis and cost/benefit ratios were useful tools in such planning, but few had reckoned with the need for humility in dealing with human relationships so that planning could become not so much systems-oriented as people-oriented.

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It may be that the success or failure of WHO's campaign to achieve "Health for All by the Year 2000" will hinge on the degree of humility exercised by "professional" health workers towards their primary health care "colleagues" in the successful development of balanced health services which are available to all. In most countries the introduction of primary health care services is like trying to fit a lower layer into a multi-layered cake. It faces the problem of integration into a medical system with a well-guarded hierarchical structure of professional domination which must now provide for the upward mobility in skills, ranking and rewards of a new class of worker.

It would be unrealistic to suppose that every primary health care worker will be content to remain such until retirement. Many will wish to become "professionals" themselves. Such doubts are prompted by reflection on the history of similar movements designed to help the poor but which became bureaucratically institutionalised just as much as the systems they were supposed to liberalise.

Many of these "discoveries" emerged out of the shared experience of experiments and programmes recounted in issues of CONTACT. It was almost as if the Commission had taken wings to remote places its staff had not yet visited. The sharing of these programmes not only encouraged others to adopt and adapt them but also led to a rapid increase in the circulation of this publication.

Turning a medical system on its head

There is no doubt that the bias in favour of curative programmes in the lesser-developed countries resulted both from the enormous numbers of people seeking treatment and the fact that the few available physicians were predisposed by their training to perform this kind of service. The inhibiting factor in the development of preventive services was the necessity to meet their cost when they offered no immediate benefit. This led many church-related medical workers to the conclusion that preventive medicine and community health were the responsibility of governments even when those governments showed little inclination to do anything about them. It was possible to finance the operating costs of clinical services by charging fees. This was particularly true in the case of surgery and gynaecology but less obvious in the promotion of hygiene and healthy life styles.

The first doubts about the effectiveness of curative programmes alone arose from the observation that a large proportion of the admissions to hospitals were for preventable conditions which could have been treated more effectively and more cheaply at an earlier stage and might even have been prevented if sanitary conditions and more nutritious food had been available. Moreover, it was disturbing to note the frequent re-admission of those, especially children, who had been discharged as "cured" only a few months before. They obviously were returning to an environment which made them sick and needed to be changed.

The planning of the distribution of medical services is usually portrayed in the form of a pyramid with self-care providing the base and then moving through primary and secondary care to tertiary care, usually represented by teaching hospitals at the apex. The entry into the system whereby one moves from self-care (usually provided by the family) into primary

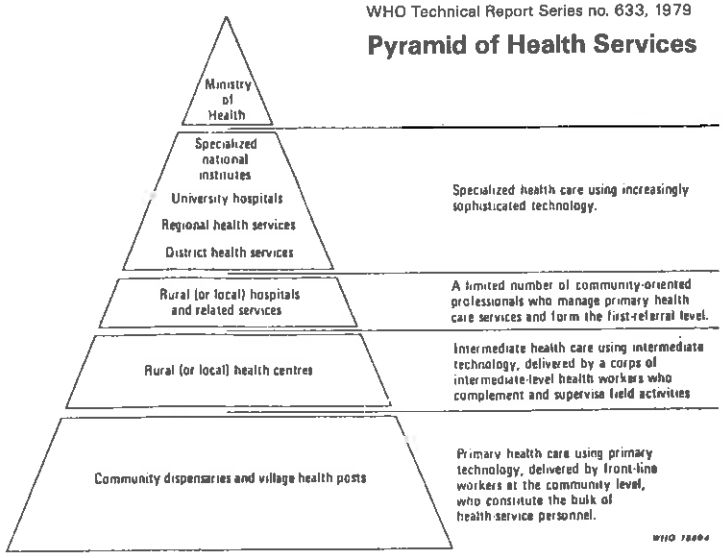
care and upwards, was for long the zealously guarded privilege of the doctor. Two things were found to be deficient in the use of this system: a) the provision of services was only the beginning, either because they lacked appropriate utilisation, or because those who had access were not necessarily those who most needed it; and b) the threshold of entry needed to be lowered because the doctor-patient population ratio would not permit adequate coverage, especially in rural areas.

A further failure of this diagrammatic pyramid was the lack of any direct reference to the patient for whose benefit, presumably, it had been designed. Another anomaly was that the narrower the sides of the pyramid became as they approached the apex, the more costly were the services they encompassed so that tertiary care absorbed more than 50% of the total national health budget even though it was designed to cater for less than 10% of the patient population. The intention of the pyramid design is that all illness episodes should proceed through a filtering system with only the most complicated reaching the teaching hospital with its specialties at the apex. However, the majority of health systems in the lesser developed countries had attempted the impossible! Their planners had started to build a pyramid from the top down and often failed to reach the bottom.

The reversal of this trend owes a great deal to the Peoples' Republic of China. The revolutionary leaders were appalled at the maldistribution of medical services, and they had the political will and ability to change the prevailing system. The World Health Organization lacks the political ability to make so drastic a change as the introduction of "barefoot" doctors, but it came close by giving its well-earned professional approval to the promotion of primary health care in 1975.

WHO Technical Report Series no. 633, 1979

Pyramid of Health Services



This approval marked a radical shift in WHO's priorities which now began to look even at traditional healers as possible allies to make health care available to all. Such healers are still the preference for many people because they appear to answer the questions, if not always the needs, of those who go to them. They are more likely to understand the patient's "world view" as related to the cause of his sickness and thus see him as a total person in the social environment where he belongs. WHO's main emphasis in the development of primary health care is that it should be shaped around the life patterns of those it serves. In this way medicine is recalled to the social mandate which it receives from a society which bears the burden of sickness. This public accountability requires an honest and objective appraisal of what medicine can and cannot do which needs to be matched by a reciprocal responsibility from the community to adopt life styles which are conducive to health in order to avoid an addictive dependency on medicine alone.

Yet, paradoxically, while these efforts work to provide basic health services for all, the recent advances in biotechnology and especially in genetic engineering and DNA analysis are making people more and more dependent on medicine and its possibilities for treatment while, at the same time, its cost threatens the allocation of services to the poor. While the peoples of the lesser-developed countries are deprived through a lack of medical facilities and manpower, an increasing number in several Western countries who may live within a few metres of sophisticated facilities are deprived of them because they cannot afford them! So what kind of society is created when economic factors override humanitarian and communal concerns in the provision of care?

When the priorities of primary health care were adopted at Alma Ata in 1978, there were some who thought that at least some of the principles would be applied to Western medical systems, but apart from a few isolated medical practitioners who have introduced patient participation into their practices, little else seems to have changed.

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1978, there were some who thought that at least some of the principles would be applied to Western medical systems but, apart from a few isolated medical practitioners who have introduced patient participation into their practices, little else seems to have changed. So, the likely result is a two-tier system with a minority in both developed and lesser-developed countries having access to high-cost technology which they hope will lead to "life extension" while the rest have primary health care.

The medical model and the need for reformation

From time immemorial theories have existed about the nature, causes and treatments of disease. Some of these depended on the conjunction of the stars and the planets; the anger of spirits and demons; or the vengeful retribution of gods for the immoral acts of individuals and communities. Cures depended on prayers or sacrifices in order to placate the offended deity, or upon conformity to the mores of the tribe or society. Today, when we speak of the medical model we usually mean the provision of services by a whole range of professionals offered (usually for a reward) to those who because of their real or imagined disease seek their help.

By and large, the professionals operate under a system which has two major components—the disease component and the engineering or technical component. The disease is manifested in signs and symptoms which can be diagnosed to discover their cause. Once the cause is "known", the treatment is largely technical, relying on interventions either by the use of drugs or surgery. There is an emphasis on specific, individual aetiology resulting in individual cures with a tendency to concentrate on the disease rather than the total person.

In reaching a diagnosis, the doctor must rely increasingly on expensive technology in the form of scanners, X-rays and laboratory equipment which can only be housed conveniently in a hospital; and so the hospital becomes central to the structures of medical care. It also becomes part of a hierarchical system in which the acute general hospital ranks above those institutions devoted to mental illness and the care of the dying. At the pinnacle is the teaching hospital which limits admissions to those cases whose complexities most challenge this investigative approach to health. Yet it is these latter hospitals which are used to train doctors, nurses and other medical workers even though the cases they observe represent only a small proportion of illness episodes. It is natural that this kind of training leads to the choice of similar interests and specialties by those who are trained in this system with the result that the long-term and aged sick whose disabilities offer little scope for technology are pushed further into the background.

While the ecologists have convinced us that there must be a limit to our exploitation of natural resources there is no similar wisdom to our expectations of medicine. The recent successes in medical technology have persuaded most people that something can be done about any form of illness. We then add to the confusion by introducing the concept of health as a human right and if we equate health with medical care, we will demand something which it is impossible to satisfy. While it may be appropriate to guarantee everyone the right of access to medical care, the right to health can only be secured by the exercise of personal responsibility. To say that health is a human right makes as much sense as claiming that knowledge and courage are human rights. It would be more correct to claim that health is a responsibility which is to be practised by everyone.

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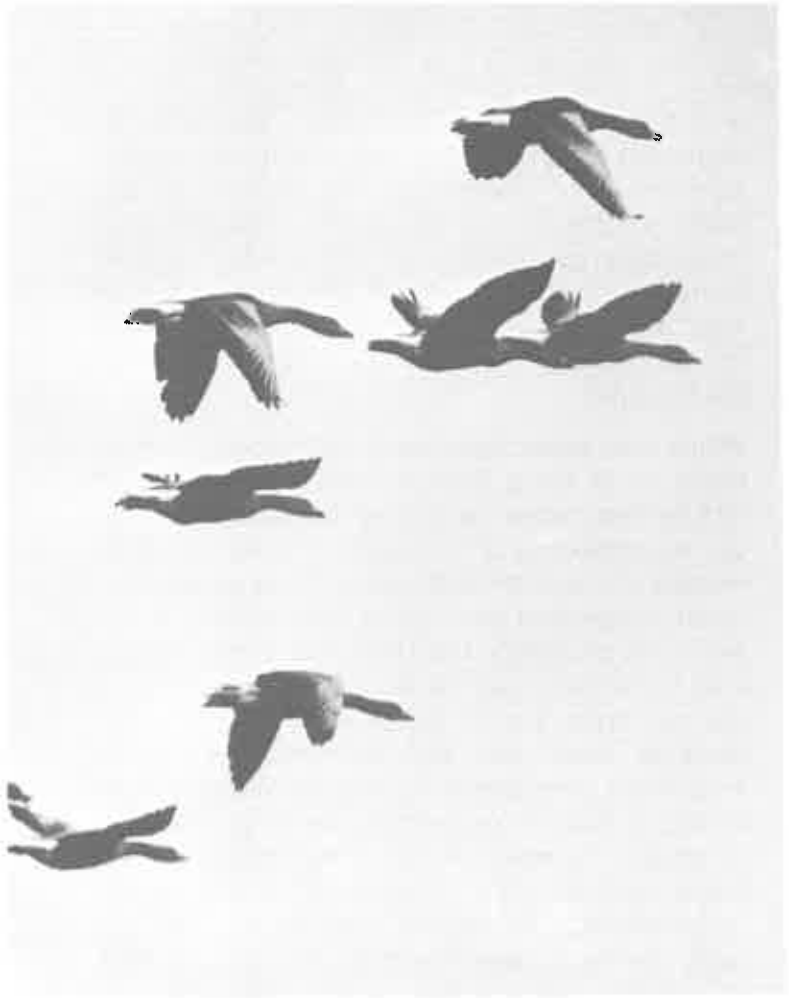
Medicine today presents a situation analogous to that existing in the pre-Reformation church. It gives the impression that access to health is through the physician who controls admission to those temples of healing called hospitals just as the Church had proclaimed that access to God was only possible through the mediation of the priest under the authority of the Church. Medicine's ideological nature has assumed the posture of a faith system which reaches out to cover our social problems as well as our diseases. Family problems and job dissatisfaction are brought to the doctor more often than to the priest.

In protesting this medical priesthood one is not questioning the expert ability of the physician to diagnose and treat diseases; nor is it enough to find fault without acknowledging that most people prefer to have the doctor make the deci-



WWF Photo by Ch. A. Vaucher

"If the geese can do it...?"

sions for them. This reflects our abdication of personal responsibility and our deluded trust in the salvation of science. On the other hand, the Church, because it has made some of the same mistakes itself and because it is aware of its constant need for renewal, must probe the unspoken assumptions of medicine. It must challenge the idolatry of an abstraction called "life" whose preservation and prolongation are the objects of medicine regardless of cost, pain or meaninglessness.

But the task of the Church is not only to challenge. It must find within itself that fellowship of healing which makes true caring possible and invigorates those who must now learn to take health into their own hands. Only thus will it regain its credibility as a Healing Church.

Since the phrase "a Healing Church" was introduced as a title for the report of the first Tübingen Consultation in 1964 it has been widely used, though not precisely defined nor extensively demonstrated. One interesting attempt to define it was the response of the listener who pointed to a flock of geese which were flying overhead in a V formation. "It must be something like that," he said. He then went on to explain that the V formation enables each bird, except the leader, to find an uplift in the vacuum created by the bird ahead of it. The lead bird quickly tires and its place is then taken by another while it retires along the line to recover. Flying in this formation, the flock can achieve speeds of more than 100 km per hour and travel almost twice as far as a single bird alone. If, for any reason, one of the birds must descend to the ground, another will accompany it in order to help and support it. "If geese can do it...?" he concluded, and left the question for us to finish and as a challenge for our response.

The Christian contribution to medicine

At a time when the Church appears to be indifferent to the de-humanising elements of the medical model, perhaps because it stands in awe of its technological achievements, it would be well to remind ourselves of the profound influences which Christianity has had on the practice of medicine in the past. Christ proclaimed that God reigned and that His rule became evident whenever healing took place and whenever the underprivileged were relieved, the broken-hearted comforted and sinners forgiven. He affirmed that it was God's will that these acts be done.

Moreover, Christ introduced a particular sensitivity to suffering which enabled him to enter into the experience of the one who suffered. As Lambourne expressed it, "He only is whole who is joined to the suffering of others."[1] One cannot claim that compassion is unique to Christianity but it is an intrinsic element of any healing which is true to the spirit of Christ. Compassion for the poor and the helpless is to be offered without any expectation of reward because such compassion is a reflection of God's nature. Thus, the quality of medical care is not to be regulated by the ability of the patient to pay. This is in sharp contrast to the "marketing" of medical care where the patient is regarded as a "consumer" who must contribute to the profits of proprietary hospital corporations.

These hospital corporations would soon be bankrupt if they accepted for admission those whom Christ healed–a blind beggar, a prostitute in trouble, the slave of a soldier of the occupying power. And Christ expected his followers to do the same. Hans Kung expresses it this way, "Jesus turns with sympathy and

[1] Lambourne, R.A. *Community, Church and Healing.* Pg. 162. Darton, Longman, Todd, London, 1963.

compassion to all those to whom no one else turns, the weak, sick, neglected, social rejects... He has no cult of health, youth or achievement. He loves them all as they are and so is able to help them... Are not these actions, though they do not infringe any law of nature, very unusual, extraordinary, astonishing..."[2]

Christ proclaimed eternal life in which death is only a transitional stage into a new life with God. His Church has experienced difficulty in making this utterly credible, for medicine looks on death as therapeutic failure or the enemy who is to be thwarted.

Christ proclaimed eternal life in which death is only a transitional stage into a new life with God. His Church has experienced difficulty in making this utterly credible, for medicine looks on death as therapeutic failure or as the enemy who is to be thwarted. A welcome change from this attitude is the growth of the hospice movement which provides a supportive environment for those facing imminent death and offers pallative treatment when death is preceded by racking pain.

The Church which tried to express a credible witness to its Lord found, increasingly, that it lacked the charisma to heal as Christ had healed. Following the conversion of the Emperor Constantine it had to adapt itself to becoming part of the official establishment of Rome. Then the Church became an institutional structure within society and the expression of its mandate to heal became institutionalised also. By the end of the 4th century "hospitals" were being established by Christian individuals and communities. Some "Aesculapea" which were a combination of temple and sick bay were adapted to become Christian hospitals.

In the history of the relationship between the Church and medicine there were some dark spots such as the prohibition of surgery which was thought to damage the body which had been created in the image of God. There were other restrictions on the development of medical science and research because they were regarded as "sinful" by an outmoded theology. The Cartesian dualism between mind and body was therefore welcomed by medicine as a release from these theological restrictions. Yet, whenever the Church has been loyal and true to its Lord, there have been glorious examples of the application of medicine to the neglected and the outcasts of society such as the initiative to bring care to those suffering from leprosy and the willingness to serve in isolated areas where the practice of medicine brings no prestige and very little monetary reward. The Christian Gospel will always present a spur to dedicated service and one which we lose to our enormous impoverishment.

For the future, the Christian contribution to medicine will primarily be at the point where it reflects and embodies Christ's own teaching, example and judgement. It can make a signal contribution to our understanding about health, extricating it from the narrow confines of medicine where it is now trapped. It is unlikely that the Church will establish many more hospitals in Western countries; and in the lesser developed countries it needs to use the rich potential of its village churches and congregations to initiate activities which would lead to primary health care.

The Church must also continue to sustain and re-invigorate those Christians who are professional medical workers of whatever kind and enable them not simply to use medical practice as Christians but to use judgement and become agents of change with the system of which they are a part. There is still little evidence that the principles of primary health care have been adopted in the West, and yet they are universally valid.*

A new relationship

Both medicine and the Church have a common objective in serving those who are less than whole; the Church will always understand this objective and work to make it credible in a wider dimension than medicine. Both Church and medicine stand in need of renewal in order to find a greater degree of wholeness than they now possess. It was the scarcity of Western style medical care resources in the lesser-developed countries and the financial impossibility of extending them which brought into focus the disparity between those few who were served and the majority who were deprived.

So our concept of health became radicalized by matching it to the dimension of social justice

[2] Kung, Hans. *On Being a Christian.* Pg. 235. Collins, London, 1978.

* The above section owes much to the thinking of the late T. Frank Davey, a renowned leprologist and former Medical Secretary of the Methodist Missionary Society who exemplified these principles in his life and service.

which raised ethical and political questions about resource allocation. In turn, these raised questions of whether the services which were to be distributed more equitably were, in fact, the most effective measures for promoting health when, historically, these were found to exist in the physical and social environment in which people lived and in their personal and social life styles.

As for the West, it had replaced its former environmental deficiencies by such unhealthy practices as industrial pollution and personal indulgence in smoking, drinking and overeating! So, knowledge of the factors which promote health does not necessarily mean that priority will be given to their implementation. The unhealthy environment is frequently due to poverty and the economic system which produced it and prefers to tolerate it rather than be changed. Similarly, efforts to change lifestyles which are injurious to health are tolerated provided they do not bring into question the system which promotes their use under the guise of exercising personal freedom of choice. So people are constantly subjected to the wiles of advertising which encourage them to want and consume more and more, including those things which are injurious to their health. In this situation, the distinction between what people need and what they desire becomes blurred with the result that desires become needs, and life styles tend to reflect this.

Our view of health is further expanded as it moves from concern for the individual to the community of which the individual is a part and to the relationships he will have with others in that community. Experiments in promoting health to whole communities which culminated in the development of primary health care were based on the view that health belongs to people both as a "right" and a responsibility. It is not something "delivered" by one person to others nor by a professional group to its patients. The patient actively participates in the health team and is both knowledgable about and intimately related to the treatment.

It takes longer to grow new crops than to eat a meal; it takes longer to dig wells and build latrines than to treat a case of dysentery; and much longer again for villagers to learn the necessity for them and how to use and maintain them. So, our view of health expands in time as well as space.

We find, also, that whereas some health problems can be tackled on a short-term basis, our expanded view of each man's relatedness to others within social space means that the significance of the problems extends over an ever-increasing span of time. It takes longer to grow new crops than to eat a meal; it takes longer to dig wells and build latrines than to treat a case of dysentery; and much longer again for villagers to learn the necessity for them and how to use and maintain them. So, our view of health expands in time as well as space.

Health also has a political dimension which reflects our values and the social structures affected by them. The fact that millions of people in Asia and Africa suffer from malaria and severe malnutrition is frequently written off as "a fact of life". Our distance from them blurs our sense of responsibility, and the fact that these conditions have existed for a long time blunts the will and initiative of those legally responsible to do anything about the situation commensurate with its seriousness. Thus, the questions of "Who is sick?" and, "Who is my neighbour?" are intimately related.

Our concept of health also expands through listening to those we seek to help. This not only requires the active participation of the patient in his or her treatement. It requires a modesty which is willing to listen and learn from other cultures which have produced their own indigenous forms of healing. While these differ from country to country and even among the tribes and castes within countries they have two outstanding differences from our western scientific approach.

Firstly, there is the overriding interest of the patient and his relatives in the reasons for the sickness or disorder; the explanation must fit into their world-view of causation. Secondly, while we tend to use analogies drawn from the world of inanimate things which have some order and predictability about them, they use analogies drawn chiefly from the world of people and their relationships.

We use what we call common sense—putting two and two together—to deduce the connection between snails and bilharzia; between mosquitos and malaria. They find it reasonable to attribute disease to unseen spiritual forces and to disturbances in relationships such as jealousies and hatreds. The former must be placated and the relationship must be restored if healing is to take place. These relationships

"... to reconcile, heal and forgive"
CIRIC photo

can involve the extended family and even the community as a whole.

A willingness to learn about and to understand these indigenous systems has interesting results. It reveals the importance of making care comprehensible to those who are being served on their terms, involving them and their families in the therapy. It also requires a willingness to discard some "rules" in order to accommodate the patient's need for supportive relationships. The Christian Medical Commission is to be commended for its patient investigation into different ethnic perspectives and practices in health care. This needs to be followed up, so that what is good might be retained and the caring elements balance the dehumanising effect of biotechnology.

So, finally, the Church needs to continue its use of medicine especially in areas of great need and where it can serve the poor and bring hope to the helpless. It is well to remind ourselves of the five challenges proposed by Dr. J.H. Bryant in an earlier issue of this publication (no. 2, Dec. 1977). "To serve the poor, redefine development to include social as well as economic growth, distribute health services equitably and develop educational programmes that will lead to competence and commitment to serve the poor."

Equally the Church needs to go much further than exploring the meaning of health in relation to salvation. It needs to promote health and healthy living in a positive sense and provide a support system for those who are liable to become sick. This need not necessarily result in a legalistic approach like that presently used by some branches of the Church, but it would certainly require becoming more completely the body which Christ calls it to be. It would need to shift from an exclusive interest in the individual and in alleviating sickness after it develops to finding ways of preventing its occurrence in the first place. The Church could then challenge medicine to admit its lack of competence in various areas of disease by displaying its own ability to offer treatment and care. Thus, it could diminish the need for medicalisation so that the domain of medicine would become more restricted to acute illness and its treatment. For some reason the Church has not seen this as "health work" and in searching for alternative therapies it has tended to abandon its very special ministry of healing.

The Church needs to recover its unique role as a channel through which Christ becomes incarnate to reconcile, heal and forgive. And this requires a cost which few of us are prepared to pay. Yet to become a Healing Church is meaningless unless one is prepared to become part of the process in which our responsibility is not for our own health only but for the health of our neighbours and our strangers. Perhaps, it would be wise for us to stop theorizing about the Healing Church and, instead, demonstrate what it looks like so that others would have models to adopt and adapt to their own situations.

THE SIGNIFICANCE OF BOB LAMBOURNE'S WRITING TODAY

By Peter Bellamy, Lecturer, Department of Theology and the Medical School University of Birmingham, Birmingham, United Kingdom; member of the Christian Medical Commission

Editorial Note

Bob Lambourne and James McGilvray were friends. Both of them were concerned with exploring the concept and reality of the Healing Church. Bob Lambourne died in 1972. But his ideas have in many ways coloured the CMC's thinking. His article *Secular and Christian Models of Health and Salvation** appeared in the very first issue of CONTACT in 1970 when Mac was Director of the CMC. Lambourne's ideas have been filtering through its pages ever since. So although you may not have heard of Bob Lambourne or read what he has written, he is no stranger to you. His passion for justice, his irreverence towards authority and reverence for "The God in every person", are echoed, we hope, in what we say and do at the CMC. Lambourne wrote only one book: *Community, Church and Healing,* published in 1963 by Darton, Longman and Todd in London. Dr. Michael Wilson, his friend and colleague, has collected Lambourne's other writings which appeared in medical or theological journals and the texts of the speeches he made. He has now brought them out in a 245-page anthology, *Explorations in Health and Salvation***, published by the University of Birmingham. In doing this, he has performed a great service to the young men and women who are entering the health professions or the service of the Church.

Who was Bob Lambourne?

In his introduction to this collection of his writings, Michael Wilson calls him "one of the foremost thinkers and writers of our time on the relationship between religion and medicine." He served as a general practitioner for 15 years in a working class neighbourhood in Birmingham, suffered a first heart attack, took a degree in theology, then another in psychiatry and became a lecturer in the Department of Theology at the University of Birmingham where he developed a diploma course in pastoral studies. All his life, he wrestled with certain themes: the solidarity of people in health and sickness, the place of suffering in the task of healing and caring, the responsible work of laity and congregations in the local church and the whole field of religion and medicine. What Lambourne was concerned with was to develop new styles of leadership for building healthy communities through reconciliation and the sharing of suffering, through the conscious letting-go of power, status and false security.

In 1967, Bob Lambourne took part in the Consultation on the Healing Church convened in Tübingen (FRG) by the World Council of Churches and the Lutheran World Federation. He became involved in the Christian Medical Commission at its inception and played a significant part in developing its mandate that shifts the emphasis from the curative services in the hospital to prevention and from there, to healthy community development. In his writing during the 1960s, he linked the quest for health to the need for justice and right relationships among people within society. Michael Wilson recalls him as "a formidable critic of institutions, professions and thought systems whose

* CONTACT Special Series No. 2. *In Search of Wholeness; Available from CMC.* 106 pages; price: US$ 5, £ 3.

** Available from the Institute for the Study of Worship & Religious Architecture, University of Birmingham, Birmingham B15 2TT, United Kingdom. Price: £ 4.00.

doors had become closed to the ever-contemporary renewal of the Holy Spirit."

> Most of the powerful "secular" gospels of today have come out of conversion experiences of people who have had a complete *metanoia,* a conceptual repentance, involving their whole person, changing their vision about what reality is and who they are... So it is not a matter of taking the gospel to heal the world, but being graced with the gospel and gracing the world with the gospel in the act of healing the world. So missionary medicine, and indeed all medicine, is not to take a known, fixed excellence of medicine to apply it triumphantly all over the world. It is to go in mission and humility, knowing that the particular realities of the world (different in every time and place) set the agenda for medicine... All this means that the Church's ministry of healing is *not* covered by any one of the following or any combination of them (though each has its place):
>
> (1) Being a nurse, doctor or social worker because you are a Christian, but without expectation of being transformed by this vocation in your personal ethical formation, your understanding of your professional discipline, your knowledge of man and your knowledge of God.
>
> (2) Providing ministers of religion to fill in the gaps in the hospital or other medical services, to add the gospel to a neutral, non-kerygmatic medicine, to take care of the dying, to bring in from outside a sacramental medicine, or generally, to sanctify a sub-optimal health service which needs to be scandalized and overthrown.
>
> (3) Voluntary services, doing in an unqualified, weak and lay way the supporting work for what the professionals feel is the essential work, but without making a vital lay renewal of the professional concepts which structure the health services.
>
> (4) Special rites like the laying-on-of-hands, unction or healing services which do not penetrate the daily life of healers and healed alike.
>
> (5) Doing the conventional medicine of the day from "superior" personal motives, thus requiring less pay or status or honour, but without renewal of the technological means of doing these services.
>
> from *A Christian Epistemology of Health for Use in Medicine and the Church's Ministry of Healing*

All Lambourne's writings contain a number of interlocking themes: the idea of *corporateness,* the problem of *defective healing* and *Christian pastoral care.*

Corporateness in healing and in developing an understanding of wholeness, is seen by Lambourne as a necessary balance to the over-emphasis on the individual which we still find today undiminished, both in medical practice and counselling. In the Old Testament world, the self had three foci: the person, the family and the historic community of Israel. The ultimate fear was separation and disunity was seen as sinful. The healing miracles were corporate experiences, significant to all present even though focused on the sick person.

> Man finds his very individuality within the network of human relationships, not in isolation from others or in opposition to the community.
>
> from *Wholeness, Community and Worship*

Both in medicine and theology, a shift was already in the air in the early 1960s away from the false separation and antagonism between the individual and the community. Lambourne pinpointed specific community needs which challenged the churches, secular authorities and professionals then—and continue to do so. They are the special needs of the elderly, the anguished and the lonely and the need to strengthen the community's sense of responsibility towards one another. A number of projects actually grew out of Lambourne's ideas. One was an inner-city general practice established with CMC assistance. Another was a community support system in Birmingham for cancer patients and their families. A multiracial London parish began experimenting with participatory worship in small groups, reaching out beyond the congregation to embrace the joys and sorrows of the community as a whole.

> When we consider that the proportion of young to aged is falling and that family dispersion is always increasing, it becomes apparent that we are facing a crisis which will teach us how much at the very basic and practical level we need one another. The heaven of new housing estates, with their paradise of homes of one's own for each, carries possibilities of a hell of loneliness which the slums they replaced never knew.
>
> from *Wholeness, Community and Worship*

Today, as in 1963, the most popular concept of healing is based on the doctor-patient model where the doctor is active and the patient is passive. Lambourne fought this model and argued that the social and psychological sciences should modify our practice of medicine and so should the New Testament studies on the historical and corporate aspects of Christ's work. Lambourne emphasized the role of the group or team in the healing task rather than the work of skilled professionals who keep free of personal involvement.

> From the point of view of the New Testament, any act of love towards another which is done "in Christ" and thus in the power of God, is Christ's healing work, regardless of whether that act be the giving of a cup of water, the injection of penicillin or the laying on of hands. In medicine and in the Christian life, the response required to sickness is a total response of the whole man to the whole man.

Defective healing was the term Lambourne used, perhaps with the idea of indicating that it is incomplete, a kind of healing that is demonstrated by the contemporary focus on the individual; salvation and wholeness are defined negatively in terms of the removal of sin and disease. The person is perceived out of his/her context and assigned a dependent, weak role. Human dignity tends to be disregarded along with the unpredictable complexities of human beings. In medicine, we find extreme objectivism while in psychotherapy and counselling, extreme subjectivism is often the rule.

> Healing is a satisfactory response to a crisis made by a group of people, both individually and corporately... Learning is.... an ability to adapt oneself to new situations. Crisis, including the crisis of sickness, is an opportunity for adjustment to a higher quality of life... Crisis is an opportunity.
>
> from *What Is Healing?*

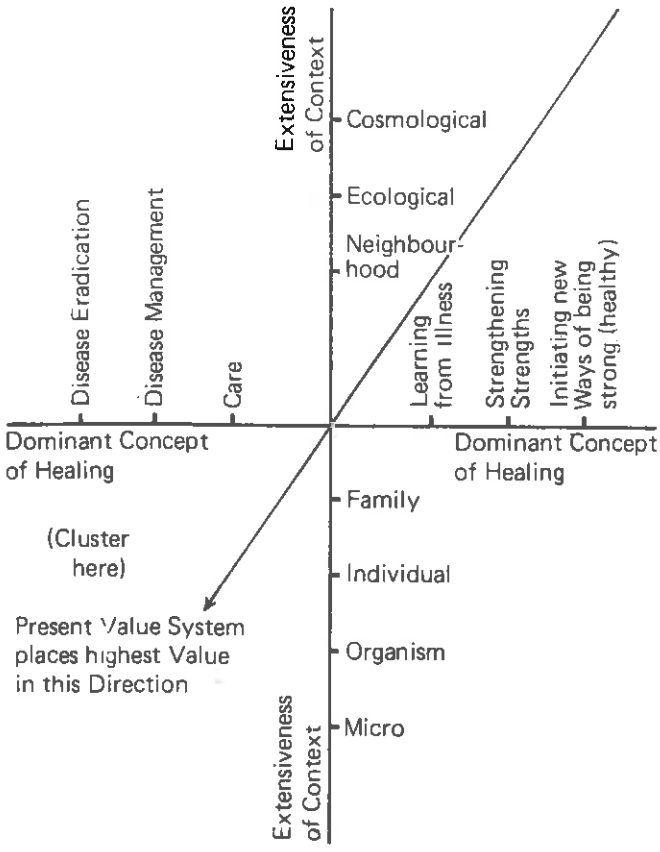
For Bob Lambourne, the model for Christian pastoral care is found in the ministry of Christ, who brought a new understanding of salvation. It was not a new power to heal, but a clearer view of health. Christian pastoral care, in Lambourne's view, is not about one person helping another, not an activity of professionals. It is rather a way of changing a whole fellowship. Lambourne believed emphatically in the "life-giving resources" of the Church, too often overlooked even by church-based counsellors. Alongside the understanding of what *is,* must be intertwined the idea of what *ought to be.*

> We are in danger of confining pastoral counselling to a "sacred" profession, using special "sacred" technical language in a special "sacred" place, whereas the truly sacred lies in the community *(koinonia)*... The theology of pastoral counselling... was... born out of the church trying to discover what it meant for them to be... the church... Paul's theology springs from the earth of particular decisions that must be made about admitting Gentiles, eating meat, sexual behaviour and so on. It soars up from these earthly particularities and touches down again with real clinical discipline. This is what we must do.
>
> from *Counselling for Narcissus or Counselling for Christ?*

A prominent feature of the Lambourne papers is the way in which different concepts are interwoven. The map below illustrates how a number of key concepts that have to do with health are related to each other. It is argued that a disproportionate amount of energy and resources is given to dealing with individuals on a deliverance-from-evil basis, which fosters authoritarian attitudes. A more open approach would be interdisciplinary care of the whole person in the context of his/her family and community, nurturing everybody's special strength. A research task was set up to test empirically the validity of the theoretical relationships between the different concepts illustrated on the map. It was conducted on students in their final year of training for seven different professions. The tests revealed a very high correlation between professional isolation/cooperation and individualistic/corporate approaches to people. The more authoritarian a student's attitude, the more individualistic and professionally isolated was likely to be his/her approach. What the Health Map seems to indicate is that in the areas of health, education and medicine, attitudes develop in training which are harmful to good relationships and destructive of community. When the professional has the right to define what is good and what is evil, the recipient is put in a submissive role where conformity is expected, diminishing him or her as a person while enhancing the professional.

This Health Map is from *Secular and Christian Models of Health and Salvation,* originally delivered as a lecture in 1969. It appeared in the first issue of CONTACT (Nov. 1970). It is closely related to the *Concepts Map of the Practice of Medicine* which Lambourne includ-

Health Map



ed in *Health Today and Salvation Today* in 1972. Some of the headings are different in this more complex diagram designed for medical students; "learning from illness" became "learning by stress", which would include illness as one form of stress. Instead of "strengthening strengths", we have "nurturing existing strengths", a role for school teachers and others (including parents) who can cultivate health in its positive sense.

Bob Lambourne's legacy is the uncomfortable one of challenging people to change, to question their complacency, to let go of their obsession with security. He rejected one-dimensional theories of salvation and by his emphasis on lay training and lay supervision of his students, he opposed the one-skill, authoritarian answer. Above all, he did not leave a blueprint of answers or even directions, but rather a methodology of taking most seriously each context in which we function as human beings and, together, pursue God vigorously and hopefully.

A sermon is the final paper of the collection. It was given at a Eucharist service during his Pastoral Studies course in 1967 and a quotation from it seems a fitting way to end:

> ...And what we offer and receive here today is what we offer and receive from those we will help tomorrow. They too are our mystery and in their flesh and blood – be what they may – we shall have this same saving vision of the real presence of Christ in our common neighbour as we have now of the mystery in this room, in our bodies and blood, in this bread and wine. We shall know this presence mostly in discovering the uniqueness of each person we serve. How hard this is. Yet we will do it and we can go out into the world to do it with the same confidence with which we now do this communion. We can do it because it is not flesh and blood, but our Father which is in heaven who does it.

NEW PUBLICATIONS

World Population Growth, A study by the Advisory Commission of the Evangelical Church in Germany (EKD) for Development Affairs, Hannover, Federal Republic of Germany, June 1984. A pamphlet in English or German outlining problems of population growth and proposing ways of reorienting ideas about population control. Information and pamphlet available from the Evangelical Church in Germany, 3000 Hannover 21, Herrenhäuser Strasse 12, Federal Republic of Germany.

Honduras: A Review of the Applied Nutrition Program, 1978-82. Meals For Millions/Freedom from Hunger Foundation, 1984. A pamphlet describes the Applied Nutrition Program in Honduras and its first five years of work, emphasizing cooperation with other agencies. Written by Zoila Alvarez, Honduras Program Director.

Price: single copies free

Available from:
Meals for Millions/Freedom from Hunger
P.O. Box 2000
Davis, CA 95617, USA

Directory for Community Participation and Education in Water and Sanitation, International Reference Centre for Community Water Supply and Sanitation, and the Water and Sanitation for Health Project, November 1983. This 165-page booklet presents data on 124 organizations from 56 countries and 10 international organizations regarding their work on community education and participation in water supply and sanitation.

Price: $ 10, or free to non-commercial organizations and individuals in developing countries.

Available from:
I.R.C.
P.O. Box 5500
2280 HM Rijswijk
Netherlands

CMC NOTES

The International Institute of Rural Reconstruction (IIRR) is offering training courses in rural reconstruction in Silang, Cavite, The Philippines. An advanced course in rural reconstruction designed to provide leaders with a strong sense of commitment towards people-oriented development will be given from February 4-March 15, 1985. Cost is $ 2,500. A senior manager's seminar is scheduled from October 28-November 22, 1985, designed to broaden and reinforce skills necessary for managing rural development programmes. Cost $ 2100. A limited number of fellowships is available for highly deserving candidates. Applications must be made no later than three months before the start of training courses.

For application and inquiry:
Dr. John R. Batten, Director
Education and Training
IIRR
Silang, Cavite 2720
Philippines

Diagnostic Kit for Urinary Schistosomiasis is available from the Program for Appropriate Technology in Health. It offers a quick, practical, and reliable method for the field testing of urine samples, using a membrane filtration technique to detect schistosome eggs.

Price: Basic cost for Kit A, $ 800.

Information from:
PATH
Canal Place, 130 Nickerson Street
Seattle, Washington 98109
U.S.A.

Correction Note: Dr. Galba Araújo, author of the main article of CONTACT No. 79, "The Ceará Experience – Traditional Birth Attendants and Spiritual Healers as Partners in Primary Health Care", wishes to correct a translation error appearing on page 3, first column, line 3. The text should read: "Sometimes the midwife hangs a rope from a rafter and the patient while sitting on a birthing stool pulls down hard on the rope using it for support during the expulsive period or second stage of labour."

Notice to CONTACT Subscribers re address changes

When advising us of any change or correction to your address, please do not forget to send us one of our old mailing labels on which your old, or incorrect, address appears. This makes updating/correcting your address a much easier task for us. Thank you.

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