
An ethic of meaningful closeness: The church's contribution to building ethical relations within healthcare

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Abstract

Illness and suffering are unique human experiences. Dealing professionally with patients is all about relationship building. The aim of relationship building is to secure a new identity for the patient. This study presents the argument that caring should be much more than merely dealing with the illness and suffering of the patient. It also impacts on the healthcare practitioner, the healthcare administrator and the manager, the family and the community.

*The emerging question is how can such a relationship be developed with the patient given the complexity of the caring environments and needs? A framework, an ethic of meaningful **closeness**, is presented as a perspective from which caring relationships can be developed. The aim of this framework is to guide the building of caring relationships with patients. The paper further advocates the important role that the church, as a community of faith, holiness and believers, can play in developing such a framework.*

The framework is built on the principles of mercy, restoring relationships, new meanings for challenges, and experiencing the presence of God. These perspectives culminate in an ethic of care as the foundation for bringing meaning and healing to the patient.

Opsomming

'n Etiek van betekenisvolle nabyheid: Die kerk se bydrae tot die bou van verhoudings in gesondheidsorg

Siekte en lyding is unieke menslike ervarings. Die professionele omgang met pasiënte is gerig op die bou van verhoudings. Die doel van die bou van verhoudings is om 'n nuwe identiteit vir pasiënte te verseker. Hierdie studie bevorder die argument dat versorging veel meer is as om net die lyding en siekte van die pasiënt te hanteer. Dit het ook 'n invloed op die gesondheidsorgwerker, gesondheidsorgadministrateur en bestuurder, die familie en die gemeenskap.

Die vertrekpunt is hoe so 'n verhouding met die pasiënt ontwikkel kan word in die lig van die kompleksiteit van die versorgingsomgewing en behoeftes? 'n Raamwerk, 'n etiek van betekenisvolle teenwoordigheid, word as perspektief aangebied vanwaar verhoudings met die pasiënte gebou kan word. Die doel van die raamwerk is om die bou van verhoudings met die pasiënte te bevorder. Die artikel betoog verder die belangrike rol wat die kerk as 'n gemeenskap van gelowiges, heiligheid en geloof in die ontwikkeling van so 'n raamwerk kan speel.

Die raamwerk is gebaseer op die beginsels van barmhartigheid, herstel van verhoudings, nuwe betekenis vir uitdagings en die ervaring van die teenwoordigheid van God. Hierdie beginsels vind neerslag in 'n etiek van sorg as die basis om genesing en betekenis na die pasiënt te bring.

Keywords: care, church, ethics

Kernwoorde: sorg, etiek, kerk

1. Suffering: a human experience

Suffering is always associated with patients – especially those who are vulnerable and are traumatized by their disease and consequent illness. This suffering is intensified when those who *cure* (doctors) and *care* (nurses, therapists) become patients themselves. In “When breath becomes air” (2017) Paul Kalanithi recounts a moving story about a doctor who, at a point where he has almost completed his internship as neurosurgeon, suddenly becomes a patient. As a doctor, he defines his responsibility very sharply as repairing the identity of his patient. This calls for meeting a patient in his/her particular circumstances. What a patient requires is not medicine only (Kalanithi, 2017: 113).

The patient’s identity is threatened by the suffering that he/she undergoes. As a patient, and not as a doctor, he experiences the devastating effect of suffering. This is a personal experience challenging his physical and emotional existence (Kalanithi, 2017: 120-121). It can be accepted that his experience as patient is intensified because of his medical knowledge. But, he experiences the same emotions as other patients. He too, is desperately seeking a *new identity* (Kalanithi, 2017: 147). This process causes more suffering. What used to be familiar is no longer a comfort zone: In the very same room where he used to sit with patients to discuss their condition, he was now waiting for “a doctor.”

A young nurse, one I hadn’t met, poked her head in. “The doctor will be in soon.”
And with that, the future I had imagined, the one just about to be realized, the culmination of decades of striving, evaporated (Kalanithi, 2017:16).

He is now a patient and needs to be treated as a patient. Not as a doctor. A patient is looking for recovery, answers and a new personal space. No two persons may experience illness and suffering in the same way, but the commonality is to search for meaning in this challenging experience.

From Kalanithi’s account, three comments are useful with regard to illness and suffering: (a) suffering and illness are very personal experiences; (b) suffering and illness challenge human existence and identity; and (c) suffering and illness are deeply imbedded in the questions informing life and death.

These observations touch the core of care: *to meet a patient in his/her situation*. Care is therefore about building a *relationship* with the patient. This comment is informed by Vanlaere and Burggraeve (2017) who present a care ethics approach that can be useful in building a relationship in healthcare.

Their point of departure is that care is imbedded in *relationships* and how people give shape to their *responsibility* for others. Care ethics defines care as a relationship, hence an involvement and a connection with the suffering of the fellow person. The *quality* of care is dependent on the connection one person can make with the other person. This relationship is not a mere instrument, it is an end itself. Within the clinical context there needs to be a special trust relationship since the patient allows the caregiver to be intimately busy with the patient through, for example, the washing of his/her body. Evidently is care no product. Gabriele (2018:20) shares a similar perspective:

... "healing" and being a "healer" are not facile experiences ... They surely are about something far deeper than the giving of prescribed medication, taking a temperature, or the completion of a temperature.

Holtzer (2015: 31-33) extends this caring relationship beyond the sick bed only. She calls on family members to take on this responsibility. In fact, she argues that it is a civic responsibility to care for others. Creplet (2013) also emphasises the fact that in healthcare there is the patient, the healthcare practitioner and the managers, administrators, funders and policy makers who play various important roles in the delivery of healthcare. The logical deduction is that multiple roleplayers are involved in care. In line with these observations, one can say that caring (in healthcare) is more than physical attention and comfort provision.

Vanlaere, Burggraeve and Lategan (published book is forthcoming in 2019) add an additional perspective. They argue that those who cure and care experience suffering as a result of dealing with illness. Curing and caring for people demand much more than medical and healthcare knowledge. They require that doctors, nurses and therapists have to express emotions such as empathy, but due to either the hospital/clinical environment and/or personal circumstances, it is humanly not always possible to behave according to the expected norm associated with healthcare. While it is crucial to understand the importance of a caring relationship with the patient, it is equally important to understand that the application of this caring relationship is very often challenged due to the nature of human relationships, the caring environment and the medical condition itself, for example, in the case of a patient who is nearing the end of life.

The emerging question is, how can such a relationship be developed with the patient, given the complexity of the caring environments and needs?

As a result of the research done in an attempt to answer this question, this paper will present a framework, *an ethic of meaningful closeness*, as a perspective from which caring relationships can be developed. The aim of the framework is to guide the building of a caring relationship between patients, *healthcare workers* and the community. [For the purposes of this article, the term healthcare workers will be used to refer to those who cure (doctors), those who care (nurses and therapists) and also to healthcare managers and administrators.] Although the concept of closeness is well-known in ethics studies, this concept takes on a particular notion in the context of caring for the sick. In addition, when this concept is viewed from a Christian perspective, Biblical views are added. To this extent becomes this framework a guide for the church's pastoral care when dealing with the sick and those engaged with, amongst others, sick people.

When dealing with the term *ethic or ethics* in this framework, the meaning of the word is aligned with the Biblical notion of a "holy life" based on Scripture and confirmed by confession and tradition. *Closeness* refers to the engagement with a person as a neighbour (see the parable of the merciful Samaritan, in Luke 10: 25-37). *Meaning* implies the change effect of the engagement. The purpose of this framework is to promote dignity and care within the healthcare relationship and to assist with personal growth and the development of hope in the patient.

In this study the church, as a community of faith, is identified as an important role player in developing a framework for an ethic of meaningful closeness applicable to the healthcare environment. Although there are more role players, the exclusive emphasis will be on the church's role.

2. Confirmation: the role of the church in developing an ethic of meaningful closeness

The central argument for selecting the church as a meaningful role player in the development of an ethic of meaningful closeness is that it cannot be denied that any kind of health challenge leaves the patient in a state of hopelessness and despair. It is here that the church, with its *history of engagement* with ill and handicapped people, can play an important role in developing a caring relationship between the caregiver and the patient. In fact, Schotsmans' study, *In goede handen* (2012), confirms the role the church can play in healthcare. He makes special reference to two contributions that

the church can make. Firstly, the church has to assist with understanding and interpreting new developments within medicine and care. Secondly, the church should understand how it can participate in healthcare. It is especially with regard to new developments in medicine and care that new ethical questions arise. The church can contribute to the debate on end of life treatment, for example, or on assisted ending of life. Lategan (2017) echoes a similar statement. It is not so much redoing church doctrines on illness, suffering and beginning and ending of life, but more about understanding and interpreting the role that the church, as a faith community, can play in promoting ethically-informed healthcare in a technology-driven world.

A selection of South African literature confirms the proactive role the church can play in caring for the sick. This confirmation is not new at all, and is supported in a number of publications. Dill, Kloppers, George, Rossouw and Strauss (1994), for instance, as well as De Villiers (1982) and Louw (1994), claim that the church as a *community*, either as a community of faith, community of holiness or community of believers, is the reason why the church interacts with and cares for the sick. From this interaction it can be observed that *(a) care as a relationship within (b) a community of faith can (c) shepherd the personal relationship between the caregiver and patient and (d) leverage the proactive role the church as body of Christ and community of faith can play in the delivery of healthcare as an act of mercy, support, comfort, healing and realisation of new relationships within the given situation*. Superseding these conclusions is the critical role the church has to play in informing the ethical debate in healthcare. Of note here is the context of increasing individualism in pastoral care, the complexity of healthcare provision and the emergence of ethical questions following from the possibilities of technology in healthcare.

The participation of the church in developing an ethic of meaningful closeness requires an understanding of the role of the church as healthcare partner.

3. The role of the church as healthcare partner

The church, through its pastoral care, is not new to addressing human illness and suffering. A random selection of South African-based literature suggests multiple approaches to illness and sickness. The following observations can be reported:

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- *God's role in illness and suffering.* The theodicy doctrine and a body of literature on illness and suffering try to explain God's involvement in illness and suffering. Without going into the detail of the theodicy doctrine, the summative conclusion is that God is not the originator of illness and suffering but that he allows this as a way to remind us of the impact of a fallen world. This perspective is used in pastoral care to assist the patient to have some insight into the meaning of his/her illness as well as to assist him/her in coping with the unavoidable reality of death. Well-known contextual references can be found in *Dominee en dokter by die siekbed* (De Villiers, 1982) in which the focus is on assisting the sick to understand their illness and anxiety, loneliness and fear of the unknown. The emphasis was on bringing hope and peace in a mostly unknown situation. This is complemented by perspectives from Rossouw (1988), amongst others. He uses the *shepherd-flock* metaphor to explain the caring relationship between members of a congregation. It is a joint responsibility to care for each other. This care is not outside the redemption of Christ. Applied to healthcare, the call is to care not only for the patient but also for those who care for the sick. This care must be practised against the background of covenant (members of God's household) and the redemption of Christ (addressing challenges in people's lives). Louw's (1994) focus on illness is even more specific. He guards against a situation where pastoral care for the sick is to go back to the same situation as before the illness. Pastoral care should open new possibilities and new hope; it should offer an opportunity for growth and a new quality of life. Sickness can never leave a person untouched.
 - *On death and dying:* This topic has been fairly neglected in recent years. The debate on assisted ending of life has brought it to the fore again. A very useful book is Van Niekerk's (2017) contribution to this discussion. Although no empirical evidence can be presented to the faith claims of an eternal life, his focus is on the meaning life has against the reality of death. This discussion coincides with new technological developments. *The development of technology* made new opportunities possible but also created new dilemmas around the beginning and end of life challenges. Technology is also extending life with the consequence that a patient can become more dependent on care. Dependency is further challenged by a growing elderly population, new medicine and therapies, access to treatment and healthcare and declining quality of medical service. From

these comments can be noted a growing body of knowledge and thinking on healthcare in a postmodern environment, with new technologies and therapies. The conclusion is the contribution the church can make towards growth in the situation, understanding the situation and constructing hope and expectation in people's lives. Of importance is the value that must be attached to human life.

- *Growing autonomy* – people want to make own choices. The first reaction is that people are less religious or are no longer prepared to accept things as they are. A generalisation would be misleading, however. A number of books do suggest that churchgoers want to understand rather than merely to accept. This is confirmed by Van Niekerk (2005), Gaum (2011) and Du Toit (2000). The solution offered is to acknowledge the role that personal faith, the church and religion can play in formulating and understanding the situation, rather than merely providing a presentation of what must be accepted in this situation. This development cannot be delinked from the fact that people *are looking for meaning and evidence*. There is a growing need for less normative and more empirical ethics. Empirical ethics suggest either the ethical issues raised through empirical research or the confirmation of ethical behaviour. *How do we know?* rather than *what should be accepted as it is?* This view coincides with that of Nullens (2000), who says that ethics has to become a way of living. This is more than the mechanical application of the commandments or final formulated answers. The postmodern person wants to be assisted and guided to make decisions. Nothing should be forced onto them. This does not mean that people do not want to believe. It is more a matter that feedback should contribute to meaning in people's lives.

From the literature it is evident that major developments have taken place in the way in which pastoral care approaches illness. These approaches have evolved from a strict justification of God's involvement, to addressing the need for patients to understand and identify meaning in dealing with illness. In this context, new medical developments (technical abilities) cannot be ignored. This relates to a growing human autonomy based on evidence rather than on mere acceptance. These developments call for an understanding of what the church can contribute towards the support of a patient. Interestingly enough, the above-mentioned situation is a familiar but somewhat neglected focus in the practice of pastoral care. The literature focuses primarily (but not exclusively) on the doctor-patient relationship and on how to guide the patient but not the healthcare practitioner (collective for those who care). The argument has also been presented that the church is silent on this matter. A textbook example is the newly proposed national

healthcare insurance. Since its launch, the church, in general, has not raised its voice on this matter. The lasting impression is that the church is silent on healthcare matters and policy (Lategan, 2017).

What can be confirmed, however, is the meaningful role the church can play in healthcare, its practice and the promotion thereof, although in a *revised* role. This has implications for at least three activities:

- Theology as discipline should research and interpret the broader phenomenon of health and care. This requires a multidisciplinary approach. Working with the patient and not directing the patient should be at the core when dealing with the sick.
- Pastors should address these topics in their preaching and pastoral care. Congregations should be guided as to how to understand the phenomenon of illness and suffering in their personal lives. Typical examples will be therapeutic interventions (such as oncology), geriatrics (care of elderly people) and death caused by violence (such a farm murders). The debate should also be opened up on how to deal with sensitive matters such as cosmetic surgery (for example breast enlargement or gender change).
- These new developments should be reflected in pastoral care – not only directed to the individual but also as an advocate for the church’s role in participating in the healthcare debate. Fundamental in this debate is better health and dealing with sickness and illness in the context of three major developments in healthcare, namely *affordability*, *access* and *quality*.

What cannot be ignored is the growing trend towards individualism in postmodern society. This has specific importance for pastoral care in the healthcare field. This growing individualism is outlined by Dillen and Gärtner (2015), who look into new developments in pastoral care in Belgium. From their study it is evident that *individualism* is a leading trend in late modern societies. Within the late modern societies, people have realised that emancipation does not mean the same thing for all people, that traditional social agreements do not work any longer or that technological developments have brought new challenges. It simply means that new “borders” have emerged once again (Dillen & Gärtner, 2015:25). Within this context is the focus on the individual (Dillen & Gärtner, 2015:26). This has specific meaning for healthcare. A person wants to be recognised for who he/she is. A one size fit all approach can no longer be regarded as sufficient in dealing with healthcare. This individualism inevitably leads to new challenges that should be considered when dealing with people in a care situation. The authors list

a number of the characteristics of such an individualised society, notably private and public, plurality and differentiation, stigmatisation and social inequality, economising of the society, and experience of space and time (Dillen & Gärtner, 2015:32-42).

Their intention is merely to point out that changing times and social constructs should be understood when pastoral care is performed. Needless to say, this will have an effect on people's experience of health, illness and care.

With regard to building a relationship with the patient, the arguments presented in this section of the paper indicate that (a) understanding a situation and understanding the meaning of a situation are in the forefront of care; (b) an overriding Biblical answer without contextualising the answer is no longer acceptable; and (c) technology-informed medicine and therapies evoke new ethical questions for which guidance should be provided.

Following from these comments, an ethic of meaningful closeness is presented as a framework to give guidance on how this relationship can be developed.

4. Framework for an ethic of meaningful closeness

This framework is informed by the following indicators:

4.1 *Mercy*

Burggraeve (2016) promotes an ethic of mercy. His argument is based on the reality that events are not always as they should be or as we have hoped that they would be. A person should be guided to move from where he/she is (reality) to where he/she wants to be, or should be (growth). This guidance is built on the extension of the fellow person's ethic (mercy) and is reflective of the person's own relationship with God. The turning point is to accept for now the reality as it is but to proactively progress to what the desired situation should be. Neither the current reality nor the desired situation can be free from values and norms.

In the context of this paper, this perspective can be applied as follows: A patient may have cancer with a life threatening diagnosis. The reality is that the patient is challenged with his/her own vulnerability. The question now is, how do the patient, healthcare worker and family deal first with this situation (for example a cancer diagnosis), and on the basis of the situation move to a more desired situation against the background of the diagnosis and treatment. Anger towards God or the fear of death should be transformed to

experiencing the presence of God, and the acceptance that this life will come to an end but that a person can live in the promise of eternal life.

The value of this ethic of mercy for the proposed framework is that a patient should be understood in his/her current situation and the healthcare worker and family should have the skill to assist the patient to be guided to a more meaningful experience of the situation. By doing so they (healthcare practitioner and family) should also arrive at a more positive experience of diagnosis and treatment.

4.2 Restoration of relationships

Both the Old and the New Testament embody the idea that ethics has a multi-phased role to play. At least four dimensions can be identified. Ethics places the person firstly in a relationship with God; secondly in a relationship with him-/herself; thirdly with his/her fellow person; and fourthly with his/her habitat. To substantiate these comments, the following references are important.

From an Old Testament perspective, Zimmerli (1987) claims that obedience and response are essential for the life before God. These concepts should inform our ethical understanding. Numeri makes the observation that obedience is essential for ethical life (Oosterhuis & Van Heusden, 2004). These comments are confirmed by Burggraeve's (2015) analysis of "ethical sistership." He comments that Sarai sets an example of engaging with others for the benefit of others. He concludes by saying that responsibility is for oneself, for the close and the distant neighbour, as well as for future generations.

From a New Testament perspective, Van der Watt and Tolmie (2014: 276-325) allude to ethics as relationship. There is a close relationship between who people are (identity) and what they are doing. What people are doing is informed by motive. The deepest meaning of ethics is found in the relationship with Christ and is expressed through love, care and forgiveness. Joubert (2012: 73-75) makes a similar comment: ethics is about responsibility. König (2017: 263) confirms this by stating that in Paul's theology the "life in Christ" and "filled by the Holy Spirit" are similar. With regard to the "life in Christ": from the Letter to the Galatians, the focus is not to improve one's life but first to lose it and then to take on a new life in Christ (König, 2017: 263). From the Letter to the Romans, the emphasis is on the freedom in Christ, in particular from sin, the law and death. Again, freedom from sin does not refer to an improved lifestyle but rather to a change of lifestyle. Freedom from the law means that God will place a person in the correct relationship with Him

(König, 2017: 265-270). Freedom from death portrays the same meaning: God has changed everything and has therefore created the space for a new relationship with Him (König, 2017: 270). With regard to the life “filled by the Holy Spirit”: in the letter to the Galatians is the message that through the Holy Spirit there is a new life in God and that a religious community should jointly live a new life before God (König, 2017: 283-291). Paul’s well-known appraisal of love (1 Corinthians 13) is meant as an inclusive life where everyone in the religious community should love each other. Love should be the basis from which the fellow person is served (König, 2017: 300-304). The intention is clear. Firstly, Christ provides a new life; secondly, a person should abandon his/her life and take on a new life; and thirdly, care should be taken for a community.

The Biblical meaning is powerful: through an ethical lifestyle, the patient, the healthcare worker and the family should take on a new life in Christ and live according to the norms and values of this lifestyle. The guiding principle is therefore not to avoid what has happened to a patient or what is happening to a patient, but rather to look at how the church (collective for pastors and churchgoers) can assist in upholding the new lifestyle in Christ. The focus cannot be limited to the patient only but should be extended to the healthcare practitioner and his/her family also in order to follow a different approach to the patient.

4.3 New meanings for challenges

A key element of hermeneutics is to seek continuously the application of a Biblical value for a (new) situation. From a medical perspective it is evident that health and sickness should be understood in the context of the Scripture’s meaning and not as a reference guide to new developments. The Bible does not reflect on stem cell research, assisted ending of life, palliative care, dying, organ transplantation, suffering, cure, health policies, etc. The Bible reflects rather on principle matters such as that life is God-given, that God never neglects the sick, the old, the handicapped, or the marginalised, and that death is not the end of the life in Christ, and so forth.

An important message of the Letter to the Philippians is that the meaning of suffering is to transcend it to the acceptance that no matter what happens, God can use it to promote the gospel. In this regard, Tolmie (2008:38) comments that illness, suffering and death can become the gospel – not only for the individual but also for the group. The question is not what happens to a person but how the person reacts to the situation. The importance of this observation is that life experiences are interwoven with the meaning of the

gospel for everyday life. The pastoral moment is that life experiences cannot be removed from the meaning of the gospel for life and one's reactions are growing the meaning of the gospel for everyday life. Joubert (2012:388-394) continues to elucidate this perspective by highlighting that, in the context of the letter to the Philippians, it is not the *now* but the *future*. Paul's immediate circumstances are bearable since the security of the future is vested in God.

It is this context that the church must identify, preach and practise a living gospel that speaks to an ever-changing life. The comfort the church must bring to the patient, the healthcare worker and the family is that Scripture is a reflection on how other people have experienced their engagement with God – and having a living relationship with God is an ongoing experience. From this observation it can be noted that the church has to empower the patient, the healthcare practitioner and the family to gain new meaning through either experiencing or witnessing suffering and illness. This empowerment should assist patients, healthcare practitioners and family with their respective engagements with each other.

4.4 Narrating God

The book of Job gives an account of God's involvement in our suffering. Job realises that in suffering it is not about having an answer to "why" a person is suffering, but rather to discover that God is *in* the suffering. What God's role is, is ultimately not clear. What is evident, is that God is not a spectator of what is happening to us. Neither is God powerless or taking revenge, hence the situation. The perspective is rather that God is not at a distance but is interconnected with the situation. The outcome is not to "understand" or to "comprehend" but rather to "experience" God. God cannot be reduced to a set of cause-effect relationship rules but should be experienced in His absolute mystery. This should be leading to questions, and not to seeking answers. In their analysis of Job, Meyer, Nell and Vosloo (2005:35) comment that God responds to Job's enquiry about the "why" of his suffering not by providing an answer as such, but by answering through questions. These questions penetrate to the deeper meaning of life and to whether a person is knowledgeable on the true meaning of life. Evidently not, since everything has to be reduced to logical comprehension (cause and effect). They continue to comment that in suffering, people are not always seeking answers but rather presence (Meyer *et al.*, 2005: 85-86). Where we are as a community when someone else is suffering, is a question we do not always have an answer for. Also, the fact that God responds to Job (Meyer *et al.*, 2005: 39-40) is unique since there is no obligation on God to answer a person (Meyer *et al.*, 2005: 98). This should move a person to the point of believing in God

because He is God and not because of what He can do for a person (Meyer *et al.*, 2005: 104). The outcome is not to understand the “why” of suffering but rather to have an experience of God (Meyer *et al.*, 2005:108).

Meyer *et al.* (2005: 114-116) arrive at a very powerful conclusion. Is there not enough evidence throughout history that life is vulnerable and should therefore be protected? If humanity does not understand this basic conclusion and act accordingly, how will mankind be able to respond to the deeper existential moments of life? The implication is that the patient, healthcare practitioners and family should do everything possible to promote the value of life and to avoid suffering.

5. Integration: the emergence of a care ethic as expression of meaningful closeness

Based on the role the church can play in an ethic of meaningful closeness for patients, healthcare workers and family, four attributes can be identified. These attributes are *diakonia* (service), *koinonia* (community), *dikaioisune* (justice) and *hesed* (mercy). These attributes inform our calling to humanity, societal institutions and the environment. They call on a lifestyle orientation that will effect or lead to positive change. An ethical lifestyle does not entail a watchdog mentality, but an active involvement with people and their living environment in order to improve (correct and enhance) this interaction. This engagement is part of a person's orientation to grow his/her own piety (*askein*) towards God.

A fundamental value of Christian ethics is to interact with society and to bring about an alternative perspective. This alternative perspective is vested in the meaning that religion, faith and trust have for an ethical lifestyle. This perspective is no democratic affair that it should attract the majority vote from society, but its value lies in the perspective it can bring about when an ethical dilemma is considered.

The ethical obligation is not only to respect people and to care for them, but to engage with them as equals (*Love thy neighbour ...*).

A care ethic can set the standard that an alternative lifestyle is required that will once again make people responsible for their behaviour towards other people (whose interest), nature (this world does not belong to people, but is managed by people on behalf of God), culture (respect differences and seek communality) and structure (no structure should enslave people but should provide meaningful ways to address the needs of the world.)

6. Summative perspective

This study confirms the important role that the church can play in developing relationships in healthcare. The following guidelines can be confirmed:

- Patients and healthcare practitioners should be treated with dignity and respect and the basis of medical-ethical relationships, namely no harm, well-being, justice and autonomy, should guide the engagement between patients, healthcare practitioners and the community.
- Care does not mean to provide answers but rather to be present in the lives of people.
- Patients are not owned by the healthcare system.
- No engagement can go without hope, growth and a changing life. It should equip people to deal with life and decisions.
- Meaningful closeness embodies the idea that through personal engagement a new perspective can be developed in the life of the patient, the healthcare practitioner and the family.

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