UNFIT TO BE UNFIT?

A CHRISTIAN CONTRIBUTION TO THE HEALTHY LIFESTYLE DEBATE

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Abstract: Molly offers me a handful to sweets from her copious bed-side supply. She is evidently over-weight and the complicity of her family offers little hope that she will shed the tens of kilograms that are inhibiting her recovery. Who am I to say 'no thanks' if that merely compounds my inner disdain at her failure to make healthy choices?

This paper invites us to reflect on a Christian contribution to the debate on healthy lifestyle choices that the Scottish Executive and NHS Scotland are currently promoting. How do we make a theologically-informed response to those who make unhealthy lifestyle choices? Where does personal responsibility and autonomy fit when our choices have fiscal implications for the wider community? Can we legitimately stigmatise people who fail to comply with others' model of health? To what extent does a Christian perspective clash with the ultimate value that the healthy lifestyle debate seems to place upon life? By exploring Christian ideas of humanity and shared non-innocence we aim to identify key responses that might enhance the contemporary practice of health promotion.

Key words: Christian, forgiveness, health, lifestyle, health promotion, sin

Promoting Health

The World Health Organisation defined health as *'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'* (WHO, 1946). In 1984 this was overtly linked with people's role or function in the *'Health for All'* programme in which the goal is, *'The attainment by all the people of the world of a level of health that will permit them to lead a socially and economically productive life'* (WHO, 1984). This requires the promotion of health, which WHO asserts as:

The process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment (WHO 1986).

Closely related to this is a clarification of the meaning of health:

Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being (WHO 1986).

The Ottawa Charter, from which these definitions arise, goes on to identify three basic health promotion strategies: advocacy, enabling and mediating (between competing interests). The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources and social justice and equity. The 1986 Charter identifies five priority action areas: building healthy public policy, creating suppor-

tive environments for health, strengthening community action for health, developing personal skills and re-orienting health services.

In 1997, the Jakarta Declaration recognised new challenges to the determinants of health and set priorities for health promotion in the 21st Century of promoting social responsibility for health, increasing investments for health development, expanding partnerships for health promotion, increasing community capacity and empowerment of individuals and securing an infrastructure for health promotion (WHO, 1997). Most recently, the World Health Assembly in May, 2004 called for an emphasis on healthy lifestyles for young people and children. (WHO, 2004).

In Scotland the Scottish Executive and NHS Scotland have been developing programmes and identifying targets in, for example, 'Improving Health in Scotland – the Challenge' (2003) where in order to achieve a 'more rapid rate of health improvement' they recognise their responsibility to:

- inspire, enable, encourage and challenge the nation to achieve that vision;
- implement policies that will transform elements of Scottish life to make a real difference to individuals' expectations of good health;
- select a few key objectives (e.g. reduce fat, particularly saturated fat consumption, increase physical activity) and deliver these effectively;
- encourage the national best practice of professionals especially in multi-agency settings to achieve their full potential;
- release the inner resources of individuals and communities by building social capital, and improve the infrastructure of communities to make rapid progress (Scottish Executive, 2003).

They advocate a broad-based approach that spreads responsibility over medical, socio-economic and individual factors:

The responsibility for achieving improved health cannot lie solely in the hands of any one agent - Government, professional groups, organisations or individuals. For example, we will have to improve the physical environment of our most deprived areas. We will have to recognise problems of social isolation, stress and fear of crime. We will have to tackle key choices like smoking and the rising problem of obesity. Scotland will have to examine its approach to alcohol as never before. The people of Scotland will need to make healthy choices in all aspects of their lives and to feel that they are supported in making these choices (Scottish Executive, 2003).

The strengths of this worldwide 'Health for All' movement are that it is visionary, values-based and viable. It is visionary in that it motivates, mobilizes and guides people in their efforts to improve human well-being and promote ecological balance. In its values-base it has integrity through promoting justice and well-being. It represents a belief that such values are the foundation of human society and thus challenges attitudes and behaviours which lead to injustice and harm people and the environment. In so doing it is political and, therefore, not always welcome. It is viable in that its proposals are based on extensive research evidence and experience and could be achieved if political, organisation and resource problems can be overcome. As a movement it also has its weaknesses such as its naivety in the face of the massive and extremely difficult political, organisational and resource obstacles that need to be overcome. It is also open to criticism for giving undue emphasis to consensus and co-operation to the neglect of strategies that appreciate conflict and opposition as factors against which health promotion must contend. For some detailed discussions see, for example, Naidoo & Wills (2001); Katz, Perberry & Douglas (2000); Ewles & Simnet (2003); and Seedhouse (1986).

There is clearly no one 'right' way for improving health. Through medical, educational, client-centred, societal change and behaviour change approaches (Ewles and Simnet 2003: 45-46), the State is actively seeking to make us healthier. The extent to which any of us co-operates (or complies) in global, national or local strategies is highly variable. By focussing on co-operation in health promotion I want now to consider a Christian contribution to the lifestyle debate whilst recognising that this is but one dimension in which a theological perspective might prove productive. (For a discussion of wider aspects such as social equality see Forrester, 2001).

Responsibility

A key value at the heart of current health promotion is responsibility. Through their literature (paper-based and increasingly on-line) experts are presenting us with the question, 'Who is responsible for

your health?' Straplines such as 'Save a life- your own' or 'Choose change, choose healthy living' are conceived with the intention of making us aware of the responsibility we carry for our own health. A superficial reading might too easily hoist on to your shoulders the *sole* responsibility for our health. However, to so do would fly in the face of the much broader, shared, responsibility that the WHO and the Scottish Executive recognise. We can make personal choices but social, economic and political factors impinge to a critical degree on not only our scope of choices but the actual determinants of our health. Inadequate accommodation, unemployment and availability of specialist medical resources are only the tip of the ice-berg.

One reason for the Scottish Executive's eagerness that we take more responsibility for our health is economic. It is to all our advantages if the costs of healthcare in Scotland can be reduced by each of us making responsible choices with regards to (for example) our eating, sexual and exercise habits. We might be able to pay less tax, have more disposable income and, by being healthy workers, contribute more to the gross national product. This leads beyond the responsibility to pursue our health into a responsibility not to be unhealthy. To choose to be unhealthy (by not actively choosing a healthy lifestyle) could be conceived as an anti-social decision (Cribb and Duncan 2002 : 76). My failure to exercise may, in the longer term, cost other tax-payers more when I have a heart attack. Attempts to stigmatise smokers and people who are obese are becoming less and less subtle in advertising campaigns. Of course, it would be a highly individualized society that would leave its members to sink into ill-health and ignore the consequences for the wider community, including those children that are born into a family unit that is failing to make healthy lifestyle choices. Yet, we could lose the rights over own health under the impetus of a political movement that originally set out to remind us of our share in the responsibility for our own health. Jurgen Moltmann, the German theologian, is critical of a utopian concept of health for its implication that to be a person in the fullest sense is to be healthy. When this is the underlying notion 'health' becomes a human right, but one which is tied to an unattainable condition. Not only medical but psychotherapeutic intervention and social therapy would have to be offered, as a right. Moltmann argues that a political therapy would also need to be developed to make this state of well-being possible. However:
this would inevitably lead to the complete deprivation of a person's right over his own health. If someone makes over to the medical system of his society his rights to his own health, he is really reverting to the state of serfdom' (Moltmann, 1985: 272).
(Moltmann recognises that more recent definitions move towards health as a subjectively ascertainable attitude in terms of the strength to be human.)

Where self-control and individual responsibility become key concepts in health promotion there are some significant contributions that the Christian faith can make. First of all it affirms the notion of our responsibility for our lifestyle choices. What it means to be a human person is linked inextricably to that particular person, Jesus Christ. We are created 'in him and for him' (Colossians 1:16) and we are set in relationship with God through Him – whether we are developing or neglecting that relationship. Our primary relationship is with God, not with the State. Yet, at the same time, that primary relationship with God only means anything if it is worked out as people in relationship with each other (see for example, Moltmann (1999): particularly his section on 'The Knowing of the Other and the Community of the Different'; or de Gruchy (1995): particularly his Chapter 8, 'The Triune God and Human Sociality'). When talking of Christ as the incarnation of God, Christians are, at the very least, saying that God's relationship with us has been fleshed-out, or lived-out, in the day-by-day life of Jesus. In other words, God's love only makes sense when it is love-in-action or love of others.

This holds individual responsibility to God in tension with responsibility to and for other people. I cannot disconnect myself from other people and say that I am merely an individual; responsible to God for my own health. Being responsible for my own health involves being responsible for the health of others; just as they share responsibility for mine. As Michael Wilson notes, *'Health is a public creation, not a private specialism'* (Wilson, 1975: 107). This means that if I along with others (as the State) see some people choosing an unhealthy lifestyle we (as the State) cannot take away their autonomy. As much as we might object to their choices and find that it costs us more in taxation, we cannot impose health on them by removing their freedom of choice.

Why; because as well as being responsible to each other, each of us remain ultimately responsible to God. It is in this creative tension that we need to place attempts to instigate healthy life-style changes. To locate health promotion within a utilitarian ethical model (in which the greatest good is sought for the greatest number of people) a community takes priority over the individual. If personal autonomy is our greatest value (the individual takes priority over a community) such isolationism breeds disregard for the consequences of our choices. A Christian contribution is one that quite deliberately holds a tension between individual and community responsibility.

Sin and Forgiveness

For some people, this contribution of the Christian faith to the debate over healthy lifestyles comes at what some might consider a rather high price. The high price is that something which Christians call 'sin'. Sin is that principle at work in all of us that tends towards destruction. Our relationships with God are fractured, as are our relationships with other people and with ourselves. It is all too easy for literature that promotes healthy lifestyles to present a utopian society in the sense that everyone chooses what is best. Such an impossible vision ignores the reality of sin as a principle that can turn any of us away from what we perceive to be good. (This temptation exists even when it is our own perception of a healthy lifestyle, not simply that presented by the experts, that is at stake.) With its understanding of sin the Christian faith shoots realism through the idea (and ideal) of a society in which all people make healthy lifestyle choices. There is no need to descend into pessimism to appreciate that even if education, social change and medical resources are all fully engaged our susceptibility to make destructive choices cannot be overcome.

The Christian language of sin is also, thankfully, the language of forgiveness. If we are to find a place in the healthy lifestyle debate for forgiveness we need to return to that tension between individual and community responsibility we outlined earlier. What happens when I realise that my heath is being adversely affected by factors in my environment that are largely the responsibility of others? It might be that a multi-national industry has built a processing plant that has polluted my drinking water. It might be that my neighbours are being irresponsible with their rubbish next to my home. I could choose to see them as the 'sinners' and myself as the one who is sinned against. I could think of myself as innocent and of them as guilty. I might be able to stop them damaging my health but fail to consider their best interests; I could become selfishly preoccupied with my own right to health. I could so easily ignore how my own choices are affecting the health of others who are yet unknown to me. I might become like my irresponsible neighbours or the owners of the polluting industry that I began to become so upset about. The Christian vision of sin emphasises that it is so radical that I, as a victim, am just as likely to choose on the basis of self-interest as those against whom I have a grievance. This is why forgiveness and loving of my 'health enemies' becomes another dimension of the Christian contribution to the healthy lifestyle debate.

The Christian gospel requires me to love my enemies and that includes those who are damaging my health. I do not love them because I ignore their actions nor because I decline to declare their actions as being unhealthy for me. I love my 'health enemies' because neither they nor I are innocent. The Christian gospel tells me that prior to any discussion about my actions I am loved by God. Similarly, to love my 'health enemies' is to love them as people, prior to any discussion about their actions (as detrimental as these actions might be to my health). This means that from a standpoint of shared non-innocence I still consider their actions to be wrong and to be challenged. However, there is space for forgiveness and, crucially, for me to become aware of my own repetition of their sins. (For am extensive development of this perspective in the context of the Yugoslav conflicts see Volf, 1996.) By not pretending to myself that I am innocent and they are wicked the Christian vision offers another way – that of the cross of Christ. This is a demanding ethic that approaches health by the path of suffering. Michael Wilson reminds us that incorporating suffering is not an accustomed perspective in a Western framework:

This way towards health, which assumes that badness is not something that can be externalized and projected is powerfully present in the crucifixion and resurrection of Jesus. The cross is the model of a different way of dealing with evil, of bearing it. On the cross Christ suffered the hatred and brutality of his enemies and his friends, withstood it, and gave back forgiveness to those who nailed his

hands, understanding to the thieves at his side, and love to his mother and John. It is this way towards health through suffering which is denied in Western culture today (Wilson, 1975: 83).

Life as the Supreme Value?

This grappling with suffering invites us to question the ultimate value that the healthy lifestyle debate places upon life. If life is the supreme value it means that when all is said and done a person's basic belief is that life is what really matters. When all other issues and questions are stripped away it is a belief that life is what is of most importance; the criteria against which all other decisions stand or fall. This means that life (including its sense of living-well) is the foundation of moral decision-making. We find this in health promotion literature that presents a vision of living that ignores the inevitability of death or at least attempts, unceasingly, to prevent 'premature' death. Such material promotes health as if the right choices (sometimes of particular branded products) enables us to defeat death – in its guise of old age, wrinkles and infirmity. Other advertising or health promotion material presents a message that says that the decision we make about life and living well are the most important decisions we can make. It assumes that we will naturally, and invariably, choose life. A Christian vision challenges this assumption by declaring that life is not the supreme value. It also opens up the discussion of what helps *keep* people healthy. In previous generations, Christian literature often emphasised ways of 'dying-well' with relationships repaired and hearts stilled by God's grace (McManners 1981).

This declaration, that life is not the supreme value, is radically at odds with much of Western society in which a secular understanding of what it means to be human has been dominant for so long. However, we only have to stop and think about how our society values those who had died in battle to see that another vision has been operating simultaneously. Life is not the supreme value when the State issues a call to arms. The State expects citizens to lay down their lives for values such as democracy or freedom when these are threatened by aggressive forces. The grounds for calling on people to surrender their lives can often be dubious interpretations of democracy and freedom (such as those being merely a covert defence of western consumer lifestyles). Nevertheless, life is not afforded a place as the supreme value under these circumstances. Within many religions, Christianity included, there is a special place for the martyr as someone who considers the values of their faith to be of higher importance than life itself. The Christian vision of a healthy lifestyle relegates life to a place of lesser importance than integrity before God. This is not in any way to suggest that life and living well is not of very high importance in the Christian vision – it is to say that life and living well are not to be given the *highest* place.

Conclusions

The practical implications of our exploration of a Christian vision in which life is not the supreme value and that we maintain a tension between individual and community responsibility can now be spelt out more precisely. When life is not the supreme value a lifestyle choice that is unhealthy in medical terms might be very healthy in broader terms. For example, it is conceivable that circumstances might arise in which a Christian person might choose to decline medical treatment in favour of someone else being given the chance to live. This self-sacrifice would be honoured and not considered an act of folly precisely because the Christian does not value life above every other value. Similarly, a Christian might refuse medical treatment because it is merely prolonging their life, with a severely limited capacity for enjoyment. The Christian vision opens out the grounds on which we might make choices for healthy living. Someone, motivated by this vision, might choose to live in an area of a town that is known to be bad for people's health. This choice might be made in the belief that Christians need to identify with a community in order to be able to bring the gospel of God's forgiveness. By choosing to immerse himself or herself in the challenges of an unhealthy environment, at the risk to their own health, this Christian is demonstrating that life is not their supreme value.

A Christian view of responsibility in the context of sin and forgiveness has profound implications for the healthy lifestyle debate because it requires much of those whose health is being damaged by others' actions. It acts against barriers between those who are making choices for a healthy lifestyle and those who are not. It addresses the realities of our attitudes to others who damage our health. But, without careful reflection, this approach could easily

degenerate into a passive acquiescence to others' choices out of a misplaced and naive 'forgiveness'. Our shared non-innocence would, it might at first appear, neutralise an adequate response when choices by others damage my health. To avoid this consequence we need further critical reflection.

Whilst it addressees the realities of our attitudes to others who damage their own or our health and denies us the right to alienate them it restrains us from an indiscriminate inclusion of people whose choices harm others. We noted above that the Christian vision of a healthy lifestyle is important when we find some people making choices of ill-health that cost others of us higher taxes. We are not entitled to remove their autonomy by imposing health nor are we entitled to exclude them. This exclusion could take the form of denying them the same level of healthcare as those who are making healthy lifestyle choices. It might mean stigmatising them in television adverts and shunning them from wider society. The Christian gospel is radical in its call to reach over socially constructed barriers and thus recognise the full humanity of each and every person – prior to any thought of their behaviour. A lifestyle approach to behaviour change can become exclusionary in that it presents certain behaviour as unacceptable and raises barriers behind which those who continue to indulge in unhealthy lifestyles are confined. These barriers may be in people's thinking but they can also be quite physical. We need only think of the scene outside so many office blocks where those who smoke are corralled, sheltering from the rain, at the front gates during tea breaks. (This is not to argue against no-smoking policies but to interrogate the way in which they are implemented in terms of the messages about people's humanity and autonomy that are conveyed.)

If we say that the Christian faith calls us to reach over the walls of exclusion we are faced with a dilemma: what do we do when people make lifestyle health choices that cost us (as citizens of the State) considerable additional expense? The Christian message of inclusion can be mistake for one of indiscriminate acceptance of all forms of lifestyle choices. The Christian vision does not shy away from discriminating (i.e. judging) between lifestyle choices that are healthy and those that are unhealthy. However, it challenges any attempt to use the withdrawal (or limiting) of healthcare as a punishment against those who make unhealthy choices (e.g. to continue to smoke). When healthcare is limited and choices have to be made between treating a person who continues to smoke and one who has made consistently healthy lifestyle choices there can be considerable pressure to offer healthcare to the latter. The person who has made the 'antisocial' lifestyle choice of continuing to smoke is effectively punished by society for that decision. A Christian vision invites us to view any such punishment as wrong because it is based on a false notion of guilt and innocence. We noted earlier how the Christian view of sin holds that everyone, without exception, is under the influence of this destructive principle. There are, therefore, none who are innocent before God. When we bring this into the debate on healthy lifestyles we are saying that although one patient may chose not to smoke, or to have ceased smoking, they are not innocent. To ration healthcare on grounds that are too narrowly focussed on one lifestyle choice creates the false impression that the person who does not smoke is more innocent than the other. It may be that the non-smoker is a serial adulterer, embezzler and drunk driver. Perhaps she is a perpetual gossip who maligns her neighbours. The smoker might be a person who offers help and comfort to people in her work as a bereavement counsellor and has never said a bad word about anyone. To make a decision about healthcare that punishes a smoker simply because she smokes is unjust.

Of course, the Christian vision we are exploring here does not easily answer the dilemma for those who have to make choices of healthcare rationing, as abhorrent a practice as the health professional finds it to be. What it does is hoist the debate out of false ideas of guilt and innocence that arise in the context of constructed images of stigmatised people who make unhealthy choices. The Christian vision undermines such healthcare allocation decisions that are built on too narrow a foundation, i.e. on whether a person has made healthy lifestyle choices or not. It actually makes such decision-making more difficult precisely because it refuses to accept limited understandings of innocence and guilt (for further discussion see Wyatt 1998 : 231 – 2).

We often face people who are making unhealthy lifestyle choices (and sometimes they stare back at us in our own bathroom mirror). From our standpoint of shared non-innocence a Christian vision denies us easy solutions that stigmatise and punish. We are not entitled to exclude the enemies of our

health, but neither are we absolved from making critical discrimination between people's choices.

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