our values: service to all

Laurence Crutchlow examines biblical equality in medicine

'To serve our patients according to their healthcare need without partiality or discrimination on any basis'

Laurence Crutchlow is a London GP and CMF Associate Head of Student Ministries.

Our first reaction to this fourth CMF value might be that it is so obvious as not to be worth stating. Surely the recent Equalities Act (2010), frequent 'Equality and Diversity' training, and repeated political talk about 'health inequalities' render this value uncontroversial?

Although almost all doctors of any faith or none might assent to this value at first glance, it is easy for our actions to fall short of it, or for exceptions to be justified.

It is also important to think about 'fair' and 'unfair' discrimination. For example, a medical school is (and surely should be) discriminatory over who passes finals. Do we really want qualified doctors who think that beta-blockers are a good treatment for asthma, or who cannot recognise signs of infarction on an ECG? Such discrimination is surely fair and reasonable; but to decide that someone could not be a doctor because they are a woman is clearly 'unfair' discrimination.

is there discrimination in this 'equal' world?

There are a number of possible situations where patients may not be treated equally. More obvious discrimination on grounds of gender or race is, at least in theory, rare; but debate continues other whether the elderly receive (or should receive) equal treatment. NHS guidelines ration certain procedures on grounds that may discriminate – classically joint replacement surgery for the obese, or IVF treatment for smokers. Such restrictions may be based on sound clinical evidence, but at what point does a clinical decision turn into discrimination?

'Partiality' (unconscious discrimination or favouritism) is perhaps more of a problem. Though few doctors will explicitly discriminate, it is common to do more for certain groups of patients – other doctors, families of practice or hospital staff, serial complainants, or even those who bring regular boxes of chocolates to the surgery(!). Very rarely is this conscious, but it can easily escalate.

What about discrimination on the basis of ability to pay? CMF's value statement was written some years ago in the context of the UK NHS, where almost all care was free; even now most care remains free, and questions of payment rarely arise. But even in a 'free' system, hidden 'costs' of healthcare (lost earnings while attending appointments, parking costs, transport) can still mean that ability to pay has some effect on access to care.

In much of the world, some upfront payment for care is usually required. To explore this in full would be a lengthy article indeed, although with both an ageing UK population and large government deficit it cannot be ignored indefinitely, even in the UK. Our colleagues at CMDA in the United States of course work in a very different system. Their ethics statements suggest that society should 'seek a basic level of healthcare for all', but not prohibit the purchase of additional care beyond this.[1]

are patients really all equal before God?

Though most Christians today would be quick to defend equality, many outside the church do not believe us. Sometimes this is justified – Christians have not always universally acknowledged equality before God.

'That slavery is sanctioned by the Bible seems scarcely to admit of a doubt'[2] is not a made up quote, but was printed in a Christian publication during the American Civil War, only 150 years ago.

Sometimes the world's view is not justified – choices made by Christians in accordance with their conscience are characterised by others as discrimination, even when clearly recognised in law (such as the conscience clause in the 1967 Abortion Act).

God's word is clear that everyone was created equal in his sight. There is no mention of differences in status before him as creation is described in Genesis 1. Adam and Eve are both held responsible for the sin in Genesis 3. If everyone comes from a common ancestor, as the biblical creation account would suggest, then surely there should be no basis on which to discriminate, at least on racial grounds.

What about those who may have caused their own illness? We know that all have sinned (Romans 3:23), and that no-one can declare themselves truly innocent. We know that human illness only came into the world at the fall, and so is a result of sin. However it does not always follow that a specific person's sin has led to their illness – a baby who becomes infected with HIV *in utero* can hardly be said to be responsible for the infection.

If we are to treat all equally, we must recognise that all are sinners, and equally culpable. Even if our own sin hasn't directly affected our physical health, it may be responsible for the ill-health of others. Denying treatment because we perceive that someone has caused their own illness suggests that they alone are a sinner; and denies the reality of our own and others' sin.

Some argue that the early parts of the Bible promote discrimination, with some distinctions made quite clear: 'Yet I have loved Jacob, but Esau I have hated' (Malachi 1:2b-3a). God chose one people, the Israelites, through whom to reveal himself, and this can seem as if others are discriminated against. Yet as we read on in Scripture, we see that these things are there principally to illustrate the real unity that is to come. When the church is described to the Ephesians, we read 'But now in Christ Jesus you who once were far away have been brought near by the blood of Christ.' (Ephesians 2:13); 'In him the whole building is joined together and rises to become a holy temple in the Lord' (Ephesians 2:21). 'There is neither Jew nor Gentile, neither slave nor free, nor is there male and female, for you are all one in Christ Jesus.' (Galatians 3:28). God's ultimate plan is for all his people to be in unity under Christ.

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what does biblical equality in medicine look like?

A simplistic answer might say 'provision of all possible care to all who need it'. However this has never been a reality, and is unlikely ever to be. Some element of choice as to what is provided to who is inevitable. The increased pressure on costs of both an ageing population and medical advances mean that difficult questions will arise more often – whether ultimate funding comes from taxation or from another model.

There are some areas where it is clear that we must not discriminate. God has created men and women and all different races equal before

him. The elderly are respected in the world of the Bible, and Jesus often singled out the marginalised, poor or widowed for special mention. Clearly we must not unfairly discriminate on these grounds, whether in the care we provide personally or nationally in the healthcare system we use.

Indeed in the case of the poor and widowed, Jesus discriminated in their favour – surely an example of 'fair' discrimination – and a reminder of how different God's kingdom is from the world we live in.

Another form of 'fair' discrimination might be when a clinical decision is absolutely appropriate, even though it may appear discriminatory to the untrained eye. For example, there is little medical evidence for offering bariatric surgery to the mildly obese – but if we don't offer it, some may say we are discriminating.

As alluded to above, more challenging cases include those where patients have been responsible for their own illnesses. Should a state-funded system pay to treat a motorcyclist who fractures their humerus whilst racing on track, or for femoropopliteal bypass surgery in a heavy smoker who openly admits that they don't intend to stop smoking? Here it would be unfair discrimination to try and work out if either was sinful and deny treatment on that basis; but it may be entirely fair discrimination to say that surgical repair of the humerus will probably be successful, but that the bypass surgery may make little difference to the ultimate outcome if the patient continues to smoke.

Looking beyond the individual patient, we might think about groups of patients who appear to have worse outcomes than others. Patients with chronic mental health problems or learning disabilities are well-recognised to be more likely to be in poor physical health. Thinking in public health terms, there are wide variations in life expectancy even just across different parts of London,[3] let alone across the world.

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what is our role now?

Our role in treating everyone equally should be obvious enough – with particular attention paid to the risk of partiality discussed above. But this value is not only for individuals; it speaks to systems through which healthcare is delivered. These may seem far from medical students; but there are opportunities to become involved throughout our careers. Some may work in public health or in commissioning roles as GPs where they have direct influence on the system. Others may do clinical research that explains (and helps us tackle) apparent differences in health outcomes.

But most importantly this value applies at a personal level, in treating every patient as Jesus would treat them. This is not an easy task, especially if tired or busy, or early in our careers when we may not be confident of our clinical skills. Such practice, though, is a powerful witness; not only to our patients, but also to our colleagues. ■

REFERENCES

1. Healthcare delivery ethics statement. CMDA, 1996 *bit.ly/1p7aECp*
2. Isaac T Tichenor, quoted in Brisfield JW jr (ed). *The Spirit divided: Memoirs of the Civil War chaplains – The Confederacy*. Mercer University Press 2006:218
3. See *life.mappinglondon.co.uk* for one researcher's take on this.