1. INTRODUCTION

Medical research inspires hope. It promises novel therapies, a decrease of pain and suffering, and an increase of health. Numbers of patients and their families await cures for devastating diseases. They are hopeful of medicine's ability to provide relief from much human misery. Many of us, perhaps even most of us, welcome medical research, new medical technologies, and therapeutic advances. Modern medicine excites admiration. At the same time, we hear the warning voices of those who anticipate dangers and risks of certain technologies both for individuals and societies, and of those who fear that some medical projects might tempt us to transcend the limits of our bodily existence.

With a similar mixture of welcoming excitement, hopeful anticipation, and cautioning concern German parliamentarians discussed embryonic stem cell research in late January 2002. The German Bundestag frequently referred to the United Kingdom as example of responsible promotion of research. While the legislative outcome was to differ significantly,[1] the debate itself showed no substantial difference to that in the United Kingdom: advocates of embryonic stem cell research referred to its therapeutic potential, the possibilities of health for the individual or groups of individuals, and to society's moral obligation of healing.[2] Yet, what some heralded as a breakthrough for health or cause for hope, others – and amongst those also patient support groups – rejected for fear of discrimination. Would money not be spent more sensibly on support structures for the disabled here and now, rather than on research of unclear therapeutic potential?[3]

1 The production of stem cell lines is prohibited in Germany. However, stem cells can be imported as long as they are derived from lines created outside Germany and prior to a specified date. In the 2002 debate, the cut-off date was fixed as 31st January 2002. In April 2008, the German Bundestag moved the cut-off date to 1st May 2007. "The result can be interpreted as a confirmation of the compromise made in 2002: the general ban on creating and working on human embryonic stem cell lines in Germany is upheld; however, it will still be possible to import cell lines that were harvested abroad prior to a cut-off date." (http://www.eurostem-cell.org/commentanalysis/german-parliament-passes-amendment-stem-cell-act, last accessed 01/2010).

2 See the references made to an "ethics of healing" in the contributions of (mainly Christian Democrat) MPs who supported either the use of embryos for embryonic stem cell research in Germany or at least the import of stem cell lines created prior to 31.01.2002: e.g. Peter Hintze (CDU), Ulrike Flash (FDP), Katherina Reiche (CDU), Maria Böhmer (CDU). Those who were more sceptical regarding the use of embryos for research criticised arguments of health benefits: e.g. Andrea Fischer (SPD), Monika Griefahn (SPD), Ernst Ulrich von Weizsäcker (SPD), Christa Nickels (Green), Ilja Seifert (PDS), Hubert Hüppe (CDU), Hermann Kues (CDU). Cf. transcript of the 214. German parliamentary debate, 30.01.2002, http://dip21.bundestag.de/dip21/btp/14/212/14214212.00.pdf, last accessed 01/2010.

3 Cf. Ilja Seifert, http://dip21.bundestag.de/dip21/btp/14/212/14214212.00.pdf, last accessed 01/2010.

Listening to the 2002 debate and thinking over these concerns, questions arose that largely covered the following two areas: (1) What *is* human life that is to be cured and cared for? Are our assessments of medical research based on a certain vision of human life, and if so, what vision is this? What understanding of the *body* (the biological aspects of human life), and of human *personhood* (that which makes human life particular, unique, *my* life or *your* life) is the foundation of moral arguments in medicine? (2) What is health? How is health understood where it is used as an argument in favour of, for instance, embryonic stem cell research? Where value is attributed to health, even to the *potential* of health, what underscores the moral claim of cure and relief of suffering?

Do we know the answers to these questions? Or do we possess, and refer to, a set of incoherent, fragmented survivals from moral knowledge and tradition, as Alasdair MacIntyre famously suggests in *After Virtue*[4] when he says,

> "Ill-assorted conceptual fragments from various parts of our past are deployed together in private and public debates which are notable chiefly for the unsettable character of the controversies thus carried on and the apparent arbitrariness of each of the contending parties."[5]

This suspicion of MacIntyre's prompted me in 2002 to explore further the above questions, and in doing so, the nature of moral knowledge and tradition in the area of medicine, medical research and health care. MacIntyre's suspicion of "ill-assorted conceptual fragments" led to a desire to understand the object and end of medicine, and the anthropological assumptions that underlie the morality of medical research and clinical practice.[6] To this end, I turned to modern philosophical accounts of health in relation to pre-modern philosophies of medicine and theological (Christian) anthropology.

In the Christian tradition, excellent work has been done on health and medicine.[7] The present study will fall short of volumes such as Stanley S. Harakas'

4 MacIntyre (1985), *After Virtue*.

5 Ibid., 256.

6 Note: By 'medical' and 'medicine' I mean *clinical medicine from the Western perspective*. I try to avoid terms such as 'scientific' medicine or 'biomedicine' as they carry the implication of a monolithic system beyond the reach and influence of culture. Social scientists have demonstrated significant variation in biomedical notions and clinical practices, see for instance, Hahn/Gaines (1985), *Physicians of Western Medicine*: *Anthropological Approaches to Theory and Practice*; Lock (1993), *Encounters with Aging: Mythologies of Menopause in Japan and North America*; Wright/Treacher (1982), *The Problem of Medical Knowledge: Examining the Social Construction of Medicine.* For the terminological distinction of biomedicine and holistic medicine see also Guttmacher (1979), "Whole in Body, Mind and Spirit: Holistic Health and the Limits of Medicine". I will not consider alternative Western medicines such as homeopathic medicine or Asian medicines often termed 'traditional' medicines.

7 Apart from the numerous articles that focus on one particular theologian, schools of theology or particular aspects of medicine, I have in mind here the excellent series *Health/Medicine in the Faith Traditions* with volumes on Health and Medicine in the Anglican, Catholic, Eastern Orthodox, Lutheran, Methodist, and Reformed Tradition as well as Hindu, Islamic and Jewish Tradition respectively (published by the Park Ridge Center for the Study of Health, Faith, and Ethics, Chicago).

Health and Medicine in the Eastern Orthodox Tradition[8] and Martin E. Marty's *Health and Medicine in the Lutheran Tradition.*[9] Yet unlike these two (and similar others), I do not aim to present one particular tradition of thought and its relationship to medical healing. I will look at Christian theology, its philosophical ancestry and present day philosopher companions[10] and will develop an account of health and healing which is largely based on an Augustinian anthropology (Augustine himself, though a saint only in the Catholic or Anglo-Catholic tradition, played and plays a prominent role in the development of Calvinist and Lutheran doctrines, too). I seek dialogue with representative voices of Orthodox theology past and present. Indeed, my aim is *to dialogue* with thinkers who were concerned with health throughout the ages – from the beginnings of rational medicine through to the present times. Half of the writers I engage with lived and wrote in the first millennium. They were either directly involved in the shaping of rational medicine as the art of curing *and* caring, or responded vividly – and at times sharply – to medicine's emerging doctrines. The other half, living and writing now or in the last century of the second millennium, was at the centre of health debates in the context of scientific medicine as we know it today.

Comparing and contrasting the interpretations of health of those who influenced medicine in its very beginnings, as well as of those who accompany its present activities, allows me to identify significant traits and/or interpretative gaps of the concept of health. Engaging with the writers of different traditions permits the explanation of how a *unitive* understanding of the natural body in its personal, social and cultural aspects may enable today's physicians to conceptualise their actions as reading natural given-ness in dialogue with their patients' personal views of disease and health in the context of social, political and cultural norms.

I will show how an orientation of human action towards God's love – which is crucial for Augustine's understanding of human morality and ethics – may direct both physicians and patients to the horizon of ultimate questions concerned with human striving for fulfilment in the face of the limitations imposed by death.

This, then, may sum up the contribution of this study to the field of medical morality and medical practice. With *critical* dialogue at its centre – a dialogue with a selection of theologians (both of East and West) and philosophers (both of past and present) – it develops an account of medicine's end that is original in its *proceedings*: it links historical and contemporary reflection on medicine, medical research and health care; it looks at the birth of modern medicine in order to understand its goals and practices today; it draws out historical and conceptual

8 Stanley S. Harakas, *Health and Medicine in the Eastern Orthodox Tradition* (Crossroad/New York, 2000).

9 Martin E. Marty, *Health and Medicine in the Lutheran Tradition* (Crossroad/New York, 1998).

10 In its philosophical aspects the present study might bear some resemblance with philosophical contributions such as Leon Kass' "The End of Medicine and the Pursuit of Health" (1975), and more recently Daniel Callahan/Eric Parens' "The Ends of Medicine: Shaping New Goals" (1995), as well as in German language Dirk Lanzerath's *Krankheit und ärztliches Handeln* (2000).

connections between the first millennium thinkers and contemporary theology and philosophy in order to identify characteristics of the concept of health; it takes seriously the relevance of the historical past as located in the present through the time-transcending spirit.

1.1 OVERVIEW OF KEY LITERATURE AND IDEAS

Health is the end of medicine. The 1964 *Declaration of Helsinki* states as a recommendation for physicians in biomedical research involving human subjects,

> "It is the mission of the physician to safeguard the health of the people. His or her knowledge and conscience are dedicated to the fulfilment of this mission."[11]

In most cultures explanatory concepts of health and disease have been developed. As Egyptian papyri and Mesopotamian medical texts show these concepts had far-reaching consequences for diagnosis and therapy, for healers' and patients' attitudes to each other and to their dealings with disease, for social reactions and care structures, and for the cultural significance of diseases.

Exploring dimensions and changes in the concepts of disease and health in the course of history and across past societies and cultures, medical historians have distinguished four causal categories: (1) Disease and health are attributed to the interplay between liquid and solid components of the body (e.g. Greek Hippocratic and Indian Ayurvedic medicine); (2) Disease and health are attributed to the relationship of body and spirit or the natural and the supernatural (found in most religious traditions); (3) Diseases are existing external entities such as demons, bacteria or viruses (ontological notion of disease); (4) Diseases are the consequence of disturbed biological functions within individuals (the so-called physiological notion of disease) and may result from either an individual's biological, psychological or spiritual disposition (endogenous) and/or external factors such as climate, food intake, supernatural powers or natural entities (exogenous).[12]

11 Declaration of Helsinki: http://bmj.bmjjournals.com/cgi/content/full/313/7070/1448/a, last accessed 01/2010. Cf. also Schmidt/Frewer (eds.), *History and Theory of Human Experimentation. The Declaration of Helsinki and Modern Medical Ethics* (2007).

12 The literature on the history of the concept of disease and health is ample. The following (chronological) list presents but a small selection on which the above summary drew; it includes some of the most influential monographs as well as overviews given in articles. Cf. Sigerist, *Civilisation and Disease* (1943); Berghoff, *Entwicklungsgeschichte des Krankheitsbegriffs* (1947); Risse, *The Conception of Disease* (1953); Temkin, *The Scientific Approach to Disease: Specific Entity and Individual Sickness* (1963); Edelstein, *Ancient Medicine* (1967); Schipperges/Seidler/Unschuld, *Krankheit, Heilkunst, Heilung* (1978); Temkin, *Health and Disease* (1973); Rothschuh, *Was ist Krankheit? Erscheinung, Erklärung, Sinndeutung* (1995); Risse, "Health and Disease–History of the Concepts" (1978); v. Engelhardt, *Health and Disease–History of the Concepts* (1995) as well as Schäfer/Frewer/Schockenhoff/Wetzstein, *Gesundheitskonzepte im Wandel* (2008).

With regard to the relevance of these categories for present day medicine, historian of medicine Owsei Temkin remarks,

> "Of the stages through which these ideas have gone, some belong to the past, others have merely seen a metamorphosis. Disease as a physiological process and disease as an entity are recurrent themes which have been likened to the struggle between nominalism and realism. […] *The history of the ideas of health and disease cannot decide these issues; it can only present them.*"[13]

Health and disease are also (and have always been) themes in art,[14] philosophy,[15] religion,[16] and more recently in the social sciences, in particular medical anthropology,[17] psychology, sociology and social theory.[18] Such wide-ranging interest immediately points to the difficulties one faces when trying to explain the concepts in medical terms only: Health and disease are complex, ambiguous, and multidimensional terms.

13 Temkin, "Health and Disease", 406 (my italics).

14 In literature examples range from the Old Testament's book of Job to Leo Tolstoy's *The Death of Ivan Illich* to Thomas Mann's *Magic Mountain*. Disease in 19th and 20th century literature is also one of the themes in Susan Sontag's 1978 *Illness as Metaphor*.

15 Plato's, Aristotle's and Galen's ideas on health and medicine are at the centre of chapter three of this study. For further key texts, see the utopian writings of Thomas Moore (1478–1535) and Francis Bacon (1561–1626) which include guiding principles for eugenic health policies; Rene Descartes (1596–1650) mechanical model of health and disease bound up with his dualist anthropology; G. F. Hegel (1770–1831) *Philosophy of Nature,* which emphasises the victory of the spirit over disease and death. Eminent physicians-philosophers were Thomas Sydenham, G. B. Morgan, Xavier Bichat, Claude Bernard, and Rudolf Virchow. Aside from the substantial medical philosophy debate on health which is the focus of chapter five, the 20th century would not be complete without philosopher-physician Karl Jaspers "Die Begriffe Gesundheit und Krankheit" (1973), Michel Foucault's *The Birth of the Clinic: An Archaeology of Medical Perception* (1973), Georges Canguilhem's *On the Normal and the Pathological* (1978) and H. G. Gadamer's *Über die Verborgenheit der Gesundheit* (2003).

16 For an overview on world religions and health, see Tillich, "The Relation of Religion and Health: Historical Considerations and Theoretical Questions" (1946); Sullivan, *Healing and Restoring. Health and Medicine in the World's Religious Traditions* (1989).

17 Apart from 'classical' anthropological and ethnographic case studies, anthropologists are often also interested in the power relations that lead to one particular set of interpretations becoming the dominant and "authentic" set of meanings. Cf. also Young, "The Anthropologies of Illness and Sickness" (1982); Latour/Woolgar, *Laboratory Life: The Construction of Scientific Fact* (1986); Pfleiderer/Bichmann, *Krankheit und Kultur. Eine Einführung in die Ethnomedizin* (1985).

18 One tradition within the sociology of health and disease focuses on how the distribution of death and disease is influenced by factors such as age, gender, race, and social class. This tradition can be traced back to French sociologist Emile Durkheim's work on suicide (1890s). The second tradition is oriented to the physician-patient relationship and is interested in the meanings of disease for each of them, and how their interpretations reflect the power hierarchies in society. This tradition began in the 1950s with Talcott Parson's discussion of the sick role (*The Social System,* 1951) and has been taken up and developed by medical psychology in particular.

They have personal, cultural, and social dimensions. In the words of medical historian Dietrich von Engelhardt,

> "Sickness and health in their natural and cultural breadth, remind medicine of its fundamentally scientific and humanistic nature. Health and disease are concerned with life and death, and are closely connected to the physical, social, psychic, and spiritual nature of humans."[19]

Whilst historians of medicine reflect on health and disease in their different cultural and societal contexts in the light of historical sources, thus uncovering the roots of modern day approaches, the philosophy of medicine is devoted to exploring fundamental epistemological and value issues that form the underpinnings of these concepts.

Twentieth century milestones in the analysis of disease, health and clinical knowledge are French philosopher Georges Canguilhem's 1948/1966 *Le normal et le pathologique* and Michel Foucault's 1963 *La naissance de la clinique*, translated as *The Birth of the Clinic: An Archaeology of Medical Perception*. Foucault's second book, it picks up from *Madness and Civilisation* in its concern with the development and organisation of theoretical and practical knowledge(s) in relation to practices of social organisation. It is a case history, which assembles details that trace the development of the medical profession and clinical knowledge in the institution of the *clinique*, that is, the teaching hospital in Paris at the turn of the nineteenth century. Modern medicine, built on the foundations of the new science of clinical pathology, requires a medical gaze, which closely observes, visually dissects, and instructs. Modern medicine owes the birth of its body of knowledge and practice to the eyes of the doctor.

Foucault's approach to medical discourse is novel, for he is, by and large, not concerned with exclusively medical discourses or a detailed recollection of their history. In *The Birth of the Clinic*, Foucault places medical discourses in a wider network of concerns with, for instance, the health of the population, the training of doctors and shaping of the professional organisation, or regimes of assistance and internment. Foucault's interest is also in the increased concern with the health and welfare of the population and with the process of a noticeable *medicalisation* of society.

Michel Foucault was influenced by Georges Canguilhem's examination of the notions of disease and health *The Normal and the Pathological.* Here, Canguilhem looked at the formation of disease and health in the context of institutions and institutional power. His interest was in the translation of grammatical norms into physiological norms. His exploration into the nature and meaning of normality in medicine and biology, the production and institutionalisation of medical knowledge is still a seminal work in medical philosophy and the history of ideas.

In the 1970s, Anglo-American philosophers started to challenge the dominant positivist ideology of medicine, which discounted personal and cultural evaluation of physical phenomena. This was done on the basis of a growing recognition of the sociology and philosophy of medical knowledge, against the background of

19 Von Engelhardt, "History of the Concepts", 1091.

Georges Canguilhem's linking of the relation between health and disease to the requirements of institutional power, and against the backdrop of Michel Foucault's analysis of the development of modern medical epistemology.[20]

Unlike 1960s French philosophy the Anglo-American debate did not focus on power structures or economic and institutional influences on the disease/health distinction but on health in its relation to bodily reality, cultural-dependent values and individually posited life goals. Though in one sense this presents a deficiency in the Anglo-American debate, it is precisely its *exclusive* focus on the themes of body, cultural dependency *or* individuality which makes it central to this study. The Anglo-American interpretations help me show how one-dimensional understandings of health (and human life) have problematic consequences for the physician-patient-relationship as well as for medical practice more widely.

In focusing on the Anglo-American debate, its ancient heritage, and the Church of the first millennium, I will not offer a comprehensive analysis of theological, philosophical or historical attitudes to health and medicine. Even though health and healing are central phenomena in the gospel narratives, I will not offer an in depth historical exegesis of key passages of the New Testament.[21] I will concentrate on the early Church writers, especially Augustine, and the relation of their thought to the contemporary Anglo-American health debate both in the philosophical and theological disciplines.

The study does not engage with medieval philosophy and scholastic theology and its dealings or reservations with medieval medicine.[22] It does not reflect on Thomas Aquinas's considerations on the art of medicine, nature, and human health, such as his view of a co-operation of interior principles of nature and exterior acts committed by the medical agent for the strengthening of nature.[23] It does not inquire into Descartes' anthropology and its mechanical undertones.

Descartes' dualist metaphysics and mechanistic interpretation of matter (not his tentative hints at a psychosomatic dependence or even union) influenced post-Enlightenment anthropologies as well as scientific medicine both methodologically and ontologically.[24] Whilst Cartesianism argued on the basis of a substance dualism, today's materialist philosophers oppose the view that there are two irreducible kinds of things that co-exist. "Materialists uniformly reject Descartes' ontological dualism, in particular, its implication that a human mind is composed of an immaterial substance different in kind from material bodies."[25] For example, the materialism of D. M. Armstrong, one of today's leading materialist philosophers, is largely *monistic* where it insists on all living bodies as nothing but material entities, and where it holds that material things also exemplify psychological

20 English translations of both works were available in the mid-1970s.

21 I touch, however, on the New Testament healing stories before looking at the Patristic writers in chapter three.

22 Cf. D.W.Amundsen on medieval medical practice in "Caring and Curing in the Medieval Catholic Tradition" in *Caring and Curing* (1998).

23 Aquinas, *Summa Theologiae*, Question CXVII, First Article.

24 Cf. Lanzerath, *Natürlichkeit der Person*, 95.

25 Moser/Trout, *Contemporary Materialism*, 4–5.

properties and phenomena such as thoughts, beliefs, desires, intentions as well as sensory experiences.

Neither of these philosophical approaches will be given their due attention in this study. This is not to deny their practical relevance or even their influence on contemporary medicine and philosophy of medicine. Yet in focusing on the beginnings of medicine and the bearings these have on the present times, and in seeking a *coherent* conceptual framework for the discussion of health, this study draws above all on Augustine's theology. In understanding the natural body in its personal and social context to be the site of God's love qualified through the life of the Son and restored by the Spirit, both physicians and patients are directed to the horizon of ultimate questions concerned with human striving for fulfilment in the face of mortality. God's care for humanity and his promise of fullness of life in the presence of death are at the heart of Augustine's Christian recognition of medicine. It reveals the art and science of medicine as an essentially legitimate but intrinsically limited means of alleviating pain and restoring health.

The next section provides an outline of the modern philosophical and early Christian understandings of health and medical healing analysed, and of the arguments developed on the basis of this analysis. A brief overview of each chapter is given; references to sub-sections follow in brackets.

1.2 OUTLINE OF ARGUMENTS

Health and disease definitions have practical consequences, and so has any theoretical analysis of them. They are concepts that motivate, guide, shape medical action and health care. They direct health care policies. They are action-guiding concepts. In setting the end for medical action, health and disease are normative concepts. Yet what kind of norm is the norm of health? Is it an absolute norm? Should health be pursued at all costs? Can health trump other moral considerations? Is it a moral virtue? Are we to be held responsible for our health? Are healthy people morally better people?

What *is* health? Illness and disease are more readily and experientially identifiable. They often involve a failure of function, an abnormal pain or the threat of immature death. A negative definition of health identifies it as the absence of disease or deformity, but how can health be defined positively? Is health a description of bodily facts, of empirical data? Or is it a value statement judging physical, social, personal states of existence? The WHO definition, for instance, has been criticised for being too broad and ill defined to guide health policy when it defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". It confuses health with happiness and medicine becomes the sole gatekeeper for human happiness and social well-being.[26]

26 It is a good definition in that it acknowledges that there is some intrinsic relationship between the good of the body and the good of the self as well as the wider human community. Yet it is

In order to illustrate how health shapes medical action and policy making, this study begins by looking at the UK policy reports on human embryonic stem cell research and cloning for research.[27] It does not ask substantive questions as to the UK government's understanding of health generally but aims at *illustrating* the role health plays in decision making (health policy decisions being but one example). The chosen documents show health to be central to the conclusion that human embryonic stem cell research and cloning for research is morally permissible and should be legally permitted.

Whilst the reports do *not* reflect explicitly on the *meaning* of health, they attribute value to the *end* of health, even to the mere potential for health. This attribution of value legitimises both medical research action and health policy decisions. Health, then, directs medical and political action. It motivates the promotion of embryonic stem cell research. The reports illustrate the normative power and practical relevance of health.

Before analysing the reports' argumentation, I recapitulate the chronological stages of UK legislation and regulation of assisted reproduction and embryo research. This provides an understanding of the legislative context in which the 1998–2002 debate took place (2.1). Following from here, I detail the reports' arguments in favour of human embryonic stem cell research and analyse how health is connected with a model of balancing values and probabilities (2.2).

In order to address the substantive question as to the meaning of health (not asked in the reports yet crucial given the end of health's normative power) the next chapter goes back to the very beginnings of Western medicine. It engages with second century philosopher and physician Galen, the father of today's medicine. Galen developed an idea of health as the normal or natural state of the body and situated bodily health within the context of the overall striving for welfare, thus combining the two positions. Yet in emphasising the union of body and soul, and the corrective influence of reason or the rational soul, which allows humans to recognise *general* principles for the improvement both of the constitution of the body and the affections of the soul, Galen moves beyond a purely naturalist or individualised welfare account of health. He explicates the need for philosophical education to enable overall human well-being (3.1).

Whilst early Christian writers were interested in Galen's naturalist medicine and in philosophical training, they considered both medicine and philosophy as fragmentary approaches to human life and health, and on this basis as insufficient for well-being or fullness of life. To explore a Christian understanding of human life, and of health, I turn to three early Christian writers: Tatian, a second century Syrian theologian and critic of naturalist medicine; Tertullian, second century theologian of the Latin-speaking West; and Basil the Great, fourth century bishop

a problematic definition, to give one example, where it claims health to be the complete state of well-being: the consequence of this would be the total medicalisation of all aspects of human life. See also: Callahan, "The WHO Definition of Health" (1973).

27 The focus is on a selected number of policy reports: an exhaustive account of the *parliamentary* or *public* debate on embryonic research and cloning will not be given in this study.

and Greek-speaking theologian of the East, defender of naturalist medicine. All three thinkers implicitly or explicitly recognise human life as a union of matter and soul. They differ in their views on the causality of disease and health, and the consequences these have for their attitudes towards medical knowledge and practice.

For Tatian diseases of the body are caused by demons, evil forces in nature that act on nature. Healing can be achieved not through naturalist medicine but through the power of God's word which commands the demons to leave the body. Tatian's demonology led him to underestimate the *intrinsic* weakness of bodily nature as potential cause of disease. It also led to his sharp rejection of reason and rationalist medical knowledge, and brought him close to the dualist Gnostic movements of the second century (3.3).

Based on the union of body and soul (which he recognises without explicating it further) Tertullian draws a distinction between physical and spiritual sickness. Spiritual sickness is caused by misguided belief and requires divine cure. Physical diseases may be caused by natural weaknesses of the body, but also by demons. Whilst the former requires knowledge of natural processes, the latter needs the exorcism of demons through the power of the word. Though supporting medical healing, Tertullian's treatment of the sacrament of baptism shows that ultimately spiritual health and healing may lead to eternal flourishing and true human fulfilment (3.4).

In linking diseases and medicine with demons both Tertullian and Tatian are in contrast to Basil the Great. He saw diseases as deficiencies of nature. For him, the body's defective state is related to the Fall not to the influence of demons. Basil supported medical knowledge and practice as an act of charity. He established what was perhaps the West's first hospital. According to Greek Orthodox theologian Stanley Harakas, the views of Basil (as well as Gregory of Nazianzus and Gregory of Nyssa) became the mainline approach of the Greek Orthodox Church towards worldly knowledge, science, and culture (3.5).

Whilst Basil developed his view of medical care from the gospel narratives, in particular the care shown to the sick and underprivileged by Jesus and his apostles, neither he nor his predecessors, Tatian and Tertullian, explicate at length the theological anthropology that underpins their understanding of health and disease.

In chapter four, I turn to St Augustine's theological anthropology which draws together the position of the human creature in body and soul in the world, the understanding of health of body and soul, and the consequences of both for medical practice.

I start with a brief introduction of Augustine's view on creation and the Creator, which explains human life as both given and in *a priori* relationship with its Creator. Augustine speaks about creation not as a scientific process but as the beginning of existence through God's will. Created existence according to God's word is *good* and *ordered*. Created bodies exist in a hierarchical order of relation-

ships, which originates in the relational love of the Trinitarian God.[28] This irrevocably attributes value to the whole that is creation and to all its parts (4.1).

Human existence is material and bodily, yet it is never the life of the body only. The body-soul union is central to Augustine's anthropology. Humans are composite beings, not bodies nor souls alone but body and soul together. The biblical doctrine of the resurrection confirms the union of body and soul: here the body is taken up into eternity and remains the very same, particular body (*my* body or *your* body). Together with the incarnation, the resurrection affirms the goodness of the body. Augustine shows that the incarnation and resurrection are the foundation of the Christian understanding of the goodness of the human body and of God's claim upon the human body (4.2).

Whilst recognising the goodness of the body, Augustine holds that the soul is the creature's superior part which not only animates, but also dominates the body. I inquire with key Augustinian scholars as to Augustine's understanding of the human soul in the context of the *imago Dei* doctrine. Augustine understands God's image, that is, goodness and love, to be inalienably located in the human soul. Here, God relates to humans, who in turn desire to relate to him: what is more natural then to love *love*?[29] The *imago Dei*, hence, indicates the relationship between the Creator and the creature, and from there between all God's creatures. The *imago* constitutes the intrinsically *personal* dimension of human life (a human being is the particular *you* of God's loving address), as well as its *social* dimension, its being directed to the other (who is also addressed as *you*). It qualifies the attitude humans should have both towards themselves and to each other as an attitude of *love*.

I will look closely at three particular aspects of Augustine's interpretation of the *imago*, namely, the relational, dynamic, proleptic aspects, which have implications for his view of health, as well as medical healing and medical morality.

I will also look at Augustine's interpretation of the Fall. Due to the Fall, the image of God's love in humans is discoloured and in need of renewal or restoration brought to humans in Christ and mediated by the Spirit (4.3).

Though Augustine resolutely defended the goodness of matter, he was also painfully aware of the deficiencies of nature which humans experience most acutely in bodily illness and in the encounter with death. He understands evil in nature (e.g. diseases) as God's punishment for the freely chosen disobedience in the Garden. Such punishment for Augustine is just and inherited. It functions as an exhortation to the conversion of people's hearts to God's love. God's salvific love is the primary context in which Augustine reflected on human health and (medical) healing (4.4).

Bodily health is a gift of grace which belongs to the history of human salvation. It reflects God's end for humanity which is happiness, joy, and well-being. God extends being, and gives well-being, temporal here and now, and perfect in the future. Augustine saw medicine as one possible means of healing. God's

28 Augustine, *City of God*, XI/10.
29 Augustine, *Trinity*, VIII/10.

mercy and grace works in the medical profession but God is also known to have healed in the sacrament of baptism and in response to prayer (4.5).

Like Tertullian, Augustine distinguished disease and health of body and soul. Illness of the soul is a result of humanity's separation from God after the Fall. This separation leads to love of self, instead of love of God, and behaviour such as lust, envy or greed. The full restoration of the *imago* (hence, of the creature's relationship to God, self, and the other) is not a sudden and immediate event. It is a gradual process, which takes place during one's lifetime and will be completed eschatologically. Healing of the soul needs to be striven for first, in remitting the cause in baptism, and second, in orienting one's *self* to the love of God and meeting others on this basis. The soul's health is valued higher than all bodily health: it leads the human creature in its union of body and soul to the fullness of love (4.6).

Chapter five focuses on the Anglo-American debate from the mid-1970s. Against the background of the unitive account of Augustine I will explicate the impact that an isolated reflection on the body, or the individual, or the social context may have on medical practice. At the centre of the 1970s debate was the question whether health and disease are natural norms shared by all members of the human species (with the exception of a few disease anomalies) or whether they are standards underpinned by value judgments and imposed on individuals in a particular socio-political context. At present, the debate is heading towards theories that seek to bridge natural-factual and socio-cultural-evaluative aspects of health and disease, and situates health increasingly in the context of human flourishing (5.1).

After an introductory overview, I look at the American naturalist philosopher Christopher Boorse for whom health is a statistical norm. Health and disease are a matter of empirical investigation: medicine reads off symptoms of bodily functioning and dysfunctioning. Whilst giving health a clear epistemological status, Boorse's approach reduces the meaning of health to bodily functionality. The body is seen as an isolated natural entity, separate from e.g. individual choices, opinions, emotions or desires. On a practical level, this means that the body, like a material object, may be handed over to the physician (5.2).

H. Tristram Engelhardt (here in his role as a medical philosopher) acknowledged that concepts of disease and health include empirical bodily parameters yet rejected Boorse's purely naturalist account. Using the example of the nineteenth century disease of masturbation, Engelhardt argued for a value-infected and culture-dependent concept of health. In raising awareness for the impact of cultural or political norms on decisions of what state of human life or what human actions are considered to be signs of health or disease, Engelhardt's evaluative understanding allowed for deconstructing the physician's assumed neutrality and authority. However, in focusing on the social and cultural context primarily, he failed to explore the individual component in interpreting the concept of health against, for instance, the horizon of one's personal life-experience and hopes for a fulfilled future (5.3).

Lennart Nordenfelt's account of health focuses on the individual dimension of human life in relation to health. For him, health is a state of life that allows us to

achieve our vital goals. These result from individual choices. As a consequence, there are as many healths as there are individual assumptions, beliefs, propositions, and choices. Nordenfelt's interpretation allows medicine and health care more generally to centre on the subjective needs and desires of the patient, and to enable his or her goal achievements. Yet the question remains whether a common (social, cultural, political or indeed natural) underpinning of health can be recognised in such subjective interpretations. A common reference point is important as basis of shared health care systems and codes of professional conduct (5.4).

The final chapter draws out conclusions for the physician-patient relationship and medical practice developed on the basis of an Augustinian understanding of human life and health in critical comparison with contemporary philosophical accounts of health.

The exegesis of theologians of the past with a view to their relevance for today's medical practices is undertaken together with an exploration of twentieth and twenty-first century theological discourse on health and the relationship between theology and medicine. Why might the study of a theologian or theologians of the past be important for debating medical morality today? For today's Orthodox theologians with their understanding of the workings of the Spirit in the present the theological predecessors of the first millennium are contemporaries.[30]

For today's Western theologians God's revelation in Christ and in Scripture and the tradition, in varying degrees according to various traditions, is not only an historical event, but is present in the church always.

In chapter six I engage with Karl Barth's views on abundant human life, health, medicine, and the relationship of the individual to God and fellow humans. I look at H. Tristram Engelhardt's work, writing now as Orthodox Christian bioethicist on issues of bodily and spiritual health and the rich Orthodox tradition of miraculous healing. I explore Stanley Hauerwas' views on the importance of the church for medical practice as a community able to be present to others in pain.

I seek to bring out how the positions of the Church Fathers presented above, and Augustine's views in particular, accord with the interpretations and views offered by our contemporaries. Against this argumentative background I will move on to develop an approximation of how health might be understood in the contemporary context when approached from a perspective that seeks to take seriously the wisdom found in the engagement with God's word in Scripture and the Christian tradition (6.1).

Grounded in Augustine's anthropology which integrates body and soul, bodily health is recognised as a component of human ontology; patients share the physical and physiological generalities of a species. Yet in facing a particular patient, the physician faces a unique person with an inimitable life story, the knowledge and interpretation of which can be decisive for success of treatment – an aspect that belongs to her ontology also. Where the body is good, its state of health is *a good*. Yet when particular practices of medical research and/or clinical treatment convey an understanding of health and healing that fails to acknowledge

30 Harakas, *Health in the Orthodox Tradition*, 6.

the ontology of the body as integrating personal particularities as is the case in the UK documents' rhetoric of repair, these practices cease to be oriented towards the good of human health which the exegesis of Augustine's anthropology developed.

Bodily health is a *temporal* and *relative* good. It is a *temporal* good due to the body's temporal finitude; it is a *relative* good measured against God's absolute love. Health's temporal nature and relative value limits medical research and clinical action against the horizon of finitude and, above all, infinite being. Where health is recognised as a state that serves human life in its orientation towards God's being, health may motivate medical action. Then, it may indeed function as a research imperative and promote medical action.