Chapter 6

Christianity and the Transformation of Medicine

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I Introduction

The care of the sick has a long and cherished tradition in Christianity. From the distinctive practices of the early Christian communities and their care for abandoned children and plague victims through to the contemporary hospital system, Christian faith has nourished and informed costly engagement with human suffering. It has also prompted careful reflection on the nature of medicine, its connection to Christian understandings of God and our calling and the roles it plays in human community. My task in this piece is to continue that conversation, paying particular attention to where medicine finds itself in the early twenty-first century and the challenges that brings to Christian understanding of medicine and its role in the academy. I will begin by outlining my understanding of the current contexts in which medicine operates, leading to a brief discussion of ways that the discipline has sought to address the issues which medicine faces. I will then present a Christian understanding of medicine as both a scholarly and a social practice, articulating the philosophical-theological framework which informs this perspective. This understanding will seek to flesh out features of medicine as an inherently moral practice, one informed by a Christian social vision and shaped by key theological commitments. I will close with some reflections on two matters: access to health care, and the implications of a Christian vision of medicine for the ethos of medical education.

II The Context(s) of Medicine in the Early Twenty-First Century

Medicine operates in diverse contexts: roughly, in a ‘Western’ context of infinite ‘want’ and the associated reduction of a profession to a product to be consumed; in a ‘developing’ context of infinite need and the associated vulnerability to exploitation and deprivation. Let me tell the stories of two young women to
Christianity and the Disciplines

illustrate and articulate this difference. One, whom I shall call Mara, is dying in an ICU in a major hospital in Australia. The other, whom I shall call Naomi, is dying at home in rural Angola. Mara is 19, and has Acute Myeloblastic Leukaemia. She was diagnosed a year ago, but has been non-compliant with her treatment regimen. She was admitted to hospital 1 week ago with an acute relapse, with septicaemia, circulatory collapse, acute renal failure and acute respiratory failure. On admission to the ICU, her condition was acknowledged to be irreversible; nonetheless, because she is young, she has been aggressively treated in ICU with artificial ventilation, circulatory support and peritoneal dialysis. After eight days of treatment, she is experiencing multiple organ failure which is unresponsive to treatment. The ICU team is attempting to persuade her family to take her off the ventilator and cease circulatory support with the knowledge that she will die soon thereafter. Naomi is 19 and has end-stage AIDS. She was infected with HIV 4 years ago after being raped by her uncle (he knew he was infected but believed that unprotected sex with a virgin would ‘clean him’ of ‘slim disease’, the local name for HIV and AIDS). She has had sporadic antiretroviral therapy, but her poverty, the fragile post-war Angolan economy and lack of basic infrastructure means that she has had no reliable access to the drugs (despite international successes in ‘universal access’ to free antiretroviral therapy), or to adequate nutritional support. She is emaciated, has multiple skin lesions and persistent diarrhoea and now has fulminant, multi-drug resistant tuberculosis (and no access to the appropriate anti-TB therapy). She cannot afford to go to hospital, which is chronically under-resourced and overtaxed, and is being cared for by her mother while she dies. This is the world in which we live, and of which a Christian approach to medicine must be cognizant.

A number of things emerge from these stories. First, the social and economic contexts in which medicine is practised variously enable and constrain possibilities of health care; indeed, those social and economic contexts are the most significant determiners of levels of health and illness for the members of those communities. This suggests that health care is not primarily about improving the health of the community, but about providing care to vulnerable people. Second, paradoxically, both the over- and under-supply of medical services can compromise this care. It is clear how the under-supply of medical services compromises the care of needy people: while I could catalogue instances, I think Naomi’s story makes this plain. But so can the over-supply of medical services. Many of the most frequently discussed issues in both bioethics and the philosophy of medicine relate to end-of-life decisions; frequently those discussions revolve around the withdrawal or withholding of life-prolonging therapy when that is seen as ‘futile’. Such questions arise in situations of ‘medical plenty’ when treatments are applied because they are available not because they are likely to be of benefit for the patient, with the result that the person and her needs are
lost in a forest of technological possibilities, and biomedicine replaces caring for a dying person. Again, I could catalogue instances, but I think Mara’s story illustrates this well enough. Third, and perhaps most obviously, huge disparities exist in the level of health care available to people in different communities (and, for that matter, different sectors of the same communities—especially in, say, the US health care ‘system’). These disparities are themselves a great challenge facing both medical ethics and the vision and practice of medicine from a Christian perspective. How have those who practise or philosophically analyse medicine responded to these challenges?

III Medicine’s Responses to These Challenges

The biomedical model has dominated views of medicine since the late twentieth century. It views health and disease primarily in terms of biological functioning and, allied with advances in medical technology and analytical tools such as evidence-based medicine, has resulted in obvious improvements in medicine as a technical practice. However, this grafting of the Baconian view of science and technology as power or control onto the tradition of Hippocratic beneficence has created significant issues for medicine as a practice. This has become particularly evident in the clash between proliferating medical technologies of increasing complexity and expense and the limitations of health care budgets even in the ‘developed’ world. From this perspective, the only legitimate constraint on treatment options is whether it is likely to benefit this particular patient’s biological functioning, without reference to broader concerns of the nature of medicine and justice. Indeed, in such a view, caring for a patient as a person has become problematic, with the healing value of the physician–patient relationship being factored out of analysis of the efficacy of treatment, and the importance of caring for those who cannot be cured being ‘problematised’. Legitimate criticism of medical paternalism in consort with ‘thin’ understandings of personal autonomy and the rampant consumerism of late capitalism have complicated this, eroding the notion of medicine as a profession (an inherently moral enterprise involving the exercise of both the patient’s and the physician’s agency), reducing doctors to service providers. Medicine becomes a biomedical consumer product aiming at ‘health’ (cure) and the eclipse of suffering and personal limitation (enhancement). As such, it becomes an idolatrous enterprise, embodying (often literally) the false values of ‘developed’ nations, offering ‘tech-fixes’ for personal and social ‘problems’. And so the personal and relational nature of medicine and the clinical encounter are lost and broader personal and social issues ignored, while health care costs and inequalities both increase.
One response is to turn to social utility as the criterion by which medicine and medical care are justified.\textsuperscript{11} While various costs and benefits are factored into different utilitarian analyses, these approaches suffer from common problems: not only do patient interests become subordinated to social concerns, but they fail to account for medicine as a distinctive practice.\textsuperscript{12} Alternatives such as Beauchamp and Childress’s attempt to develop a ‘theory-neutral’ principlist approach to medical ethics,\textsuperscript{13} or Jensen’s proposal of a particularist, communitarian theory of medicine are equally inadequate:\textsuperscript{14} the first, because it results in a ‘thin’, procedural approach to medical ethics and fails to consider what medicine is as a social practice; the second because it does not allow for moral critique of the values of the particular communities that generate priorities in health care, leaving intact the commodification of health care as a consumer product.\textsuperscript{15} Neither addresses the fundamental moral nature of medicine or its location in broader issues of social vision and normative perspectives on human beings and the human community.

\textit{IV Christian Responses to These Challenges}

More effective responses have come from Christian philosophers and theologians of medicine. Hauerwas criticizes modern medicine for its failure to operate out of a coherent story of humanity and human community, and calls on the Church to furnish communities of moral agency, grounded in the lived practices of the Church, which can nourish an alternative medical practice.\textsuperscript{16} Furthermore, he reminds us of the centrality of suffering and vulnerability to the human condition and that, whatever else it might be, medicine is a response to that vulnerability, rather than a technique to gain mastery over the human condition.\textsuperscript{17} Verhey, taking a similar line, has called on Christians to remember and articulate their story in the context of medicine, noting the many ways that it both informs and challenges medicine as it is currently practised.\textsuperscript{18} Meilaender has shown the ‘thinness’ of the moral vision that underlies most discussions of medical ethics and bioethics, with the result that bioethics (and medicine informed by it) has lost both the ‘soul’ and the ‘body’; more adequate reflections on health care need to be informed by a (Christian) ‘worldview’.\textsuperscript{19} This need not lead us to conclude that a Christian vision results in radically incommensurable medical practices,\textsuperscript{20} as Pellegrino and Thomasma illustrate.

Drawing on both the Thomistic tradition and phenomenological approaches to medicine, Pellegrino and Thomasma argue for a philosophy of medicine that is derived internally from the defining features of medicine as a social practice, in contradistinction to biomedical and other reductionist models.\textsuperscript{21} While Pellegrino’s alternative analysis rests on a flawed demarcationist understanding
of medicine,\textsuperscript{22} there are, nonetheless, certain phenomena which are central to or paradigmatic of medicine. For Pellegrino, medicine is an inherently moral enterprise whose fundamental features arise out of the exposure of human vulnerability in the experience of illness and the response to it in the healing relationship of physician and patient. The power differential inherent in this experience means not only that medicine cannot be reduced to a commodity to be freely traded in the market, but that it bears moral freight. The physician’s power – both of knowledge and skill and the freedom to use them – meets the patient’s need with the goal of caring for a needy person and, where possible, returning them to autonomy. Properly understood this autonomy is not that of late modern capitalism’s myth of the unconstrained pursuit of whatsoever goals an individual may choose, but the freedom to live within the constraints of the human condition as an agent. Furthermore, such care is incumbent on all human communities. Rooted in the Hippocratic tradition and its developments in medieval and modern medicine, this helping and healing relationship allows for the appropriate care of those who cannot be cured – and the refusal to provide futile ‘curative’ treatment to them – and for that to be done in a context that values the \textit{relationship} between physician and patient for both its intrinsic and its instrumental value.\textsuperscript{23}

Clearly, Pellegrino wants philosophy of medicine to emerge from medicine as a practice, especially (the phenomenology of) the clinical relationship. While he sees the need for a Christian vision to inform the practice of medicine, especially in a biotechnological world which leaves us ‘abandoned to a plethora of means and a poverty of ends’,\textsuperscript{24} this is largely overlaid on an understanding of medicine that he sees as emerging by way of reflection on its phenomenology as a social practice.\textsuperscript{25} While there is some truth in this claim, it relies on a particular understanding of medicine as a practice, even the primacy of the healing relationship, which is derived from or coheres with, a bigger vision of human life. This is not peculiar to Christian theorists: all understandings of disciplines such as medicine are informed by and are expressions of a particular belief system.\textsuperscript{26} This brings me to a Christian philosophical-theological framework for medicine which provides the necessary context for understanding medicine and its role in human life.

\section*{V A Philosophical-Theological Framework for the Christian Practice of Medicine}

A neo-Calvinist approach to scholarship adopts an epistemology that is both person- and situation-specific and critical-realist in contrast to both the supposed value-neutrality of modernist scholarship with its quest for rational consensus
and the relativism or radical pluralism frequently associated with what is often called ‘postmodernism’. Nicholas Wolterstorff encourages Christians to engage in scholarship in such a way that the central beliefs entailed in Christian faith critically inform the practice of scholarship, and the vision of *shalom* central to the biblical story informs the projects in which they engage.  

That is, Christian faith functions internally in a Christian’s scholarly practice as a control in the devising and appraising of theories and in shaping heuristic decision making. While such a view recognizes the inherent plurality of scholarship necessitated by the different presuppositions that inform different intellectual traditions, it does not require that a Christian’s scholarship be different from that developed by their non-Christian counterparts, merely faithful to their Christian commitments. A truly Christian understanding of medicine, while acknowledging the paradigmatic features of the discipline and practice of health care, is framed in a broader Christian vision of the world, human community and the nature of human existence grounded in the biblical narrative.

There are key ‘moments’ in the grand-narrative of God’s relationship with the cosmos and its creatures that inform a Christian view of medicine. This story of the creation of *shalom*, its distortion by sin, God’s work of restoration of *shalom* in history culminating in the incarnation, ministry, death and resurrection of Jesus and its consummation in a new heavens and earth, is both our story as Christians and our call as followers of Jesus. It is the context for our life in the world, including the practice of medicine: ‘that is the context for medicine: in the alleviation of the bitter consequences of the Fall; in staying the hand of death, for a season; in anticipating the final resurrection of the body’. As creatures who are intrinsically finite and who live in a world which is now frequently hostile, we are both inherently vulnerable and gifted with inestimable dignity. As such, illness both reminds us of that inherent vulnerability and calls forth our compassion and care turning to those who are ill in loving relationships, rather than abandoning them in the isolation that suffering generates. But it also reminds us of our own limitations and that of our care: for such vulnerability is inherent in the human condition and cannot be transcended; such weakness will persist until the final transformation of all things, a goal that can only be attained following the cruciform path of our Lord. There is no escaping vulnerability or death, just as there is no escaping the call to action that the vulnerability of others and the threat of a (reasonably) avoidable death mediate, as we see in the healings of Jesus.

Furthermore, medical research, both in the fundamentals of biomedical sciences and in clinical practice, is justified and compelled by this story. By virtue of our creation in the image of God, we are entrusted under God with the task of understanding and shaping the world in which we live: as creatures we are both subjects who seek to understand, and objects of our own study.
Christianity and the Transformation of Medicine

Furthermore, the brokenness of the world and of human existence compels us to understand it and seek to devise ways to ameliorate its effects on our fellow creatures. Both this research and the care it enriches ought to have a particular concern for the weak and the vulnerable: not only are they the special object of God’s concern, it is that vulnerability that evokes the care that shapes and justifies the very existence of medicine (something that Christians involved in medical research ought to bear in mind). Thus, medicine is a practice of enquiry that seeks to understand the world (including human beings) and a social practice that seeks to change it so as to care for vulnerable people and better enable human flourishing.

VI Medicine as an Inherently Moral Enterprise and a Christian View of Society

This vision also reshapes medical practice (and so education), so as to encourage the effective moral agency of both professionals and patients. The power differential intrinsic to the doctor–patient relationship itself generates a moral call, for in a Christian view of the world, power and privilege generate a corresponding responsibility to serve (Mt. 20.25–28). Illness, injury or handicap are problems because they adversely affect people and interfere with their ability to function in relationships, exposing their vulnerability and diminishing their flourishing. Medicine as a social practice (or profession), in turn, exists in and for a given community and aims to care for people in their weakness and vulnerability, deal with the disruption caused by disease processes, injury or deformity and return people to proper functioning in their relationships and as persons, as far as this is practicable. This both justifies the existence of medicine and establishes its goal. While fighting disease or improving a community’s health are important, they are means (or the appropriate goals of other practices) rather than the ends of medicine. Medicine’s telos is to provide care for vulnerable people and, where this is possible and as far as this is practicable, to remove impediments to human flourishing, restoring people to proper personal and relational functioning. Such a perspective both enhances the moral character of medicine as a practice and enables us to resist the ‘technological imperatives’ which can overwhelm personal concerns for the sake of technical possibilities.

This enables us, in turn, to discern what health care ought to be provided for the members of a community, and to question the appropriateness of some uses of medicine. Practically (and philosophically), we need to distinguish between caring and curing: the first is always the concern of medicine, the second sometimes. Theologically, we need to distinguish between medicine as an idolatrous
attempt to wrest mastery over the human condition and delude ourselves that we can transcend our creaturely limits, and our responsibility to humbly care for the vulnerable in response to the realities of human frailty. Victory over death is God’s gift in the Gospel, one we will receive in the eschaton, not medicine’s gift that we can claim here and now. As we know from the Gospel, overcoming weakness is not the only form that response to vulnerability takes, for our God is the one who uses the weak to shame the strong, and whose power is most clearly manifest in our weakness (1 Cor. 1.26–31; 2 Cor. 12.7–10). This, allied with the realization that the Gospel proclaims only an eschatological victory over death, and one which necessarily passes through suffering and death rather than bypassing them, reminds us both of the limits of health care and of the responsibility to care for people in their weakness and suffering, doing what we can in shared humanity to care for them in their incurable suffering or dying.

VII A First Application: Access to Health Care

As we turn to issues of access to health care, we need to realize that medicine exists in and for a given community and is both individual and corporate: individual, inasmuch as the very essence of the clinical relationship is a person in need going to another person so that need can be met; corporate, inasmuch as the existence of the institutions, and the ability of medical professionals to engage in such a clinical relationship arises out of, and is funded by, a community’s commitment to meet the health needs of those who comprise it. In relation to the latter, the vision of shalom generates ‘sustenance rights’, to goods which society has an obligation to provide, such as food, water, housing, education, basic health care and so on. These are rights, because they are necessary for functioning in community, and without them people are unable to function meaningfully in relationships and pursue the ends for which they were created. Beyond these sustenance rights that societies are obliged to meet, society may choose to offer us other services, which go beyond meeting those basic needs. When applied to medicine this gives rise to two interlocking criteria: health care services are justified if (1) they are components of basic health care to which everyone is entitled as a ‘sustenance right’ or (2) their provision offers reasonable hope of return to a reasonable level of relational functioning, and will not impinge on the provision of sustenance rights to others. These criteria mean we should always provide those basic health services which, within a given community, can be justified as sustenance rights, and provide just and equitable access to other resources. It also means we should refrain from mere enhancement, as it fails to meet these criteria and ignores the inherent morality of medicine as a practice.
Determining exactly which services can be included legitimately within the scope of ‘basic health care’ is a complex and situation-specific task, but a good case can be made for including those services which ‘cluster’ around community health and good quality GP services, because such services are required if the relational dysfunction occasioned by illness is to be effectively overcome.\textsuperscript{46} Other services (such as critical and tertiary levels health care) should not be included in our sustenance rights, but seen as extra services that society offers to those in need (health care ‘mercies’) which are to be judged on a ‘relational cost–benefit analysis’.\textsuperscript{47} We need to realize that ‘[n]o system, however ingeniously devised, can gratify all wants, tamp down all worries, or remove the mark of mortality from our frame’.\textsuperscript{48}

This, of course, has significant implications for a global perspective on medicine and the inequalities in the distribution of health and health care services, as can perhaps be best seen by returning to the cases with which I began. Mara’s care, it seems to me, is frankly inappropriate and ethically unjustified. While it is appropriate to initiate a trial of a particular treatment to see whether it might have effect,\textsuperscript{49} in this case, Mara was clearly dying. The appropriate response is to care for her (and her family) while she dies, rather than using sophisticated ‘curative’ therapy when that is acknowledged to be futile. Such treatment both medicalizes her dying, alienating her and her family from her dying body, and is an unjust use of limited resources. It seems not only to cohere with an unacceptable notion of medicine as a consumer product, but to verge on being an idolatrous and self-deceiving attempt to overwhelm human vulnerability rather than care for one who suffers because of it.\textsuperscript{50}

Naomi’s case is equally clear, and equally unacceptable. Here we see the inevitable enmeshing of medicine in a broader social context, so that the instability and poverty of the nation as a whole adversely impact on the community structures and functioning, undermining the very possibility of a sustainable level of basic health care. Of course, dealing with these underlying social issues would not only establish the conditions in which an appropriate level of health care could be provided, it would itself be a major factor in improving the overall health of the community.\textsuperscript{51} This involves not just significant changes in the domestic circumstances and policies of countries such as Angola, but a significant contribution from other, wealthier countries, including assistance in providing a decent basic level of health care. One effect of adopting this vision of medicine is to challenge physicians (and physicians in training) with their responsibilities as global (medical) citizens: we need to expand our horizons beyond those of our own countries and our possible career paths, to include the greater suffering and vulnerability of those in ‘developing’ countries. This does not mean that we must all become medical missionaries or volunteers for \textit{Medecins Sans Frontier}: but some of us should, perhaps a great many more than are currently involved.
VIII Conclusion: A Christian Vision of Medicine and the Ethos of a Medical School

Let me conclude by summing up my argument, and reflecting on what it might mean for the shape of medical education from a Christian point of view. The diverse contexts in which medicine operates, contexts of oversupply and commodification, and undersupply and injustice, require an effective response, one that is best provided in a Christian vision of medicine in the context of human community. This enables us to see medicine as primarily providing care to vulnerable people and, in light of that, seeking to help people return to a reasonable level of relational functioning either by way of ‘healing’ their illness or enabling them to cope with it. It is an inherently moral enterprise, which, as well as entailing appropriate research into human vulnerability and its treatment, requires the shaping of moral agents. It also enables us to understand the value and limitations of medical care and consider the appropriate levels of its provision in the various contexts in which we find ourselves.

In applying this to medical education, I want to consider not curriculum design or pedagogical strategies, but ethos. Issues of values, social vision and so on should be written into the whole of the curriculum rather than having them quarantined in particular subjects on ethics or philosophy of medicine; it certainly needs to go beyond a narrow focus on legal and bioethical issues. By analogy with theological education, perhaps medical education should have three main ‘competencies’ that it seeks to foster: acquisition of the knowledge base required to be a good clinician (such as the basics of medical science and an understanding of human vulnerability and the workings of interpersonal relationships); acquisition of the skill base required to be a good clinician (such as the basics of personal engagement with suffering and vulnerable people, history taking, physical examination, the appropriate use of investigations and so on); the shaping of persons as moral agents and spiritual beings who might be the kind of people who are able to care for those who are ill and who understand their role in the human community. This last might be achieved through a kind of ‘moral apprenticeship’: just as we identify people who are exemplars of the knowledge and skills required for good medical practice and equip them for the task of training their medical successors as clinicians, so we ought, perhaps, to identify people who are exemplars of the moral excellences required for effective helping and healing and equip them for the task of shaping their professional successors as moral agents. And just as clinical training requires the enlisting of a range of people and institutions, such as research facilities, universities and teaching hospitals, so this shaping of moral agency might enlist institutions such as the Church, along with individuals who are ‘experts’ in ‘Christian practice’. 

Christianity and the Transformation of Medicine

So might the Christian moral vision, and the institutions that seek to live by it, bring about the transformation of medicine, and its practitioners.  

Notes

1. See, for instance, Allen Verhey (2003), Reading the Bible in the Strange World of Medicine (Grand Rapids: Eerdmans), pp. 1–13.


5. On caring when there is no reasonable possibility of ‘cure’, see Ramsey, The Patient as Person, pp. 113–64.


10. For the notion of ‘technique’, see Jacques Ellul (1964), The Technological Society (New York: Knopf); What I Believe (Grand Rapids: Eerdmans, 1989); for medicine
and idolatry, see Joel Shuman and Brian Volck (2006), Reclaiming the Body: Christians and the Faithful Use of Modern Medicine (Grand Rapids: Brazos).


17 Stanley Hauerwas (1990), Naming the Silences: God, Medicine, and the Problem of Suffering (Grand Rapids: Eerdmans).


23 Pellegrino and Thomasma, Helping and Healing, pp. 13–66; Edmund D. Pellegrino, ‘Humanistic Basis of Professional Ethics’, in The Philosophy of Medicine Reborn,
Christianity and the Transformation of Medicine


24 Pellegrino and Thomasma, Helping and Healing, p. 4.
27 Nicholas Wolterstorff (1983), Until Justice and Peace Embrace (Grand Rapids: Eerdmans); Wolterstorff, Reason Within the Bounds of Religion; Sloane, On Being a Christian in the Academy.
30 Wolterstorff, Until Justice and Peace Embrace, pp. 69–72. He sees shalom as characterized by relationships of justice, equality and delight.
35 I retain the language of ‘profession’ and ‘patient’, as it reminds us of the vulnerability of the ill, the power inherent in the healing relationship and the attendant responsibility. Patients are vulnerable people in need of the care of moral agents, not clients or customers in a more-or-less powerful position requesting a service from a morally neutral provider.
36 For the notion of moral call, see John Hare (2001), God’s Call: Moral Realism, God’s Commands, and Human Autonomy (Grand Rapids: Eerdmans).
Andrew Sloane (1998), ‘Painful Justice: An Ethical Perspective on the Allocation of Trauma Services in Australia’, *The Australian and New Zealand Journal of Surgery* 68: 760–3. I will use the term ‘illness’ as a shorthand expression for illness, injury or handicap, recognizing that they are nonetheless distinct phenomena.


See also Baum, *The New Public Health*, p. 3; People’s Health Movement (2001), ‘People’s Charter for Health’.

I will refrain from using the term ‘primary health care’ because it means very different things in the context of public health and the (medical) health care system. ‘Basic health care’, by which I mean those services which, roughly speaking, cluster around a good general practice, avoids that confusion. For the relation of basic health care and public health, see Rogers et al. (1999), ‘Linking General Practice with Population Health’ (Bedford Park, SA: National Information Service of the General Practice Evaluation Program).

George, ‘The Need for Bioethical Vision’, pp. 98–100. It also allows for the exercise of the physician’s moral agency in the face of ‘consumer’ demand, for which see Edmund D. Pellegrino, ‘The Physician’s Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective’, in *The Philosophy of Medicine Reborn*, pp. 281–306. Most purely cosmetic surgery provides a good case in point: it generally deals not with what interferes with proper relational functioning, but with inscribing on our bodies the values of late modern consumerism with its valuing of youth and corresponding fear of death) and its devaluing of age and wisdom.


For this, see Baum, *The New Public Health*, pp. 227–45, 77. For general issues of poverty and its alleviation and their impact on communities, see www.un.org/

It might be worth considering a ‘capping’ unit which seeks to have a student incorporate the more diffuse discussions of ethos, etc., through the course into an integrated whole and reflect on what this means for them as morally responsible medical agents in a global context.

Such as is evident, in say, Consensus Statement by Teachers of Medical Ethics and Law in UK Medical Schools (1998), ‘Teaching Medical Ethics and Law Within Medical Education: A Model for the UK Core Curriculum’, *Journal of Medical Ethics* 24: pp. 188–92.


I would like to express my thanks and appreciation to a number of people who helped me think through these issues and commented helpfully on earlier drafts: Phill and Di Marshall of Morling College and SIM; Dr James Clarke of Newcastle; Professor Wendy Rogers of Macquarie University; Dr Margaret Wilkins of Morling College; Professor Peter Hampson of the University of West England.