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SOCIAL WORK & CHRISTIANITY

AN INTERNATIONAL JOURNAL

EDITORIAL

Pluralism, Tolerance, and Respect for Diversity: Engaging Our Deepest Differences within the Bond of Civility

ARTICLES

What Do We Owe the Elderly? Thinking Christianly about Rationing Health Care Resources

Perceptions of Conflict between Christianity and Social Work: A Preliminary Study

A Forgiving State of Heart: Narrative Reflections on Social Work Practice from a Christian Perspective

Religious Discrimination in Social Work: An International Survey of Christian Social Workers

Maximizing the Contribution of Faith-Based Organizations to Solve Today's Most Urgent Social Problems

Journal of the North American Association of Christians in Social Work

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Journal of the North American Association of Christians in Social Work

Pluralism, Tolerance, and Respect for Diversity: Engaging Our Deepest Differences within the Bond of Civility

David A. Sherwood

Appropriate tolerance for others and respect for diversity are more complex and difficult to achieve than the rhetoric of either relativism or absolutism would lead us to believe. Despite the rhetoric, few, if any, social workers are relativists. At some point we all find ourselves confronting something other than "diversity," something which we believe to be "wrong" and morally obligated to oppose. Moral rules, whether from the Code of Ethics or the Ten Commandments can guide us in our moral reflection, but they can't give us absolute prescriptions when they come in tension with each other in practice. Real tolerance and respect for diversity requires honest recognition of differences and civility in the exploration of their meaning.

Appropriate tolerance for others and respect for diversity continue to be hard to achieve in real life, no matter how much we social workers flatter ourselves about this being one of our primary virtues. This is true for both those who naively pride themselves on their tolerance and those who fear that tolerance means a pact with the devil.

Let me tell a story. A social work educator refused to write a letter of reference for a graduate of his BSW program when she applied to an MSW program that included a Christian identity in its mission on the grounds that he believed the program to be inherently discriminatory and oppressive because it did not in his view affirm all lifestyles. This social work educator refused repeated offers to meet with faculty of this MSW program to explore the nature of the program and any possible differences they may (or may not) have. Presumably this social work educator believes himself to be acting in keeping with, and indeed in defense of, social values regarding social justice including tolerance and respect for diversity. Not all would agree that his attitude and actions are in keeping with these values.

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The Problem with Relativism

Tolerance is cheap if it simply means moral relativism. Those who say they believe in moral relativism tell themselves (and others) that everything should (interesting word for a relativist) be tolerated, indeed "respected," since nothing is wrong (except, of course, "intolerance"). All difference is to be affirmed. To make value or moral judgments is to engage in oppressive acts. Values are only subjective preferences and morality is only individually and culturally constructed.

Many social workers have long talked this game—some under the guise of "scientific" materialism or modernism, some more recently under the guise of postmodernism. The thing is, people may talk this way, but it is just that—talk. The concept is simply self-negating when it comes to values, and the practice of it is virtually non-existent. Moral relativism is an intellectual possibility, but almost impossible to believe and act upon with any consistency.

I have never yet met a social worker who was a real moral relativist. Certainly the social worker in the story above is not a functional relativist. We are all full of strong views regarding how things *should* be, and zeal to advance those views. They are often called social work values and ethics. Unfortunately, sometimes they are our own biases that we should be very careful about imposing on others. However, if all values are completely relative, you can just forget the idea that people "should" be anything, including tolerant and respectful of diversity. The only people I have met who are complete relativists have little interest in what they "should" do and instead tend to get other labels, such as psychopath. (This itself is an interesting phenomenon. If you follow the logical conclusions of relativism, you must be biochemically or psychosocially defective, but not wrong or evil).

Many years ago now, C. S. Lewis made the point very graphically in the first section of *Mere Christianity* (1943) which he subtitled "Right and Wrong as a Clue to the Meaning of the Universe." He says we can learn something very important from noticing the kinds of things people say when they quarrel. He says people don't merely say the other person's behavior doesn't happen to please them (about all you could say if moral relativism is the whole story). They seem to be appealing to some kind of standard of behavior which they expect the others to know about and feel obliged to, some values involving justice or regard for the good of others. And, he says, the other person "very seldom replies: 'To hell with your standard.' Nearly always he tries to make out that what he has been doing does not really go against the standard, or that if it does there is some special excuse... It looks, in fact, very much as if both parties had in mind some kind of Law or Rule of fair play or decent

behaviour or morality or whatever you like to call it, about which they really agreed. And they have. If they had not, they might, of course, fight like animals, but they could not *quarrel* in the human sense of the word" (1943, p. 17)."

Respected social work ethicist Frederic Reamer makes the same point quite clearly. "If one believes that conclusions concerning ethical values and guidelines reflect only *opinions* about the rightness and wrongness of specific actions and that objective standards do not exist, there is no reason to even attempt to determine whether certain actions are *in fact* right or wrong. One opinion would be considered as acceptable as another" (1990, p. 55). At some point, most of us find ourselves convinced that we are confronting something other than "diversity," something more sinister that we find "wrong" and morally obligated to oppose. The prime politically (and I would say morally) correct example of this in our time has been the Nazi treatment of Jews and other marginalized groups. As Lewis points out, "We all do believe that some moralities are better than others. . . If your moral ideas can be truer, and those of the Nazis less true, there must be something—some Real Morality—for them to be true about" (1943, p. 25).

Social workers who claim there is no place for moral judgments in the discussion of social work practice usually are thinking about what they perceive to be factual or scientific truth or moral judgments they happen to disagree with. It is easy to be a champion of diversity and tolerance if you happen to heartily approve the diversity in question. However, this says nothing about our ability to practice real tolerance, which is about how we treat ideas, behavior, and even persons we genuinely disagree with. The social worker in my story seemed to find no contradiction between his zeal for practicing tolerance and his unwillingness even to explore the nature of his perceived difference with the program.

Social workers who believe that family structure is unimportant or only a cultural artifact get no diversity tolerance virtue points for "affirming" the equal validity of all family arrangements. However, these social workers might have their diversity tolerance virtue tested by encountering an actual family arrangement which seemed to challenge a value which they in fact care about (as I do)—such as gender equality. As Lewis says, "You would not call a man humane for ceasing to set mousetraps if he did so because he believed there were no mice in the house" (1943, p. 26).

So, platitudes about "respecting diversity" and "practicing tolerance" don't get us very far. We have to get into much more complex questions about what kind of difference we are talking about, what the meaning of that difference is, and what the relevant values at stake happen to be.

The Problem with Absolutes

If moral relativism doesn't work and doesn't clarify the meaning of tolerance, how about the other end of the spectrum—moral absolutes? If our virtually universal sense that there are some sort of transcendent moral standards that go beyond our personal preferences and which morally obligate us is true, what does that mean? Does a belief in the reality of moral rules mean we have clear sailing in determining what is "diverse" and ought to be respected and even celebrated, and what is wrong and ought to be opposed? Does tolerance mean a pact with the devil? I don't think we're going to get any easy answers here either.

First of all, our understanding of the rules (social work or Christian) is always going to be clouded by our human condition. From a Christian perspective, it is always necessary to remember who we are—fallen and finite. Christian theology says that God reveals through creation, the prophets and apostles, scripture, and ultimately through the incarnation—the person of Jesus Christ (Psalms 19; Hebrews 1:1-2; II Timothy 1:8-14, 3:15-17; John 1:1-18; Romans 1:18-32, 3:9-31). However, our ability to understand is very limited. We are sinners saved by grace by God whose thoughts are higher than our thoughts (Ephesians 2:8-10; Isaiah 55:6-9). Our hearts are deceitful (Jeremiah 17:9).

Even if we boil the rules down to their most fundamental elements, the "exceptionless absolutes" of love and justice, as Arthur Holmes called them (1984) and see them embodied in the words and person of Jesus Christ, we still only dimly understand what they mean. We "know only in part . . . for now we see in a mirror, dimly" (I Corinthians 13:9, 12).

Once we get past these "exceptionless absolutes" of love and justice, the rest of the moral rules become less absolute (yes, I said less absolute). Even "love" in the sense of beneficence must be tempered by justice. Lewis says, "You might think love of humanity in general was safe, but it is not. If you leave out justice you will find yourself breaking agreements and faking evidence in trials 'for the sake of humanity,' and become in the end a cruel and treacherous man" (1943, p. 24).

Moral rules derived from love and justice, such as those found in the Ten Commandments and the Sermon on the Mount (or the social work Code of Ethics), articulate more specific values that help us to understanding the meaning of love and justice in various spheres of life (tell the truth; keep your promises; be faithful to your spouse; forgive as you have been forgiven; share with those in need;

challenge oppression). All of these rules are "true" and they give us real guidance in making the moral judgments we are challenged with in life and in professional practice. However, they can and do come into tension with one another in the complexities of a particular situation. Often we find ourselves having to make a judgment about how to prioritize legitimate moral values when any action we take will advance some of our values at the risk and perhaps cost of others. Negotiating with terrorists may save some lives while putting others at risk, but is it loving and just for those of us who are not in present danger to say to the actual hostages that we are sacrificing you because the odds tell us that by doing so we will be saving more hypothetical hostages in the future? Maybe, but it isn't a simple call.

However, we must in fact make those tough moral judgments in our personal and professional lives. And (I would argue) we always make them based in part on our best current understanding of the moral rules. Perhaps the largest influence on our judgments is not our understanding but our character. For the most part I think this is a good thing—our commitment to be a good person and our disciplined steps in that direction over a lifetime often embodies more wisdom than our heads. However, this also means we always make these judgments based in part on our selfishness, fear, anger, and ignorance.

Pluralism: Engaging Our Deepest Differences within the Bond of Civility

So how does all of this relate to the issue of tolerance for others and respect for diversity? I think it means that both those who pride themselves on their tolerance and those who pride themselves on their ability to know good from evil need to be very careful.

Real tolerance and respect for diversity requires that we figure out how we should deal with ideas, behavior, and persons we genuinely disagree with, some of which we believe to be not simply different but wrong. All disagreements do not carry the same weight, but not all differences can simply be "affirmed." We need to avoid either underestimating or overestimating what is required for tolerance and respect for diversity. Consequently, situations which test our tolerance are situations which call for utmost honesty and clarity regarding what is truly at stake.

Tolerance and respect for diversity which have integrity are much needed virtues for our times. I would argue that this kind of tolerance and respect for diversity are Christian virtues as well as social work values and that religious values ultimately make the strongest foundation for tolerance. Persons are made in the image of God, with inherent value including God-given freedom of choice and

personal responsibility, which ought not to be overthrown or oppressed.

Pluralism is the condition under which we live and in which we practice social work today. Indeed, "Pluralism—meaning that we live together with people who inhabit different worlds of meaning—would seem to be the permanent human condition" (Neuhaus, 1999, p. 72). This means social workers need to come to terms with pluralism of all kinds among clients and among other social workers. This means we will continually have to be challenged with what it means to maintain integrity with our own values, including social work values, while respecting the values of others who differ from us. The sociological fact of pluralism does not mean that social work or religious values can or should be kept out of public life, including our practice of social work. The only practical choice we have is whether or not we handle our values with self-awareness and integrity. As Neuhaus says, "Pluralism is not pretending that our deepest differences make no difference. Pluralism, rather, is engaging those differences within the bond of civility. Pluralism requires mutual respect for persons, not indifference to truth" (1999, pp. 72-73). Civility requires respectful encounter with those who appear to differ from us.

Honest recognition of differences and civility in the exploration of the meaning of those differences will advance our practice of tolerance and respect for diversity more than any amount of rhetoric about tolerance and diversity or simplistic zeal in opposing those who appear to us to be wrong, whether they be clients or colleagues.

The social work educator in our story was right to take his understanding of the nature of discrimination and oppression seriously, even to the point of understanding that not all views can simply be tolerated or affirmed. But I think he was quite wrong in not respecting the persons with whom he disagreed and in not being willing to engage his perceived differences within the bonds of civility. I would like to think he would have changed his mind. But whether or not he changed his mind, he would have kept better faith with his social work values. ||||

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David A. Sherwood, Ph.D., LICSW, ACSW is editor of Social Work & Christianity and Professor of Social Work at Roberts Wesleyan College, 2301 Westside Drive, Rochester, NY 14624. Email: sherwoodd@roberts.edu (O); david.carol.sherwood@mciworld.com. Phone: 716-594-6185 (O); 716-889-3477 (H).

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WHAT DO WE OWE THE ELDERLY? THINKING CHRISTIANLY ABOUT RATIONING HEALTH CARE RESOURCES

Cheryl Kreykes Brandsen

This paper considers how policy practitioners might respond to inevitable health care rationing concerns among the elderly. Since any form of rationing results in people going without beneficial services, Christian social workers who make and implement such policy decisions will need a deep and thoughtful Christian and social work ethic to guide their work. Implications of stewardship in a community of image-bearers involving both love and just are explored. An understanding of being made in God's image moves us toward affirming egalitarian conceptions of justice, within a context of democratic deliberation, as being congruent with our calling to image God as policy practitioners.

RECOMMENDATIONS THAT CERTAIN FORMS OF HEALTH CARE BE denied to the elderly in the United States began to emerge in the early 1980s. Empirical data reported that those over age 65 (then 11 percent of the population) were consuming one-third of the nation's annual health expenditures, and that 30% of Medicare funds were being spent on five to six percent of Medicare insurees who die within the year (Schulte, 1983). Against this background, Richard Lamm, then governor of Colorado, was widely quoted as stating that older persons "have a duty to die and get out of the way" (Slater, 1984, p. 1).[1] Media and press coverage portrayed the elderly as "greedy geezers" (Fairlie, 1988), affluent, and selfish (Longman, 1989).

Although such portrayals of the elderly are often recognized as unfair stereotypes, concerns about justice, health care, and rationing persist—and for good reason. A few observations. Today the elderly constitute nearly 13 percent of U.S. population; by 2030, over 20 percent of the population will be over age 65. Health care expenditures on the elderly have outpaced the gross domestic product by 3.5 to 4.0 percent in recent decades; if expenditures continue to grow as they have in the past, health care for the elderly in 2020 will require 10 percent of GDP, compared with 4.3 percent in 1995 (Fuchs, 1999).[2] In 1997 the Medicare program financed $214.6 billion in health care spending for its 38.4 million participants (HCFA, 1997). Al-

though future Medicare costs are uncertain, reasonable projections of costs point to major financing problems. Among the elderly, those over age 85 constitute the fastest growing group of the elderly. Seventy-two percent of these individuals need assistance in daily living activities. Fifty percent of this group have some form of dementia. Forty-three percent of the elderly can expect to spend some time in a nursing home before they die, with average costs of nursing home care ranging from $40,000 to $65,000 yearly. These changing demographics and accompanying health care costs for acute and long-term care continue to fuel significant concerns about health care rationing among the elderly.

The use of medical technology among the elderly is also a concern. Callahan (1988) observes that with the exception of birth control pills, each of the medical technologies developed since 1950 have had the most significant impact on people over the age of 50. New technological advances, while having only a modest effect on expenditures initially, are refined and more heavily utilized over time, particularly among the elderly (Fuchs, 1999). Or consider this scenario. Recently, the use of Left Ventricular Assist Devices (LVADs) have been perfected and used to strengthen the part of the heart that is failing when patients are in congestive heart failure. These devices add an extra year or two of life. The costs of implanting one of these devices is between $100,000 and $140,000, the anticipated demand for LVADs are estimated at about 200,000 patients per year, and most of the patients in need of such a device are Medicare recipients. Subsequently, if such costs were to be covered by Medicare, we would add $20 to $28 billion per year to our health care budget and most of this to Medicare. In contrast to limited hearts available for transplants, there will be virtually no limit to the number of LVADs which can be produced. As a matter of justice, how many LVADs should be produced and how should these be distributed?[3]

The purpose of this paper is to consider how Christians,[4] especially those whose work involves developing and implementing health care policy, might think about and respond to complex problems of health care rationing in regards to the elderly. The concern is not whether rationing is necessary, but rather how it should be accomplished in a fair and just manner. I am working from the assumption that rationing of health care resources is unavoidable and that in fact, we have been rationing health care, albeit invisibly, for many years through market mechanisms such as ability to pay, DRG's, or physician bed-side rationing.[5] Is it, for instance, ever morally permissible to signal the elderly as a particular population to whom certain types of rationing decisions apply? If so, when and how might such decisions be made in a way that is faithful to

God? To develop these ideas, I will first clarify key terms. Second, I will explore the implications for policy practitioners about the biblical notion of being made in the image of God. Third, I argue that extensions of egalitarian philosophical perspectives into health care justice support some understandings of age-based rationing and are congruent with our calling to image God as policy practitioners.

Key Terms

Rationing. The terms "rationing," "health," and "the elderly" are subject to different interpretations. Ubel and Goold's (1997) broad definition of rationing as actions that encompass "any explicit or implicit measures that allow people to go without beneficial health care services" is used here (p. 209). This definition recognizes both explicit rationing, such as administrative decisions which deny health care goods to some people, and implicit rationing, such as allocating goods by the free market and ability to pay. Rationing also involves decisions about distributing absolutely scarce resources, such as human hearts for transplantation, and allocation decisions, such as how many artificial hearts to produce. Finally, rationing involves decisions about withholding possible beneficial services because the benefits are perceived as not worth the costs.

Health. To consider rationing decisions about health care, it is important to have some notion of how we define health. The World Health Organization defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (as cited in Callahan, 1990, p. 34). While such a definition is commended for its wholistic construct to understanding health, its usefulness in the policy arena is limited. Such a goal is unrealizable in this life, even if resources were unlimited, and can lead to medicalizing every dimension of our lives. A more useful construct of health in terms of the goals of medicine is to think of health as "well-working" or "well-functioning" (Kass, 1975).

The Elderly. In referring to the elderly, I am referring to those persons over the age of 65. Admittedly, chronological age does not reflect the tremendous heterogeneity of the elderly. Yet, because of its prominence in available health and demographic statistics and its relevance to eligibility criteria for Medicare, the chronological age of 65 or older as a marker for the elderly is used here.

Imaging God: Stewardship in a Community of Image-bearers

Because rationing results in people going without beneficial health services, Christians who make and implement such policy decisions will need a deep and thoughtful Christian ethic to guide their work. Such decisions must be faithful to and informed by Scripture and guided by centuries of Christian thinkers. This raises interesting

methodological challenges, however, since the medical dilemmas we face today were unheard of even 50 years ago. When Jesus healed the sick, he had neither the benefits or burdens of organ transplants, ventilators, or LVADs at his disposal. Scripture does speak, however, to the attitudes and dispositions that must shape our character and conduct. Recalling the biblical concept of being made in the image of God will take us far in forming biblically faithful convictions as we enter policy arenas and consider health care policy and rationing for the elderly.

What is it to be an imager of God? Genesis 1:26 illuminates our roles as God's representatives as stewards of creation: "Let us make man in our image, after our likeness; and let them have dominion over the fish of the sea, and over the birds of the air, and over the cattle, and over all the earth, and over every creeping thing that creeps upon the earth." Such a task "requires the capacity for reflective choice-making" and "recognizing and accepting the exhilarating freedom and the sobering burden of making moral judgments about proper stewardship" (Bouma, Diekema, Langerak, Rottman, Verhey, 1989, p. 32). Thus we image God, in part, by thoughtfully carrying out our mandated governance of creation.

In the context of covenanting with Noah, God says, "Whoever sheds the blood of man, by man shall his blood be shed; for in the image of God has God made man" (Genesis 9: 5,6). Calvin's commentary on this passage is instructive:

> Men are indeed unworthy of God's care, if respect had only to themselves; but since they bear the image of God engraven on them, He deems himself violated in their person. Thus, although they have nothing of their own by which they obtain the favour of God, he looks upon his own gifts in them, and is thereby excited to love and care for them. This doctrine, however, is to be carefully observed, that no one can be injurious to his brother without wounding God himself. Were this doctrine deeply fixed in our minds, we should be much more reluctant than we are to inflict injuries (Wallace, 1959, p. 149).

Thus, we image God by being in community with other image-bearers whom God has created, by caring for, revering, and delighting in the mirror-image of God that we see in them, and they see in us.

As imagers of God, then, we find ourselves in a complex matrix of relationships and responsibilities. We are in relationship with God who calls us to become more God-like, to grow in the grace and knowledge of Jesus Christ. We are in relationship with creation as stewards of God's good gifts. We are in relationships with other people and we are in relationships with ourselves as self-reflective, responsible, choosing creatures. The question, then, is how can an understanding of imaging God provide us with principled convictions to carry with us as we consider health care policy and rationing for the elderly. I suggest three requirements for policy practitioners that flow from an understanding of what it means to image God.

Imaging God in Our Care for Other Image-bearers. Policy practitioners who are intentionally aware of what it means to be an imager of God will be profoundly aware that those who stand to gain or lose by policy decisions are fellow image-bearers of God, worthy of deep respect and reverence. To harm another is to harm an image-bearer of God. Here again, Calvin takes great care to impress upon us the persistence of God's image in those we encounter:

> . . . [We are] to look upon the image of God in all men, to which we owe all honor and love. . . Therefore, whatever man you meet who needs your aid, you have no reason to refuse to help him. You say, "He is a stranger"; but the Lord has given him a mark that ought to be familiar to you, by virtue of the fact that he forbids you to despise your own flesh. You say, "He is contemptible and worthless"; but the Lord shows him to be one to whom he has deigned to give the beauty of his image. You say that you owe nothing for any service of his; but God, as it were, has put him in his own place in order that you may recognize toward him the many and great benefits with which God has bound you to him. You say that he does not deserve even your least effort for his sake; but the image of God, which recommends him to you, is worthy of your giving yourself and all your possessions. . . . It is that we remember not to consider men's evil intention b!ut to look upon the image of God in them, which cancels and effaces their transgressions, and with its beauty and dignity allures us to love and embrace them (1960, Institutes III, vii, 6).

If such awareness is deeply rooted within us, strict utilitarian attempts to capture the costs and benefits of services and use such analyses in policy development should give pause to Christian policy practitioners. For example, utilitarian measures can be criticized for their lack of preciseness in being able to capture all that we value in health care and treasure in other image-bearers. Quality Adjusted Life Years (QALYs) have an inherent bias against the aged, the disabled, and the ill. A "life-years saved" measure negates for some the intuitive value placed on life quality, and yet for the elderly, it is not at all clear that they would choose quality of life over quantity (Cicarelli, 1997) . The use of a "lives saved" measure makes no

distinction between saving the life of a five year old over the life of a 95 year old. Quality and quantity of life are of value to many, and efforts to ration care based on such measures must not lose sight that what is at stake is the life of an image-bearer of God.[6] Furthermore, using age as a sole criterion for determining treatment severely compromises the richness of what it means to be an image-bearer of God.[7]

On the other hand, policy practitioners who have a deep and pervasive awareness of the elderly as God's image bearers might be tempted to see such lives as priceless, and thus advocate that economic costs should not be part of the moral equation, that rationing of health care should never occur. "Because human beings image God," such a practitioner might say, "we should do whatever possible to save human life, regardless of how diminished such life might be, and irrespective of costs." Shortly I will argue that such a move is misguided and morally irresponsible.

Imaging God in Our Love for Justice. Given that as image-bearers we are in relationship with God who calls us to become more God-like, it is essential to recognize that God loves justice (Isaiah 61:8; Psalm 37:28) and God does justice (Psalm 103:6; Psalm 140:12; Psalm 146:7-9). Not only do we do justice because it "is a *manifestation of our respect for* the image of God in persons," we do justice "as *constituting (part of) our imaging* of God" (Wolterstorff, 1995, p. 18). To image God, we must love and do justice. As Calvin suggests in his commentary on Genesis 9, to treat another unjustly is not only morally injurious to another, but wounds God as well (Wolterstorff, 1987).

From the Old and New Testament scriptures, we conclude that the contours of justice include meeting the sustenance needs of the widows, orphans, aliens, and the poor. Although this argument cannot be fully developed here, there are many biblical events—Moses' farewell speech in Deuteronomy, the exhortations of the prophets, Jesus' persistent attempts to bring the disenfranchised into community, Jesus' identification of himself as the herald of justice in Luke 4, and Jesus' ministry to the sick wherein he demonstrated his concern for physical as well as spiritual well-being—which point to God's love for justice and the positive rights of the poor and marginalized for sustenance. A just society "must bring into community all its weak and defenceless ones, its marginal ones, giving them voice and a fair share in the goods of the community" (Wolterstorff, 1995, p. 18). Justice, an indispensable component of shalom, or flourishing, will be concerned that needs for sustenance are met such that individuals can prosper and carry out their vocations.[8]

Two points are noteworthy here: justice is concerned about meeting sustenance needs and justice is concerned about bringing all into community. Does health care "count" as a sustenance need? Is there a general right to health care that one can assert, such that by denying care to an individual, we have treated that person unjustly, morally injuring that person and injuring God? Yes (but within limits, as I will argue shortly).

As Daniels has argued (1988), health is necessary to carrying out our life plans; to lose one's health diminishes or obliterates such opportunities and may result in death. Health care protects and restores our health, furthers our "well-working," and enables us to flourish and participate in the life of the community. As well, our concern for health care as a matter of sustenance will extend to all individuals, not just those who can afford to purchase health care insurance. Not only is there a strong correlation between poverty and poor health in the medical and social science literature, there is strong evidence that poverty causes disease.[9] Link and Phelan (1995) assert that poverty is a "fundamental cause" of disease because lack of economic resources limits "access to resources that can be used to avoid risks or to minimize the consequences of disease once it occurs" (p. 93). Furthermore, given that such variables as race, ethnicity, and gender are so closely tied to economic resources or lack thereof, marginalized statuses "should be considered as potential fundamental causes of disease as well" (p. 93).

Subsequently, access to adequate health care for all individuals is a matter of justice, not beneficence.[10] Health care belongs to the category of those things "...which cannot be satisfied by market mechanisms. There are important human needs which escape its logic. There are goods which by their nature are not, and cannot be mere commodities" (John Paul II, 1987, p. 40). Sick elderly people (along with other groups such as the very young, the chronically ill, the disabled, and sick poor) are prime targets for discrimination in market-based, managed care plans since such plans avoid enrolling those who with great needs who use resources disproportionately. Who will want to want to negotiate with them on matters of health care?

Yet we will need to bracket or qualify such an assertion that access to adequate health is a matter of justice. We cannot afford to meet all health care needs without seriously compromising other social goods. Fleck (1989) argues that "there is no perfectly general right to health care, though individuals do have highly complex rights to many specific forms of health care. What these rights are in any specific instance will be a political *and* moral construct. . . " (p. 168). Even if we agree that access to adequate health care is a

matter of justice, such agreement leaves many important issues unresolved such as defining what constitutes "adequate" health care.

And, in terms of imaging God in our love for justice, we can begin to reflect on whether we wound God by leaving legitimate health care needs of the elderly unmet. Once again, policy practitioners who have a deep and pervasive awareness of wounding God by wounding the elderly might default to the "pricelessness" argument. Such a move, however, ignores a third critical dimension of imaging God.

Imaging God as Stewards. Exclusive loyalty to affirming the pricelessness of human life ignores our responsibilities to be faithful stewards of the resources God has given. Because health care resources are indeed limited relative to needs and desires, affirming the pricelessness of human life results in invisible rationing efforts that are hidden from public scrutiny or individual resistance. Not only are such rationing decisions invisible, they are usually the result of the politically and economically powerful imposing such decisions on the sick, poor, and politically powerless. They undermine the moral foundations of social collaboration and make impossible the realization of autonomy. This invisibility is what is morally problematic about health care rationing (Fleck, 1990a, 1990b).

The health care policy decisions which followed the 1972 End Stage Renal Dialysis (ESRD) Medicare amendments exemplifies this. These amendments provided public funding for all those who could medically benefit from renal dialysis or a kidney transplant. This was a public affirmation of the pricelessness of human life. At the same time, however, hemophiliacs were seeking public funding for the clotting factor K, which was just as important for sustaining their lives and also just as unaffordable for many of them as dialysis and transplants were to people with ESRD. Congress denied funds to this group. Preferential compassion, not justice, occurred here.

While invisible rationing allows us to avoid making public tragic choices,[11] it also fosters a system of patchwork polices and practices in the delivery and financing of health care which leaves over 44 million Americans without health care insurance. Continued defaulting to affirming the pricelessness of human life when health care resources are scarce gives policy practitioners no guidance in making the difficult rationing decisions that must, in fact, be made. The pricelessness position "is a morally vacuous notion" with "morally insidious consequences" (Fleck, 1990a). In regards to the elderly, for instance, affirming pricelessness does not help us determine whether or how research funds directed toward extending human life can be traded for research funds directed at pain management, or funds directed toward acute medical care can be channeled into long-term nursing home or home health care.

Our biblically-shaped dispositions to care for and honor each other must be tempered by responsible and thoughtful decisions about allocating and prioritizing health care costs, and such decisions must be visible and public. Furthermore, these decisions must take seriously the demands of justice in meeting sustenance needs and achieving an equal voice and standing for all persons in the community.

Deliberative democracy provides a context where such conversation can occur—where thoughtful policy practitioners can indeed carry out their imaging of God by making visible and public decisions that include the voices of all in the community. Daniels' egalitarian conception of health care justice, which takes seriously the demands of justice in meeting sustenance needs, provides a framework for a Christian voice in the deliberation.

Imaging God in Rationing Decisions: Deliberative Democracy

Ezekiel Emanuel (1996) says that there is growing agreement "between liberals, communitarians, and others that many political matters of justice—and specifically, the just allocation of health care resources—can be addressed only by invoking a particular conception of the good" and that "there may even be a consensus about the particular conception of the good that should inform policies on these nonconstitutional political issues" in deliberative democracy (p. 13).

At the heart of deliberative democracy is "the idea that citizens and officials must justify any demands for collective action by giving reasons that can be accepted by those who are bound by action" (Gutman and Thompson, 1997, p. 38). Because health care resources of goods, services, and funds are limited, deliberation promotes the legitimacy of collective decisions by making public the reasons (if not the deliberation itself) for its policy decisions in terms that citizens can understand and accept, even if they disagree with them. Because people tend to be egocentric when arguing about contentious health care policy, deliberation seeks to encourage a "public-spirited" perspective on public issues. Because we live in a pluralistic society with incompatible moral values, deliberation works toward promoting respectful decision-making, assisting participants to recognize moral merit in the views of those with whom they disagree. Because we have incomplete understandings of most moral conflicts, deliberation helps correct the mistakes that citizens and policy practitioners inevitably make, and, for those who are certain that their views are best, deliberation over time will tell.[12]

Deliberative democracy is not a panacea for solving difficult rationing problems, yet adaptations of it seem promising. Consider, for instance, the Oregon Health Plan. In the early 1990s, the state of

Oregon adopted a set of priorities for its publicly funded health care under Medicaid. Its goal was to provide basic health care to all Oregonians below the poverty level by trading high-cost, low-yield interventions for a basic level of care likely to result in mortality and morbidity outcomes on a par with other industrialized countries. The Oregon Health Services Commission (OHSC) was established to create a prioritized list of diagnoses and treatments. They did this through an elaborate process of consultation, which included community meetings at which participants were "asked to think and express themselves in the first person plural. . . as members of a statewide community for whom health care has a shared value" (Gutman and Thompson, 1997, p. 41). The prioritized list was eventually submitted to the state legislature, who then determined the cut-off point such that treatments below the line would not be reimbursed by Medicaid. Although the plan was initially severely criticized for its targeting of the poor, it has been commended for a number of bold moves, including public dialogue concerning rationing decisions, attempts to include those who must live with rationing decisions in the dialogue, and its emphasis upon increasing access to medical care for the poor. Since the plan went into operation in 1994, "more than 100,000 people have been added to the Medicaid program, and it is politically popular. Serious complaints about the prioritized list are hard to find. Major problems exist, but they mirror the difficulties of the health care system around the nation" (Bodenheimer, 1997, p. 651).[13]

Fleck (1994) argues that "no matter how fine-grained a conception of health care justice we develop, it will never be fine-grained enough to generate a uniquely correct complete set of just rationing protocols" (p. 382). Consequently, we turn to processes of rational democratic deliberation to yield a concrete choice that will be "just enough." Rationing rules that are adopted through this process will be morally legitimate if certain conditions are met: we are all stable members of some similarly situated health care plan, and as members of some plan, we have a fair opportunity to shape rationing decisions which we agree to honor through thick and thin. The moral space in which democratic deliberation occurs is bounded and structured by health care principles that have "a status akin to constitutional principles, which is to say that any proposed rationing protocol that violated one of these principles would have to be rejected" (pp. 383- 384).[14]

Examples of these constitutional principles include a Publicity Principle, a Fair Equality of Opportunity Principle, an Equality Principle, an Autonomy Principle, a Just Maximizing Principle, Need-Identification Principles, Priority-Setting Principles, and a Neutrality Principle (Fleck, 1994). Furthermore, the adequacy of any set of principles will be a product of wide reflective equilibrium, considering coherence among various aspects of a theory of health care justice, considered moral judgments about cases and policies, and attributes of our current health care policy environment.

Imaging God in Rationing Decisions: A Christian Voice in the Deliberation

Deliberative democracy works toward achieving the equal voice and standing in the community that a Christian view of justice-in-shalom implies. As well, it provides a context in which policy practitioners, alongside of those who must live with the outcomes of such decisions, visibly struggle with difficult stewardship decisions. Now we must ask what views of health care justice, particularly in regards to the elderly, might be publicly presented and defended in the deliberation by Christians, being mindful of the demands of justice. Daniels' work provides an effective frame through which to consider age-based rationing from a lifespan perspective.

Fair Equality of Opportunity. Grounding his arguments in the second part of Rawls' principle of equality, Norman Daniels argues for a just health care system based centrally on the principle of "fair equality of opportunity" (1985). A just health care system will guarantee people fair equality of opportunity over a lifetime. Social institutions that shape health care distribution will be arranged in such a way so as to allow individuals to achieve a fair share of the normal range of opportunities present in a given society. The normal range of opportunity is determined by the range of life plans one could reasonably hope to pursue, given his or her talents and skills. Like Rawls, Daniels recognizes positive obligations to reduce or eliminate barriers that prevent fair equality of opportunity. Because disease and disability are perceived as undeserved restrictions on one's opportunities to meet basic goals, forms of health care that significantly prevent, limit, or compensate for reduction in functioning should receive priority in designing health care systems and allocating care.

Fair Allocation Over a Person's Lifespan. In *Am I my parents' keeper* (1988) Daniels confronts the problems of justice between age groups, that is, the perception that the old and young are locked in conflict for scarce public welfare resources where attempts to redistribute funds away from the elderly to the young, or vice versa, appears discriminatory and age-biased. This synchronic approach to allocation furthers competition between groups. By contrast, Daniels suggests that consideration of health care resources be considered diachronically, or across a lifetime, and argues that "justice between age groups . . . is a problem best solved if we stop thinking of the old and the young as distinct groups (p. 18). We all age, and

the young will eventually be the old. The task, then, is not one of furthering justice between groups but rather a question of what health care resources should be available for each stage of life. More precisely, Daniels asks, "How would rational agents design institutions to prudently allocate fair shares of basic social goods over their lifespan?" (p. 66).

What System Would We Choose If We Didn't Know Our Place In It? To answer this question, and drawing heavily upon Rawlsian commitments to egalitarianism and features of the social contract associated with the "original position," Daniels develops his "Prudential Lifespan Account." Rawls' concept involves a "thought experiment" in deriving a just social contract by persons in the "original position" of ignorance regarding what position they themselves might have in the system they construct. "What social arrangements, institutions, and policies would we choose under a veil of ignorance regarding our own position in the system (social class, status, wealth, natural assets and abilities, age, gender, etc.)?" This account offers an account of health care rationing by age that would not be age biased. Daniels sums up his Prudential Lifespan Account in this way:

> Specifically, our health-care rights might give us legitimate claims to services at one stage of life but not at another. This may happen because meeting certain needs is more important at one stage of life than at another, or it may happen because life as a whole will be better if resources are rationed by age. The inequalities in entitlements held by different age groups do not, however, mean that people are being treated unequally, at least over the course of their lives, as I pointed out earlier. Over the lifespan, our rights to health care will be equal rights, even if those equal rights yield unequal entitlements at different points in the life span (p. 81).

The type of health care system that Daniels envisions prudential choosers might design from behind a modified veil of ignorance is one like this:

> Therefore it seems prudent for me to reserve certain life-extending technologies for my younger years. I would thus maximize the chances of my living a normal lifespan. I might also use some of the resources "saved" in this way to provide myself with more social-support and home-care services if I turn out to need them in my old age. I might reason that such services could vastly improve the quality of my life in old age and that such an improvement is worth the increased risk of slightly shortened age. I would then—through my benefit package—instruct the providers to treat me accordingly, that is to appeal to an age criterion in their utilization decisions concerning me (p. 53).

Daniels is clear that his argument does not, in general, sanction rationing by age. Appeals to an age criteria are acceptable only when they are part of the basic designs of institutions that distribute resources over the lifetimes of the individuals they affect. What Daniels rejects is the piecemeal use of age criteria sometimes employed by health care systems and physicians. As well, the principles of justice and their reasoning for age-based rationing must meet Rawls' conditions for publicity; the fact of rationing and the reasons for it must be made public.[15]

Daniels' ideas for lifespan age-based rationing are certainly congruent with our convictions about rationing, justice, and the elderly. Here the elderly are not singled out as the only group to which rationing applies, but we are all asked to thoughtfully consider what we might want to give up for our own future elderly selves. At the same time, those who are less well-off receive priority in the design and delivery of health care. Daniels' question, "How would rational agents design institutions to prudently allocate fair shares of basic social goods over their lifespan?" (1988, p. 66) can be adapted to consider, "How would rational, committed Christians design institutions to prudently allocate fair shares of basic social goods over their lifespan?" I offer the following preliminary ideas in response to this revision of Daniels' question, focusing particularly upon Medicare.[16]

Obviously, to do justice to Daniels, we would need to consider his question in the context of service-delivery systems from "womb to tomb." Space constraints do not permit this. Also, there is the much larger question of health care reform, and what a Christian voice might be in this deliberation. I can only point to, but not develop or defend here, what such a system might include. Surely the demands of justice would require that all Americans have access to a thick package of health care services—a package substantive enough that few people, including those who are economically secure, would feel compelled to go beyond to purchase additional health care, lest we perpetuate tiered systems of health where the minimal tier is nothing more than token gestures at justice. While there are different mechanisms through which universal access to a thick package of health care benefits might be achieved, a system of Accountable Health Plans which cover the lifespan, and does not sequester Medicaid and Medicare from the rest of the plans, ensures a place in the community for those most likely to be marginalized.

Imaging God in Our Love for Justice: The Case of Medicare

Because Medicare is the primary shaper of health care services to the elderly, reforms in Medicare should be congruent with the primary goals of health care for older adults. The management of multiple chronic disease, the prevention of functional declines, and the promotion of successful aging are the current central challenges in geriatric medicine (Cassell, Besdine, and Siegel, 1999). Subsequently, when considering how might we think about allocating social goods, and health care in particular, to the elderly, we must consider what kinds of health care and social institutions are best able to preserve functional abilities, and restore or compensate for losses of normal functioning.

The current Medicare system, however, is a catastrophic health insurance program, focused upon the diagnosis and treatment of disease. It is organized around discrete, disconnected service events that occurred in the past. As a reactive, episodic model, it is inappropriate for its beneficiaries, 88 percent of who have at least one chronic condition (Whitelaw and Warden, 1999). Services aimed at prevention of further functional decline—rehabilitation, routine physical examinations, foot and dental care, prescription drugs, assistive devices for sensory impairments, and so forth—are not available through Medicare. Such services can be purchased through expensive Medigap supplements, but millions of poor elderly have no such options.

Could we envision a deliberation among future Medicare cohorts about Medicare reform and the kinds of benefits and trade-offs they wish to make for their future selves as elderly persons? Do we value the extension of life at all costs, and thus, for example, advocate for including TIAHs as a Medicare benefit? Might we be willing to trade expensive treatment, such as organ transplants, for more extensive home, rehabilitative, or institutional care currently not covered in any substantial way by Medicare? Should including such basic benefits as prescription coverage take precedence over life-sustaining treatments? Might we be willing to trade high-technology outpatient treatments and repeated hospitalizations for systems of interdisciplinary coordinated care that moves seamlessly between acute and long-term care?[17]

This is not to suggest that in our re-design of Medicare we could arrive at a package of benefits to which all could agree. Some individuals, for instance, might wish for such a plan to include coverage for physician-assisted suicide, while others would find such an inclusion morally intolerable. Respecting the principle of autonomy, we could envision different sorts of health care plans created by large groups of people in which they collectively agree to certain rationing protocols in their elder years. Inevitably we would find a

range of Medicare managed care organizations (MCOs) that reflect particular values people hold in respect to quality and quantity of life.[18]

But could we not imagine a Medicare MCO which works intentionally towards imaging God in our love for justice? This Medicare MCO would provide access to adequate care for all members, regardless of ability to pay or level of health. To meet the requirements of justice regarding membership in the community, Christians, especially those with wealth and privilege, would be willing to live within the limits set (as determined from rational democratic deliberation) such that the health care needs of diverse elders could be adequately met. To meet the requirements of justice regarding sustenance needs, it seems reasonable that thoughtful Christians would argue that in their MCO's benefit package, expensive life-prolonging treatments be forgone in return for more comprehensive basic health care, including prescription drugs, such that poor elders would not have to make difficult trade-offs between food and medication, for instance. Extensive home and institutional care targeted toward restoring or compensating the normal losses of aging would be offered instead of costly hospitalizations aimed at curing. Social support, mental health services, spiritual care, and assistance with end-of-life care would be recognized as integral ingredients to include in the design of institutions that care for the elderly. As with an ideal universal health care plan, the benefit package would be substantive enough that few people would be compelled to go beyond to purchase additional health care, lest the reformed Medicare program be nothing more than cursory gestures at justice.

In our re-design of Medicare, policy practitioners will remember that health care is but one of many social goods that we require as elders, or indeed, over the course of our lives. If we design for everyone a Cadillac Medicare plan to honor the pricelessness of human life, we will leave other important goods underfunded. Thus, we must deliberate publicly about such allocations, and live within the hard budget limits set for ourselves. This point is particularly poignant in regards to the elderly, as their primary source of health care coverage is a publicly-funded program. Dollars directed to Medicare cannot be directed to education, housing, access to basic health care services for non-elders, and other important social goods. Extended length of life for some elderly may well be compromised by honoring justice commitments which extend participation in community life to the disenfranchised. Faithfulness to God requires honoring the elderly, but nowhere is such honoring defined narrowly in terms of extended length of life at all costs. These are the tragic, albeit not necessarily unjust, decisions that faithful stewards

must make. We will never be able to afford all that health care can deliver, and so as faithful stewards, we must make decisions that only God, with God's wisdom, can truly make.

Conclusion: Deliberation Among Image-bearers

As we reflect on how best to think about and make decisions about age-based rationing in the context of deliberative democracy, some might argue that Christian policy practitioners have settled for "second best" in opting for a form of procedural justice or non-ideal justice over substantive principles of justice in rationing. In response to this concern, I offer, although I cannot explore further here, the following.

First, even if such substantive principles exist, given the limitations of our human thinking, our fallenness as image-bearers of God, we likely will not be able to uncover substantive principles to guide each and every rationing decision that must be made. Second, if such substantive principles exist, we are most likely to realize them through rational democratic deliberation. Deliberative democracy provides a context in which not only policy practitioners but all of us can struggle communally and publicly with the tensions inherent in imaging God. As participants in either broad moral conversations or at the level of state or organizational planning, we must be "givers and hearers" of reasons for health care rationing decisions, mindful that our reason-giving must extend beyond the confines of a particular Christian community.[19] Furthermore, in our giving and hearing of reasons, we must be deeply cognizant that our discussion partners are image-bearers of God, and thus worthy of respect.

I have tried to argue that recalling the biblical notion of imaging God will help us form biblically faithful convictions to undergird our work as policy practitioners. Such a concept will shape how we care for people, how we understand justice, and how we fulfill our stewardship responsibilities. When we extend our awe and respect for individuals as image-bearers of God to all of God's people, which is what justice requires of us, we will find ourselves confronted with agonizing decisions of rationing which extend to the elderly. Although difficult, such decisions need not be unjust or immoral. Age-based rationing undertaken from a lifespan perspective, and including in the deliberation process those who must live with the outcomes of deliberation, is biblically defensible, given our calling to image God. |||

Endnotes

1Although Lamm stated that he had been misquoted, he has since delivered similar, but more tactfully worded, messages (Lamm, 1987; Lamm 1989a; Lamm 1989b).

2Health care expenditures in the United States surpassed the $1.1 trillion mark in 1997 (estimated $1,146 trillion in 1998). Health care spending as a share of the gross domestic product (GDP) was 13.5 percent in 1997 (estimated 13.7 percent in 1998). This is higher than other industrialized countries, yet does not result in better health outcomes (Levit, et al, 1997). In spite of these expenditures, the number of uninsured persons in this country has risen from 30.5 million in 1979 to nearly 43 million.

3I owe the details of this example to an email conversation with Leonard Fleck, July, 1999.

4It is presumptuous to think that there is but one way to "think christianly" about this subject. These ideas are the reflections of one Christian, grounded in a Reformed tradition. I hope that some of what is said here will resonate with other Christian and non-Christian faith traditions as being faithful to the obligations of a just society in regards to its elderly members.

5For a defense of the inevitability of rationing, see, for instance, Churchill, 1987; Eddy, 1994.

6An analysis of the strengths and limitations of such measures is beyond the intent of this papers. Interested readers will find the following sources useful: Cubbon, 1991; Goold, 1996; Mooney, 1989; Redelmeier, 1993; Williams, 1992.

7Callahan, a communitarian, argues that the elderly who have completed a "natural lifespan" be willing to forgo cure targeted at extending life and opt instead for care. He operationalizes his concept of "natural life" as being those who have lived long enough to "accomplish, for the most part, those opportunities that life typically affords people and which we ordinarily take to be the prime benefits of enjoying a life at all - that of loving and living, of raising a family, of finding and carrying out work that is satisfying, of reading and thinking, and of cherishing our friends and families . . . My own view is that it can now be achieved by the late 70s or early 80s" (1988, p. 127).

8In Christian theology as well, there are strong assertions that the poor have claim rights to sustenance as a matter of justice and that "...in the relations and events in the life of His people, God always takes his stand unconditionally and passionately on this side and on this side alone: against the lofty and on behalf of the lowly; against those who already enjoy right and privilege and on behalf of those who are denied and deprived of it" (Barth, 1955, p. 138). See Wolterstorff, 1983, 1987, 1995, 1998 for further examples and additional citations.

Within the Catholic tradition in particular there is a consistent stream of sound scholarship which links Scriptural themes of justice to sustenance needs. The Catholic "preferential option for the poor" demands "a compassionate vision which enables the Church to see things from the side of the poor and the powerless and to assess lifestyle, policies, and social institutions in terms of their impact on the poor" (United States Catholic Conference, 1986, p. 52).

[9]The literature here is extensive. For starters, interested readers will want to consult Blendon, Aiken, Freeman, and Corey (1989); Cooper, Simmons, Castaner et al (1986); Kahn, Pearson, Harrison et al (1994); Padgett, Patrick, Burns, and Schlesinger (1994); Weissman, Stern, Fielding, and Epstein (1991).

[10]There is a large argument to be made against Engelhardt's (1996) libertarian extensions into health care justice, but this argument cannot be fully made here.

[11]See Calabresi and Bobbitt (1978) for a defense of invisible rationing.

[12]There is, of course, much more that can and should be said about deliberative democracy. Interested readers may want to consider Cohen, 1989; Gutman and Thompson, 1996, 1997; Rawls, 1993. One issue here is that if we allow that it is morally permissible to solve some rationing problems through democratic deliberation, we will need to consider which rationing decisions can be made through such a process and which decisions must be non-democratically determined. As well, we will need to consider if there ever might be rationing decisions that result from deliberation that we might wish to challenge, and if so, what challenges does this raise for the moral legitimacy of democratic deliberation. Such a discussion is beyond the scope of this paper.

[13]The Community Dialogue Project on *Genome Technology and Reproduction* carried out by the University of Michigan and Michigan State University, funded by the National Institute of Health Human Genome Project, is another example of how such moral conversations can occur in deliberative democracy (1996 - 97).

[14] These principles are further developed in Fleck's forthcoming book, *Just caring: the moral and political challenges of health care reform and rationing* (Oxford University Press).

[15]Daniels (1988) is critical of physicians in the British National Health Services in their treatment of adults over the age of 55 who need hemodialysis. So that scarce dialysis resources can be used for younger patients, few people over the age of 55 receive dialysis. What older patients are told, however, is that "there is nothing more that can be done for you" when the reality is that "there is nothing that society is willing to do for you, given your age" (see chapter five).

[16]16I focus on Medicare specifically for two reasons. First, the health care needs of the elderly are the focus of this paper. Second, as the nation's largest public payer of health care, Medicare is the single most powerful and influential force shaping health care organization and delivery today. In addition, it shapes research agendas and medical schools' curricula. While reforms of Medicare address only one part of needed health care reform, changes here will ripple throughout the health care system.

[17]An interesting model in the U.S. for integrating acute and long-term care is the Program of All-Inclusive Care for the Elderly (PACE).

[18]See Daniels and Sabin (1998) for an interesting extension of democratic deliberation to managed care organizations in the context of autologous bone marrow transplants for breast cancer. Given that people wi!ll weigh certain values differently, and given that general principles of distributive justice are too indeterminate to solve rationing problems, Daniels says we must solve rationing problems through "fair, publicly accountable procedures" which "produce reasons that all can accept as a basis for making decisions" (1996, p. 11). Daniels suggests that this fair process includes four conditions. First, publicly accessible rationales for decisions made about health care coverage (or lack thereof) are available. Second, these rationales "should aim to provide a reasonable construal of how the organization should provide 'value for money' in meeting the varied health needs of a defined population under reasonable resource constraints" (1997, p. 323). Third, mechanisms for challenging or revising limit-setting decisions will be in place. Finally, there will be voluntary or public regulation to ensure that these conditions are met.

[19]I owe this phrase to Bouma et.al (1989).

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Cheryl Kreykes Brandsen, MSW, is Director of Social Work, Department of Sociology, Social Work, and Criminal Justice, Calvin College, 3201 Burton SE, Grand Rapids, MI 49546. Email: brac@calvin.edu. Phone: 616.957.8538.

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Perceptions of Conflict Between Christianity and Social Work: A Preliminary Study

Dwain A. Pellebon

A sample of 145 church members recruited from nondenominational churches to measure perceptions of social workers and the social work profession. The study examined two dependent variables: 1) perceptions of conflict between Christianity and the social work profession and 2) the degree of agreement with social work values. Statistically significant findings indicate that this sample both perceives a high degree of conflict with social work and disagrees with humanistic interpretations of social work values. The study highlights the importance of social workers engaging in spiritually and religiously sensitive exploration of clients' perceptions in order to understand them and to help the clients understand social workers and their roles.

The social work profession has shown a growing interest in spirituality. Recent papers on spiritual topics include spiritual and religious principles in social work practice (Ballenger & Watt, 1996; Elhany, McLaughlin, Brown, & Bertucci, 1996), the inclusion of spirituality in human behavior and practice courses (Marton & Bailey, 1996; Thornton & Garrett, 1996; Russel & Derezotes, 1996; Robbins, Canda, & Chatterjee, 1996), and the benefits of examining one's own spirituality (Dudley & Rice, 1996). Others have looked at the contributions of religion to social work (Canda, 1988; Siporin, 1986), the religious beliefs of social work educators and practitioners (Bergin, 1991; Derezotes, 1995; Sheridan, Bullis, Adcock, Berlin, & Miller, 1992; Sheridan, Wilmer, & Atcheson, 1994), including spirituality in social work course content (Canda, 1989), religion in social work research (Faver, 1986), as well as debates about spirituality in social work (Cornett, 1992; Hemert, 1994).

The profession should recognize the relevance of religion/spirituality issues for practice, research, and education because it is an issue of cultural competency. Though the process of identifying spiritual or religious groups is subjective (Kropf & Isaac, 1996), religion and spirituality are diversity issues. As cultural diversity is considered when developing interventions (Henderson, 1994; Locke, 1992), spiritual and religious diversity must also be taken into account (Joseph, 1984). Therefore, the profession requires data that will provide insight into the perceptions within these cultural groups.

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And, despite some interest in spirituality, negligible attention has been paid to how the client's religious or spiritual world view may influence his or her perception of social workers or the profession. This type of data is necessary to help social workers reduce potential barriers to practice, such as stereotypes, biases, and countertransference issues, that may be based on uninformed perceptions.

Few articles have addressed spirituality and religion in the context of practice. With the exception of Locke, Garrison, and Winship's (1998) generalist practice text, a review of other major practice texts (Compton & Galaway, 1994; Hepworth & Larson, 1993; Kirst-Ashman and Hull, 1993) finds minimal attention given to spirituality. Religion is briefly mentioned as part of the assessment process, but these texts do not discuss how religion may impact the client as a system or how the profession is perceived. In many instances, failure to recognize the client's religious beliefs and practices and/or their "spiritual hurting" leads to premature or misapplied intervention plans. This can lead to the establishment of mistrust between spiritually-based clients and social work practitioners.

To begin to gain insight into the perceptions of spiritually-based clients, this study explores a subset of this group's perceptions of social workers and the profession. This will be done using a test survey that attempts to capture general spiritual beliefs and measure perceptions of social workers, their practice, and the profession of social work. Because the questionnaire's validity and reliability are being tested, only one religious group has been selected for preliminary exploration. Specific hypotheses follow in the data analysis section.

Methodology

Subjects

145 non-random participants were recruited for this study. One nondenominational church in the states of Wisconsin, Oklahoma, and Nevada agreed to allow the researcher to give a brief presentation to the Sunday morning service. These churches were selected because they were similar in their theology (non-Catholic, generally evangelical), the researcher was acquainted with their leaders, and they were located in various regions. Those who chose to participate were asked to take the survey home, complete it, and use the return postage-paid envelope. The mean age for the sample was 43 years (six did not respond to that item). Gender was divided into 36.4% male to 63.6% female with five non-respondents. The sample was relatively homogenous in race with 89.2% reported to be European-American, 4.2% Latino-American, 2.1% accounted for African-American and Asian-American respondents, and 2.8% for the remaining ethnic groups. There were five non-respondents. When asked to identify a denomination or spiritual/religious group, 98.6% of the sample were categorized as contemporary Christian (non-Catholic).

Measures

The participants were given a 42-item questionnaire, of which 12 items were used for this analysis. Because there are no existing instruments that measure the perception of conflict with social work, the researcher developed two six-item scales for the dependent variables "Perceived Conflict with Social Work" and "Social Work Value Statements from a Humanistic Perspective." Both instruments used a five-point likert response scale to measure the degree of agreement with each item. "Perceived Conflict with Social Work" was comprised of the following items:

1. "It is my experience that social work agencies are generally in conflict with religious and/or spiritual goals."
2. "If I had to go to a social worker, I believe the person could be trusted."
3. "The social work profession has different political beliefs about issues that I have strong feelings about."
4. "I would go to a social worker."
5. "I would refer believers with a spiritual need to a social worker."
6. "A social worker would have to share similar religious and/or spiritual beliefs to understand my spiritual needs."

Reliability analysis showed moderate intercorrelations (.38) between items when all the correlations were averaged. With all items included, the alpha was .71 for the scale. "Social Work Value Statements from a Humanistic Perspective" asked the respondent to react to each item with the following instruction—"Imagine seeing a social worker for counseling. During your first meeting the social worker said the below statements." Respondents were asked to agree or disagree with each item. The scale was comprised of the following items:

1. "It is my belief that all humans are born good."
2. "It is mostly what is happening outside the person that causes them to behave as they do."
3. "Because you are the most important person in life, your decisions should meet your desires."
4. "I know you have strong beliefs, but these beliefs cannot protect you from mental illness."
5. "Taking medications for mental illness is necessary for staying well."
6. "A person should not be refused a job, an education, or their

desired housing because of their race, religion, sexual orientation, political views, and/or sex."

Reliability analysis showed moderate intercorrelations (.40) between items when all the correlations were averaged. The alpha for the scale was .76 with all items included.

Data analysis

This is a non-random volunteer sample. Therefore generalizations beyond the sample are not possible. However, this sample showed a relatively normal distribution on the dependent variables, and when the population mean is unknown, the One-Sample t Test is an appropriate statistical procedure (Glenberg, 1988, pp. 234-250). The t statistic will be able to determine if the mean of the sample is significantly higher or lower than that of an estimated population.

The researcher made directional hypotheses regarding the dependent variables. The first hypothesis states that this sample would perceive a high degree of conflict with social work. also, it was hypothesized that this sample would disagree with those items that reflect particular humanistic interpretations of social work values. For both variables the statistical significance is measured from a test value = 3.00 on the scales. In other words, the mean response "neither agree nor disagree" (3) will be considered a neutral perception that may be held by clients who are in the spiritual belief system. If the mean differs significantly in the expected direction from this test value, it will be considered a finding that rejects the null hypothesis.

Results

Statistical analysis supported the alternative hypotheses for both dependent variables. Table 1 shows that the respondents perceived a high degree of conflict between their spiritual world view and social work ($t = 7.22$; $df = 144$; $p < .01$) as measured by the "Perceived Conflict with Social Work" scale. Their mean score was significantly higher than the 3.00 test value. Similarly the "Social Work Value Statements from a Humanistic Perspective" items showed respondents in disagreement with these statements ($t = -4.96$; $df = 144$; $p < .01$).

Though the degree of disagreement varied across items, the test showed a significant difference from the test value in the direction of the stated hypothesis. Table 2 lists each item from both dependent variables and reports their percentages of agreement and disagreement. The listing of percentages shows the degree of relative strength for each scale item.

Table 1: Results of the Two Dependent Variables

DEPENDENT VARIABLES	X	t	df	p	SD	N
Perceived Conflict with Social Workers	3.41	7.22	144	.000	.697	145
Agreement with Social Work Values from a Humanistic Perspective	2.61	-4.69	144	.000	.936	145

Note: One-Sample t Test using a 2-tailed confidence level of .95% was used to analyze the date. The test value was 3 on the five-point agreement scale

It is noteworthy that when conflict is stated as a general concept (e.g. "It is my experience that social work agencies are generally in conflict with religious and/or spiritual goals") there is only a small percentage who disagree (8.9%). The following five items show the nature of the issue regarding perceived conflict. The statement that "The social work profession has different political beliefs about issues that I have strong feelings about" (61.3% agree) may be the conceptual center of the general negative perception. The other responses may be a function of the perception that social work as a profession is "politically liberal." If this is true, the other statements and their percentages logically follow.

The item "Because you are the most important person in life, your decisions should meet your desires," recorded much greater disagreement (84%) compared to the others. This finding should not be surprising considering that evangelical Christianity endorses selflessness. Hewlett (1986, p. 1444), in his commentary on the book of James, writes that it is likely that Christians would disagree with persons seeking to meet their own desires over the good of others. "Looking to the interests of others rather than to one's own is entirely opposed to the spirit of the world so truly described in Psalms 49:18, a man gets praise when he does well for himself." It is also possible that the phrase regarding self importance may have been too vague in that it does not clarify "compared to whom." Such an general statement may have contributed to the high percentage of disagreement.

Another noteworthy item is that 63.8% of the sample perceived that beliefs can protect a person from mental illness. However, this finding does not clarify what was behind the response. For example, did they think that beliefs are a total protection, making medication

Table 2: Percentage of Agreement or Disagreement with Scale Items			
Scale and Scale Items	**Agree-ment**	**Disagree-ment**	**N**
Perceived Conflict with Social Workers Scale (Six Items)			
1. ...social work agencies ... conflict with religious and/or spiritual goals.	51.7%	8.9%	143
2. If I had to go to a social worker, I believe the person could be trusted.	25.6%	31.9%	144
3. The social work profession has different political beliefs about issues that I have strong feelings about.	61.3%	4.1%	145
4. I would go to a social worker.	17.3%	48.6%	144
5. I would refer believers with a spiritual need to a social worker.	8.3%	69.4%	144
6. A social worker would have to share similar religious and/or spiritual beliefs to understand my spiritual needs.	68.3%	15.2%	144
Social Work Value Statements from a Humanistic Perspective (Six Items)			
1. It is my belief that all humans are born good.	36.8%	54.8%	144
2. It is mostly what is happening outside the person that causes them to behave as they do.	28.1%	64.0%	142
3. Because you are the most important person in life, your decisions should meet your desires.	7.6%	84%	144
4. I know you have strong beliefs, but these beliefs cannot protect you from mental illness.	27.0%	63.8%	144
5. Taking medications for mental illness is necessary for staying well.	25%	39.5%	144
6. A person should not be refused a job, an education, or their desired housing because of their race, religion, sexual orientation, political views, and/or sex.	49.3%	40.9%	144

Note: Responses of "strongly agree"/"agree" and "strongly disagree/"disagree" were collapsed into dichotomous agreement and disagreement categories in the table. Those respondents who answered "neither agree or disagree" were not included in the table because this group was the comparison for determining the mean differences.

unnecessary, its use betraying a lack of faith, or might the response also mean that beliefs make a significant difference but that medication is not excluded and in fact may also help? This item shows the potential relevance of such further research when looking at implications for practice and illustrates the importance of social workers not making assumptions but rather engaging in relevant exploration with clients. A social worker who has a client with this perspective may want to examine this client's spiritual point of view regarding why or how beliefs can combat mental illness. This information may be invaluable in how the worker will approach the issue as well as the client's inclination to collaborate on an intervention plan.

Discussion

This preliminary study used an untested instrument to measure conflict with social work and with certain humanistic interpretations of social work values. In establishing the validity of these scales, it was useful to identify a religious/spiritual group from which high probability hypotheses could be tested. In other words, is there a religious group in which we could expect high perceptions of conflict and value disagreement? If so, items with face validity on such constructs should show the alternate hypotheses when tested. The rationale for selecting non-Catholic, evangelical, and predominately European-American Christians was the general association of this population with conservative political activity (Nassif, 1996; Reed, 1994). Many of the values and ideals of social work could be perceived as politically "liberal" in nature, and this could be a basis for predicting potential conflict with social work. For example, the profession's support for certain gay/lesbian rights and/or welfare services for indigent groups may not resonate with some Christian groups because they infer disagreement with theological absolutes. If some measure of conflict was significant beyond a norm, it would support the validity of the dependent variable scales.

The findings provide support for the hypotheses, but the items should be examined more specifically in order to interpret their potential meaning. Further investigation may show that more indices are required to capture dimensions of a complex construct in order to increase construct validity. For example, the notion of a person being "born good" or more concretely describing "mental illness" could be two items that may have several interpretations.

More research is needed in the area of understanding a spiritually-based client's world view. This information will help guide the social worker into sensitive practice in the same manner that culturally specific information assists for culturally-sensitive practice. One

potential research goal could be to develop a spirituality scale that is capable of measuring spirituality in a manner that would capture the individual's general beliefs. Such a scale could be used across different belief-systems with the purposes of identifying and measuring the belief in specific spiritual principles. Such a scale could be used to study associations between particular spiritual principles and areas of practice. For example, a positive relationship emerged doing Pearson Correlation between the items "beliefs cannot protect one from mental illness" and "perception of conflict" (.497, $p < .01$). Such associations in other areas would build a knowledge-base that has the potential to predict how persons with certain spiritual beliefs may respond to practice interventions.

A primary limitation of this study relate to the non-random sample. As such the sample may not reflect the views of most non-Catholic Evangelical Christians. The study could be enhanced if it had incorporated more diversity within this group (i.e., ethnicity, SES) and between groups from other belief-systems. This would allow for a comparison to see if expected tendencies in other groups could be predicted using these scales. The findings must be examined for indications that the sample may have misinterpreted scale items. These areas can be addressed now that these items have been measured with the one sample. The "Social Work Value Statements from a Humanistic Perspective" scale may measure and reinforce a liberal stereotype of social work more that it does core social work values. The Values Scale may need to be revised to more clearly focus on core social work values as articulated in the code of Ethics and the CSWE Curriculum Policy Statement as opposed to humanistic derivations (e.g. "the innate value of every person" as opposed to "born good").

In spite of its limitations and preliminary nature, this study clearly highlights the importance of social workers engaging in spiritually and religiously sensitive exploration of clients' perceptions in order to understand them and to help the clients understand social workers and their roles. ||||

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Dwain A. Pellebon, Ph.D., is Assistant Professor of Social Work, School of Social Work, The University of Oklahoma, 1005 Jenkins Avenue, Rhyne Hall, Norman, OK 73019-0475. Email: dpellebon@ou.edu. Phone: 405.325.1402

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A Forgiving State of Heart: Narrative Reflections on Social Work Practice From a Christian Perspective

John R. Graham & Cathryn Bradshaw

This article shares the experiences of two social workers who conceive of forgiveness in relation to their Christian formation. Three practice case examples illuminate the inextricable links between the theological and social work practice applications of giving and receiving forgiveness through vulnerability, the unguarded heart, and release. Coming to forgiveness is a grief process—a process of remembering, of experiencing and owning the emotions, of choosing to acknowledge the pain, and of releasing one's self and the other. This reflection is anchored by such mystics/thinkers as Bonhoeffer, Niebuhr, Tillich, and Van Der Post.

Attaining a forgiving state of heart is part gift, part grace—in some measure the result of a choice, and inner healing. The reflections presented here represent the authors' experiences of integrating spirituality with professional practice. Social work is often focused on vulnerable and suffering peoples. One of the most powerful tools available to social workers is the worker-client relationship. This relationship involves a clinical technique, but also a spiritual stance. Indeed, the spiritual informs the clinical, and vice versa.

The following pages convey various examples of forgiveness as experienced by two practicing Christians. One, an associate professor of social work, is an Anglo-Catholic ("High Church") Episcopalian. The other, a former nun and current social work practitioner/consultant, is a Roman Catholic. We have found that the "what" of our belief can be distilled, to a considerable extent, into the "how" of believing it (Soren Kierkegaard cited in Cupitt, 1997, xii). To this end, the human act of forgiveness is a marvelous vehicle for demonstrating and testing our faith. Conversely, faith furnishes the values and assumptions that, for us, lead to a forgiving state of heart. And it provides the foundation upon which we can attempt to carry out forgiveness. But faith is, in essence, the most profound act of risk of which we are capable. It insists that we trust without certainty something that may appear, at first blush, to be at times unreasonable and at times beyond reason.

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