
Church and healthcare: Time for a new debate?

Laetus OK Lategan

Director: Research Development & Postgraduate Studies

Central University of Technology, Free State

Bloemfontein

llategan@cut.ac.za

Opsomming

Kerk en gesondheidsorg: Tyd vir 'n nuwe debat?

Dit is duidelik dat die Christelike godsdiens 'n kleinerwordende rol in gesondheidsorgbeleid en -praktyk speel. Dit beteken nie dat die kerk nie 'n rol het om te speel nie. Die vraag is, wat moet die rol wees van die kerk in die verstaan van gesondheidsorgontwikkeling en -praktyk? Die fokus van hierdie artikel is op die rol wat die kerk in die bevordering van eties-gedrewe gesondheidsorg in 'n tegnologiese samelewing kan speel. Hierdie is duidelik 'n verwaarloosde tema in kerkbeleid en navorsing oor hierdie onderwerp. In die aanspreek van hierdie onderwerp, word die standpunt onderskryf dat kwesbaarheid nie tot 'n pasiënt beperk kan word nie, maar dat dit uitgebrei moet word na almal betrokke by gesondheidsorg, naamlik die dokters, versorgers, terapeute, bestuur en gemeenskap. Om die kerk se rol in gesondheidsorg te verstaan, is die dominerende invloede op gesondheidsorg en watter verskuiwings gevolglik plaasgevind het, ondersoek. Uit die analise is dit duidelik dat hierdie die ruimte is waarin die kerk betrokke moet wees. Die kerk moet betrokke wees by die kompleksiteit van gesondheidsorgdienslewering en die wye verskeidenheid van mense daarby betrokke. Die roeping van die kerk is om verandering na al die mense betrokke in gesondheidsorg te bring. Die kerk as 'n geloofsgebaseerde organisasie kan nie haar rol ontken in die herstel van menselewens deur die transformerende boodskap van verlossing en herskepping nie. Die rol van die kerk in gesondheidsorgbeleid en -praktyk is geskoei op individuele, sistematiese, gemeenskaplike en sosiale betrokkenheid.

Abstract

It is evident that Christian religion plays a declining role in healthcare policy making and healthcare practice. This does not mean that religion has no role to play. The question is, what role should the church play in understanding medical developments and how should it participate in healthcare? The focus of this article is to look at the role that the church can play in promoting ethically-informed healthcare in a technology-driven society. This appears to be a neglected topic in church policy and research into the field of ethics. In addressing this matter, the article presents the view that vulnerability is not limited to the patient only but relates to all in healthcare, namely those who cure, care and control, as well as to the community as a whole. The article unpacks the dominant influences on healthcare coupled with a number of shifts. This analysis confirms that these influences and shifts create a space in which the church can function. It is further evident that the church's role is to deal with the complexity of healthcare and the wide range of people who should be cared for. The calling of the church is to bring revival to vulnerable people in healthcare. The church as a faith-based organisation cannot deny its role to restore the life of people through its transformative message of re-creation and redemption. The role outlined for the church in this article is framed around individual, systemic, communal and societal engagement.

1. Orientation

Paul Schotsmans' book (2012) *In goede handen* (translation: *In good hands*) looks into the relation between healthcare, medical ethics, bioethics, sexual ethics (in relation to health) and the church.

In this book, written in the context of Catholic Flanders, the author shows that he is very much aware of the *declining* role that the Christian religion may play in *healthcare policy making and healthcare practice*. This does not mean that there is no role for religion in healthcare policy making or practice, or that the church should take a back seat in healthcare, medical ethics and bioethical matters. He argues convincingly that Christianity and the church can play a role in healthcare. The concluding interpretation is that the role of the church should not be diminished. The question is rather: *what role should the church play and how should that role be performed?*

A dual challenge emerges from the above-mentioned book. Many healthcare policymakers and healthcare practitioners experience a disjunction between the church's view on healthcare challenges and the ethical understanding of these challenges.

The book poses two important questions for this research article: *firstly*, what role should the church play in understanding medical developments, and *secondly*, how should the church participate in healthcare?

Schotsmans' study gives at least three important directions for this discussion.

- *Firstly*, new developments in contemporary day medicine open new ethical challenges for which new ethical guidelines and frameworks are required – something that may be challenging to existing church policy or unacceptable by a particular faith community. For example, the church cannot force people to accept or reject a view on the ending of life. This presupposes an “open-mindedness” from all involved in this matter. This open-mindedness is informed by *aggiornamento* (openness to a new world) as formulated by the Second Vatican's Council. It should be noted that even in the same church community there can be agreements and disagreements on a variety of subjects. Typical examples of agreements are those related to organ donation, organ transplantation and palliative care. Representative examples of extreme differences are the debate on the status of the embryo, stem cell research and therapy, active euthanasia and the right to request assistance to end a life.
- *Secondly*, the awareness exists that ethical challenges associated with contemporary modern day medical developments require *new* answers. The challenge is not the *new* answers but what the *basis* for these new answers should be. How is the drive for *rationality* and *evidence* in ethical decision making balanced by revelation as basis for religion and church doctrine and tradition? Is there a shared understanding on the meaning and impact of technological developments?
- *Thirdly*, there is the role that the Christian religion can play in understanding global healthcare challenges and formulating guidelines for these challenges despite the fact that a Christian orientation may play a minor if not an absent role in this debate. Where is the church where it matters most?

In essence, Schotsmans makes the church community aware of both *responsibility in* and *delivery of* care. The title of his book evokes two impressions: good healthcare (as performed by caregivers) and the church's constructive engagement with healthcare as part of its service to the world.

The point is clear: *the church has an active role to play in healthcare and medical ethics*. This view informed the focus of this article: is it not time to open the debate again? Revisiting the debate on the church's role in healthcare and medical ethics or bioethics is not meant to give an account of different opinions or even outstanding matters. Neither does the article intend to open up discussions on doctrines such as the theodicy question, nor whether church ceremonies and pastoral care are sufficient to address challenges of healthcare and medical ethics. The intention of this article is to outline the role that the church as a faith community can play in promoting ethically-informed healthcare in a technology-driven world.

2. A neglected topic in South Africa

A survey of major Christian-oriented journals (*Journal for Christian Scholarship*) and/or theology journals (*Hervormde Teologiese Studies*, *In die Skriflig*, *Nederduitse Gereformeerde Teologiese Tydskrif*, *Stellenbosch Teologiese Tydskrif/Stellenbosch Theological Journal*, *Acta Theologia*) in South Africa over seven years (2010-2016) suggests that the theme has hardly been attended to. Apart from a article by Wils (2016) and a response to this article by Foster (2016), no attention in particular has been paid to this topic.

The conclusion is simply that although one may accept that it is an important theme in church life, the church (in general) does not participate in the national healthcare debate. The purpose of this article is to prepare a position for the church from which to participate in the debate on ethically-informed healthcare.

3. Scope and research orientation

This article is the result of qualitative research into a debate for which limited information has been available in South Africa over the past five years. Of value is Foster's (2016) argument that the church has as part of its role in society, the responsibility to promote *just health*. He questions how it is possible to have such a high number publicly professing Christians yet something like the treatment of HIV/Aids is not being well attended to. He also comments very critically on the two medical systems in the country, namely private providers and primary healthcare, and emphasises that current medical ethics is removed from social injustice and inequality because of politics (former and present political systems), economy and apathy. For

him it is a matter of the church being active to promote “just health” as part of its role of public theological responsibility. He comments on Wils: “... the Christian church has the public theological responsibility to seek a different *oikonome* [a management of the resources of the household of God] to engage neo-liberal capitalism” (Foster, 2016:4). Foster hints at the important role the church can play but suggests that the engagement between church, healthcare and society is limited.

For the purpose of this article the claim may be made that the discussion of the broad-based theme of this study, namely the role of the church in the healthcare debate, is limited. Published studies concentrate on ethical themes and not on the role the church can play in private and public healthcare. The scope of the research on studies published in Flanders serves as a background to this article.

The *purpose* of this study is to raise the question as to how the church should extend its understanding of its role in promoting healthcare in a technology-driven world.

The *aim* is to argue that healthcare deals primarily with the vulnerability of people and that dealing with vulnerability is the task of the church. The complexity of the matter is that vulnerability is not only a challenge of the patient but also of all involved in caregiving. This “all” is informed by Glouberman and Mintzberg’s (2001) outline of the four worlds in healthcare in support of the patient: *cure*, *care*, *control* and *community*. Cure refers to the doctor, care to nurses and therapists, control to the managers of the healthcare system and community to the relatives of the patients and society at large.

The *thesis* of this study is that it is not only the patient who is vulnerable but all who work in support of the patient. Studies by Vanlaere and Burggraeve (2013), Phalime (2014), Schotsmans (2012) and Lategan and Van Zyl (2017) argue convincingly that vulnerability in healthcare is not limited to the patient only. *This has been, up to now, a neglected focus in the church’s service to its congregation.*

The *focus* of the article is the church as institution and not the church as denomination (Protestant, Catholic, Charismatic) or sub-denomination (Dutch Reformed, Baptist, Anglican). The idea is not to denounce doctrine differences but rather to focus on complementary views.

4. New developments in healthcare, medical ethics and bioethics

Healthcare, medical ethics and bioethics cannot be understood outside five dominant domains. These domains are:

- *Healthcare economy and industry influence:* The healthcare industry is very much challenged by the question of health improvement and profit margins. Whilst the health industry is known for its ongoing drive to improve on the delivery of quality healthcare, pharmaceutical industries are contributing to the hiking of prices. Health improvement is part of the World Health Organisation's drive to promote global health and healthcare as part of the quality of health. The pharmaceutical companies play a crucial role in support of the global drive for quality of health. At the same time, however, new drug developments are extremely expensive, and often a booster for a new technology or a catalyst for profit rather than a health improvement. The point is that healthcare cannot be understood apart from economic and healthcare industry development (Remans, 2005; Ten Have, 2011; Vanlaere & Burggraeve, 2017b). There is another downside: Ezeh (2017) argues that if the United States were to cut down on its healthcare aid to global health, this could have a significant impact on programmes dealing with Aids, tuberculosis and malaria. Although the Abuja Declaration committed African countries to spend at least 15% of their budgets on healthcare, the absence of quality data makes this difficult to confirm. A cut in funding of global health makes healthcare extremely vulnerable and changes the landscape of healthcare. This in reality coincides with Penfold's (2015) earlier comment that sustainable healthcare as part of the sustainable development goals is threatened due to high poverty levels and overdependence on donor funding.
- *Healthcare as a basis for human and constitutional rights:* The South African Constitution (Republic of South Africa, 1996) makes provision for the right to healthcare. Sections 7 (2) and 27 (1-3) affirm the state's responsibility towards healthcare, access to healthcare services and the right to emergency medical treatment. The 1948 Universal Declaration of Human Rights, the Constitution of the World Health Organisation and the 1966 International Covenant on Economic, Social and Cultural Rights all recognise healthcare as a human right (see Moore, 2017). The World Health Organisation emphasises special care for the vulnerable, specifically women, children and refugees (displaced people), elderly people and those with mental disabilities. From these observations it is clear that quality of health cannot be waived by any government, and

neither can the healthcare profession and industry turn a blind eye to the vulnerability of people. It is, however, very sad to note that healthcare as a basic human right has become a political playing field. Part of addressing the problem is the debate on how the medical curriculum should be shaped to increase comprehension for human rights and the provision of healthcare (Moore, 2017). Moore (2017:71) advocates that access to healthcare facilities and services should be without any discrimination.

- *Technological developments:* Technological developments have opened up many new possibilities. A growing development is that of additive manufacturing (3D printing). Typical examples are prostheses such as hands, arms or legs that increase the functionality of the patient. Implantations and reconstructions such as those of the jaw or ear have assisted patients to be part of the social environment again. These developments do not contribute only to improved health but also to the socialisation of these patients. At the same time there are challenges to these developments: the classical question remains as to whether we should do everything that we are able to do versus the opinion that we should not do everything that we are able to do. At the same time, one should also acknowledge that technological developments can instil fear in patients. Phalime (2014) observes that many patients who are not familiar with technology, fear it because it is unknown to them and they don't understand it.
- *Pay more attention to the human factor:* It is evident that healthcare cannot only be about *cure* and *care* but is also about the renewal of patients' life challenged because of their illness. Well-known medical-ethical codes promote respect for life, dignity and well-being. The Georgetown mantra, for example, is known for its principles identified for patient care (Ten Have, 2011:27 & 28). What is perhaps intended but not well articulated is the improvement in a patient's quality of life in spite of a health challenge. It is here that the medical humanities can play a very important role. The medical humanities may be defined as understanding the human side of a patient. The objective of understanding the human side of the patient is to promote a holistic understanding of the patient and not just to have a clinical picture of the patient (Lategan, 2014). Lategan and Van Zyl (2017:9) promote this understanding by stating that "Quality healthcare is important due to safety associated with the healthcare value chain. The core of the value chain is not healthcare as a product but healthcare as a relationship." Vanlaere and Burggraeve (2017a:46-47) echo the same sentiment: "Care should not be considered in the first place as a product

that must be performed according to certain specific standards, but rather as a relationship in which the relationship itself takes precedence over the content or over what is subsequently specifically done.” As a result, Lategan and Van Zyl (2017:130) formulate the following pointer as part of a suggested healthcare code: “Healthcare is about a mutual relationship between the patient, the healthcare practitioners and the community.”

These new developments are accompanied by seven dominant shifts in healthcare. These shifts are:

- *Healthcare is a human right but also an expensive right.* The question is, how is access to (primary) healthcare balanced by affordability? Although no one will deny the importance of access to basic healthcare and the support of health in general, it cannot be denied that this is a costly service to deliver, especially where the government cannot provide for all kinds of healthcare in a society where there is such a high percentage of poverty and unemployment. The challenge is therefore the conflict between constitutional responsibility and affordability. Kaulfuss (2017) echoes the same sentiment by asking whether healthcare is a human right or an expensive entitlement.
- *The World Health Organisation identifies vulnerable and marginalised groups as a special priority in healthcare* (see Chan, 2017). Within these groups there is vulnerability within vulnerability. Two examples inform this statement: the lack of sufficient funding makes healthcare extremely vulnerable, and the absence of well-qualified healthcare practitioners and services, especially in rural areas, makes it very difficult to perform cure and care. A complementary observation is that healthcare in South Africa is still very unequal. Income, membership of a medical fund, geographical location and accessibility determine the level of access to healthcare. In addition, groups such as the mentally disabled are largely neglected in healthcare. The recent scandal around the treatment and subsequent death of a large number of mentally disabled people, portrays the vulnerability and voicelessness of such groups.
- *The focus is no longer on the patient only.* For a very long time the focus of medical ethics and bioethics has primarily been on what was good for the patient. Attention was centred around the doctor-patient relationship. Although the aim of ethical endeavours is still to promote patient care, this is no longer the only objective. The increase in bioethical considerations necessitates a new look at what informs the care of the patient.

-
- *Healthcare is not only about the doctor-patient relationship with the emphasis on the patient: the cure provider and the caregiver must also be taken into consideration.* There is a growing need to extend ethical care to the healthcare practitioner. Lategan and Van Zyl (2017:6-10) promote this idea, following on studies by Vanlaere and Burggraeve (2013) and Phalime (2014). Lategan and Van Zyl's central argument is that quality healthcare depends on skill, physical, human and financial infrastructure, attitude, behaviour and practice. Following from this, the conclusion is that healthcare is no isolated activity. These authors state in relation to healthcare ethics, that "The healthcare practitioner deserves the same respect for his/her values as does the patient" (Lategan & Van Zyl, 2017:9). MacKinnon and Comber (2017) also promote a wider view on healthcare than the patient only. They refer to research that points out that "Japanese resident physicians were more likely to include the patient's family in end-of-life decisions" (MacKinnon & Comber, 2017: 57).
 - *Illness and disease remain very personal and culture-bound.* No "one size fits all" approach exists. Although global health sets out to promote universal health, it can never ignore the uniqueness of a community. Lewitt, Campbell and Cross (2017:91) highlight that healthcare research moves from working "on" communities to working "with" communities. Ten Have (2011:21ff) points out that ethical dilemmas will be understood differently in different communities. This is very evident in the end-of-life-decision debate that is now going on. This debate is informed by the protection of life, the right to dignity, and the argument that life cannot be taken even with consent, among other things. MacKinnon and Comber (2017) outline the roles of culture, individual values and religion in healthcare. The "clash" in decision making and therefore treatment can often be attributed to different viewpoints because of culture, individual values and religion. The challenge is for healthcare practitioners to understand their own positions and those of fellow healthcare practitioners and patients. Lewitt *et al.* (2017:85) remark that "ethical considerations should encompass respect for community as well as for individual autonomy".
 - *The informative conclusion is that being "ill" is no longer a matter of diagnosis only.* While it is no less a human experience than it was in the past, it is a fundamental issue challenging human existence. Once again the elderly, handicapped and children are most affected. Cure may

not be enough. A multi-faceted perspective is warranted to understand the treatment of a patient. In his discussion on the role of spirituality in healthcare, Swart (2017) affirms that it plays an important role in healthcare although it is never a replacement for proper healthcare. The advantage is, however, that the healthcare now looks different to the patient and the patient should also look different to him-/herself.

- *The added advantage is that it necessitates a different lifestyle.* An appropriate example is that good health is often associated with good food and good nutrition. This assumption is challenged by the concept of food security as availability and safety of food. *Food security* has become a pressing challenge due to genetic manipulation, climate change, limited water resources and many developing countries that are in no position to provide in their citizens' basic food needs. The challenge of food safety is an issue closely related to food security. Food security suggests the general availability of healthy, safe and nutritious food (see World Food Summit 1996 of the World Health Organization), whilst food safety refers to the controlled and monitored treatment as well as the management of food destined and suitable for human consumption (United Kingdom, *Food Safety Act*, 1990). Although there may well be adequate food supplies in a country, quite often many still experience difficulty in accessing quality and healthy food or even access to any food at all.

The following may be identified from these developments and shifts in healthcare:

- Healthcare is not a matter of illness and disease only. It is a human experience where personal autonomy and individual views can never be removed from a community or a system.
- Healthcare is vulnerable due to lack of financial and technological ability and a lack of political will to uphold quality healthcare as a human right.
- Although women, children and handicapped people are especially vulnerable, due to abuse the voiceless are vulnerable within their vulnerability.
- Upholding humanity, dignity and securing access to quality healthcare are the focus points of healthcare in any system.
- No proper healthcare system can operate without sufficient finance, infrastructure, skills and support.
- Technology can challenge and improve healthcare.

From the scope of this article an important observation from these developments and shifts is that health has taken on a new meaning: *care for oneself*. Although there is nothing wrong with such an approach, two eminent challenges exist: (a) what guidance is provided not to slip into a narcissistic self-centred focus, and (b) how to assist those without any power (the vulnerable). Can we concur with Schotmans' comment that patients are always "in good hands" and does the church play its role sufficiently to secure quality healthcare as a relationship and not a product?

The follow-up question now is, what role can the church play to support healthcare as a relationship and how can it contribute towards the church's participation in the debate on healthcare delivery?

5. The role of the church in healthcare: A perspective from Paul

The church as a faith-based organisation cannot deny its role to restore the life of people through its transformative message of re-creation and redemption.

This message is in particular applicable to healthcare. The role outlined for the church in this article is framed around individual, systemic, communal and societal engagement. The aim of the engagement is for the church to guide the patient to the confession that he/she has experienced God (similar to Job's confession: Job 42:2 "I know that you can do all things.") and the acknowledgement that life's challenges contribute to the preaching of the gospel (Philippians 1:17).

This role can be well-informed by Paul's view of the church. In his systematic analysis of Paul's view of the role of the church, König makes the following comments with regard to Paul's view of the *body of Christ*. Based on 1 Corinthians 12 different body parts (diversity) are required for the proper functioning of the body (church). However, the different body parts cannot function independently from each other, hence the interdependence of church members on each other's respective well-being. Following on these perspectives is the conclusion that the stronger body parts should care for the weaker parts (König, 2017:335). These three comments suggest interdependence and care for one another regardless of the uniqueness (strengths/abilities/opportunities) of the individual. König (2017:336-342) continues discussing the meaning of the body of Christ by saying that its aim is to contribute to the development (prosperity) of the church. The

development of the body of Christ has as its aim the growth of faith in Christ. Christ plays a unique role by being the “head” of this “body”. This metaphor suggests that believers grow “in” Christ and “from” Christ. Growing in Christ means that a person becomes more like the image of Christ. The growth in Christ will contribute towards unity and Christ becoming visual to the world through what people are doing. The growth from Christ informs believers’ service to the world. These perspectives contribute further to unity amongst Christ’s followers (disciples) and their holiness in God. This unity embodies the idea of application in practice, and holiness refers to their moral life (see for example the letter to the Ephesians) (König, 2017:342-344). These perspectives fit into the broader meaning of ethics in the New Testament. Paul’s letter to the Romans confirms that people’s way of thinking should change; his letter to the Colossians mentions that they have in Christ a new life before God; and the missive to the Galatians states that Christ has freed men and women from the slavery of the law. The common understanding of these commands (also known as *paraenesis*) is to act accordingly (Van der Watt, 2014:289-291). This ethic is based on the relationship with Christ through believe and following (Van der Watt, 2014:295-298). Following on this is an ethical behaviour illustrated through love, and love is evidence that a person belongs to Christ (Van der Watt, 2014:298-305). Mettepenningen (2011:56-64) links love to mutual community – between God and fellow persons. This community can best be illustrated in how church members express their care for each other.

From these comments the role of the church can be outlined as follows:

- The church as the metaphorical body of Christ has as task to unite people with Christ through faith. This unification depends very much on the knowledge of God through Scripture, tradition, revelation and human experience; the confession that Christ is the Redeemer and the Re-creator of the relationship with God and fellow persons.
- The church has the responsibility to serve the world, protect the vulnerable and to grow the relationship with fellow persons through the community with God.
- The church has to preach redemption as gospel. The difference is that Christ through his crucifixion has already restored the relationship with God and fellow persons but that this redemption must now become a visual reality.
- The body of Christ presupposes service to the world and the living testimony of God’s holiness in the world.

These perspectives develop the role the church should play in ethical healthcare in a technology-driven world.

6. The church's role in ethical healthcare in a technology-driven world

Applied to the role the church has to play in healthcare, the following comments can be made based on the assumptions and statements developed through the notion of the body of Christ:

- *Healthcare is a service to vulnerable people.* This vulnerability should be protected and cared for by the church. Christ's redemption is aimed at putting an end to seeing human vulnerability as hopeless, rejected and not favoured by anyone.
- *Healthcare is to see service through Christ's re-creation.* Through Christ's redemption, a fallen world could be restored, firstly through the new relationship with God through Christ and secondly through the calling of being like Christ for a new world. This "being" refers to compassion, care and mercy as signs of our engagement with people, systems and society.
- *Healthcare is to equip people to have a new relationship with themselves, fellow persons and the human ecology at large.* The church has to communicate this perspective through its sermons and practise and apply this new relationship through its pastoral care. Pastoral care is not to ease people outside the congregation but to assist them to confront and heal broken relationships.
- *Healthcare is to bring dignity to all people, especially the vulnerable.* The church has a role to play in the protection and upliftment of vulnerable people. This starts with being a church that reaches out to people where they are, and that does not wait for people to come to the church first.
- *Healthcare benefits from a just, righteous and equal society and world.* Part of the church's role to secure unity and to promote holiness, is to actively engage with the society to promote dignity, righteousness and equality. For too long a time, this was reserved for the "political will" and not well accepted as a calling of the church. Promoting a sustainable society, the environment and access to quality healthcare, for example, as well as advocating food security and safety, are all duties of a church through preaching and living the gospel of the kingdom.

- *Healthcare is to challenge existing practices and to accept new realities.* The church can no longer allow race, income or geographic location to determine what kind of healthcare should be available or what the quality of this healthcare should be. The church has to confront both private and public sector to contribute to healthy societies and to bring equality to accessing healthcare.

Healthcare should take the church out of its comfort zone. For a very long time the church's participation in the healthcare debate was limited to the declining of requests for abortion on demand, and the debate on euthanasia or genetic engineering. *The Abortion Act (Act 2 of 1975)* coincides with the church's doctrine that unborn life should be protected, but the church has been fairly silent on the legal shift from therapeutic abortion to abortion on demand (*Choice on Termination of Pregnancy Amendment Act, Act 38 of 2004*; Lategan, 2007). The church has a well-articulated perspective on no mercy killing on request (see Lategan, 2017) and its accompanying palliative care perspective but has not yet articulated itself with regard to assisted life-end decisions. Church doctrine has to balance the meaning of suffering, dignity, impact on family and friends, and self-determination with the claim that people should live at all costs. This is not to promote self-killing but attempting to understand why a person may demand assisted suicide and how the family and friends could be counselled in such events. The debate on genetic engineering was ended prematurely. Is there any consensus on stem cell research and transplantation, gender change or the treatment of mentally handicapped people? Has the church protested against the death of the almost 100 mentally handicapped people in 2016 (see for the latter Sonderup, 2017)?

- *The church should monitor the state's responsibility with regard to the delivery of healthcare and human rights.* The church has to influence the provision of healthcare services as part of a basic human right. Consider the Abuja Declaration (paragraph 2) and the South African healthcare budget for 2016/2017. Was it ever monitored and evaluated? Is it not a church's responsibility to question the morality of the management of healthcare?
- *Healthcare should restore mercy and meaning in the life of people.* The church has as its role the promotion of mercy in a society. Mercy ("hesed" in Hebrew) refers to the all-encompassing care of people. At the same time is it about bringing meaning to people through the *unity, holiness*

and services of life.

These pointers will assist in building an ethics of *meaningful closeness* as a response to how the church can contribute to the promotion and roll-out of healthcare.

7. Conclusion

This study engages with Schotsmans' study on the role the church can play in healthcare and its delivery. From his book, it is evident that although Christian religion plays a declining role in healthcare policy making and healthcare practice, it surely does not mean that religion has no role to play. The question following his comment and the basis for this article is, what role should the church play in understanding medical developments and how should it participate in healthcare? One cannot simply ignore the value (Christian) religion has in understanding human challenges. The declining role of religion in healthcare ethics is vested in the common belief that ethics should be free from any religious influences together with the belief in the rationality of science.

This article builds on Schotsmans' view that the church has a role to play in healthcare (ethics). The focus of this article is the role the church can play in promoting ethically-informed healthcare in a technology-driven society. Evidently this is a neglected topic in church policy and research in South Africa.

The article holds the thesis, after Phalime, Vanlaere and Burggraeve and Lategan and Van Zyl, that vulnerability is not limited to the patient only but relates to all in healthcare, namely those who cure, care and control, and the community. These four medical worlds are identified by Glouberman and Mintzberg.

The article argues that there are five dominant influences on healthcare, and a number of shifts in healthcare practice and ethics as a result of these influences. From these influences it is notable that healthcare cannot be understood apart from economic and healthcare industry development or technology development. In return these developments have an influence on the practice of healthcare, the way illness is experienced, and any new

ethical dilemmas that originate from these developments.

Although healthcare is a basis for human and constitutional rights, it has become a very expensive and in some cases an unaffordable right. At the same time, technological developments can have a very positive but also very challenging impact on the life of people. More attention should therefore be given to the human factor in healthcare.

These influences and shifts create a sphere of influence for the church. It is further evident that the church's role is to deal with the complexity of healthcare ethics, practice and services and the different stakeholders and practitioners in and beneficiaries of healthcare services.

The calling of the church is to bring revival to vulnerable people in healthcare. Vulnerable people include the sick, the medical staff who work under challenging conditions, and the community that is part of the patient's life.

The article looks at the role of the church from a Pauline perspective. The church as a faith-based organisation cannot deny its role to restore the life of people through its transformative message of re-creation and redemption. In Paul's letters the focus is on community through love and "new" people and not simply on changed people.

These perspectives assign a very specific role to the church in healthcare. That role is to create community, to restore justice and to promote well-being – not only for the church members but for all society (structure and people) working in and benefitting from healthcare.

Bibliography

CHAN, M. 2017. *Ten years in public health*. 2007-2017. Geneva: World Health Organisation.

EZEH, A. 2017. How Trump's proposed US aid cuts will affect healthcare in Africa. *The Conversation*, 10 April.

FORSTER, D.A. 2016. An appreciative contextual response to Jean-Pierre Wils, "Is there a future for 'medical ethics'?" Just Health as a public theological concern. *In die Skriflig*, 50(1), a2122. <http://dx.doi.org/10.4102/ids.v50i1.2122>.

GLOUBERMAN, S. & MINTZBERG, H. 2001. Managing the care of health and the cure of disease. Part 1: Differentiation. *Health Care Management Review*, Winter 56-69.

KAULFUSS, R. 2017. Health care – human right or expensive entitlement?

Beyond economics, 15 March.

KÖNIG, A. 2017. *Paulus*. Vereeniging: CUM.

LATEGAN, L.O.K. 2007. Kommentaar op die verskuiwing in die hersiene wetsontwerpe oor die vrywillige beëindiging van 'n swangerskap. *Tydskrif vir Christelike Wetenskap*, 42 (4):139-149.

LATEGAN, L.O.K. 2014. The role of medical humanities, ethical coaching and global bioethics in addressing the ethical vulnerability of health care practitioners. *Ned. Geref. Teologiese Tydskrif*, 55(3&4):669-684.

LATEGAN, L.O.K. & VAN ZYL, G.J. (Eds.). 2017. *Healthcare ethics for healthcare practitioners*. Bloemfontein: SUN MeDIA.

LATEGAN, L.O.K. & VAN ZYL, G.J. 2017. An introduction to healthcare ethics. In: Lategan, L.O.K. & Van Zyl, G.J. (Eds.). *Healthcare ethics for healthcare practitioners*. Bloemfontein: SUN MeDIA. pp 5-10.

LEWITT, M., CAMPBELL, P. & CROSS, B. 2017. Community-based participatory research in healthcare. Ethical issues an impact on healthcare practitioners. In: Lategan, L.O.K. & Van Zyl, G.J. (Eds.). *Healthcare ethics for healthcare practitioners*. Bloemfontein: SUN MeDIA. pp 81-95.

MCKINNON, J. & COMBER, A. 2017. The influence of culture, values and faith on end-of-life-decisions. In: Lategan, L.O.K. & Van Zyl, G.J. (Eds.). *Healthcare ethics for healthcare practitioners*. Bloemfontein: SUN MeDIA. pp 53- 63.

METTEPENNINGEN, P. 2011. *Welke kerk? Vandag en morgen?* Leuven: Davidsfonds Uitgeverij.

MOORE, A. 2017. Ethics and human rights in healthcare. In: Lategan, L.O.K. & Van Zyl, G.J. (Eds.). *Healthcare ethics for healthcare practitioners*. Bloemfontein: SUN MeDIA. pp 65-72.

PENFOLD, E. 2017. Universal healthcare is a tall order given southern Africa's poor finances. *The Conversation*, 22 October.

PHALIME, M. 2014. *Postmortem: The doctor who walked away. A true story*. Cape Town: Tafelberg.

REMANS, J. 2005. *De boom van goed en kwaad: Over bio-ethiek, biotechniek, biopolitiek*. Leuven: Acco.

REPUBLIEK VAN SUID-AFRIKA. 1975. *Wet op vrugafdrywing en sterilisasie*, Wet 2 van 1975. Pretoria: Staatsdrukker.

REPUBLIC OF SOUTH AFRICA. 2004. *Choice on Termination of Pregnancy Amendment Act*, Act 38 of 2004. Pretoria: Government Printer.

REPUBLIC OF SOUTH AFRICA. 1996. *Constitution of South Africa*, 1996.

Pretoria: Government Printer.

SCHOTSMANS, P. 2012. *In goede handen: Geneeskunde en ethiek binnen die kerk van vandag*. Tiel: Lannoo Campus.

SONDERUP, M. 2017. Politicians must account for the deaths of 94 psychiatric patients in South Africa. *The Conversation*, 5 February.

SWART, M. 2017. Spirituality and healthcare. In: Lategan, L.O.K. & Van Zyl, G.J. (Eds.). 2017. *Healthcare ethics for healthcare practitioners*. Bloemfontein: SUN MeDIA. pp 113-128.

TEN HAVE, H. 2011. *Bioethiek zonder grenzen. Mondialisering van gezondheid, ethiek en wetenschap*. Nijmegen: Uitgeverij Valkhof Pers.

UNITED KINGDOM, 1990. *Food Safety Act*.

VAN DER WATT, J. 2014. *Etiëk in en van die Nuwe Testament: om anders voor God te leef*. In: Van der Watt & Tolmie. pp 276-353.

VAN DER WATT, J. & TOLMIE, F.D. 2014. *Ontdek die boodskap van die Nuwe Testament*. Vereeniging: CUM.

VANLAERE, L. & BURGGRAEVE, R. 2013. *Gekkenwerk: Kleine ondeugden voor zorgdragters*. Tiel: Uitgeverij LannooCampus.

VANLAERE, L. & BURGGRAEVE, R. 2017a. The quality of healthcare: a care ethics approach. In: Lategan, L.O.K. & Van Zyl, G.J. (Eds.). 2017. *Healthcare ethics for healthcare practitioners*. Bloemfontein: SUN MeDIA. pp 43-52.

VANLAERE, L. & BURGGRAEVE, R. 2017b. "Our responsibility for the Suffering Other": *Care-Ethical Reflections on Ethical Education*. Lecture at the South African Association Health Educationists. University of the Free State. 3 May.

WORLD HEALTH ORGANIZATION. 2007. *New health threats in the 21st century* (Chapter 3, pp. 34-43). Geneva: WHO.