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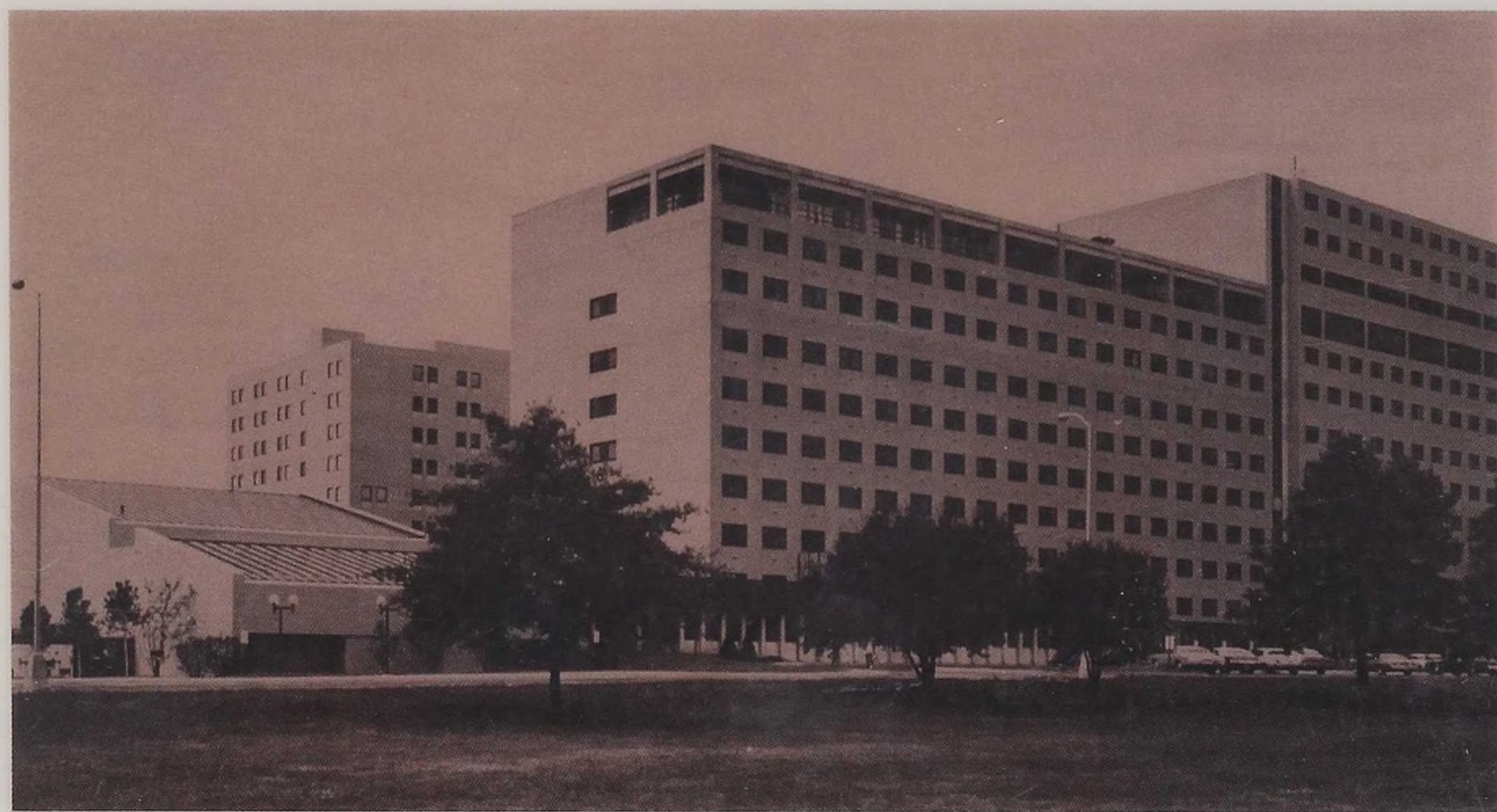
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Lutheran General Hospital: An Institution Intent On A Moral Purpose

Memory • Challenges • Prospects

Kenneth L. Vaux



Lutheran General
Hospital

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Human Values At Lutheran General Hospital

What do you see as major value questions at this hospital?

“The eighty-year-old, not the forty-year-old, patient was selected to leave ICU to make room for another. It’s the little things that say something about our values.”
a doctor

“This hospital sees people like Jesus did—as whole persons.”
a doctor

“The \$5,000.00 for my sister’s hospitalization. Thank God I’m on the Kaiser prepaid plan in California.”
a patient’s brother

“The smoking in the cafeteria.”
a woman

“The moral uniqueness of this hospital is the nursing service, not the doctors, not the chaplains, not ecology. We can’t let it go down the tube.”
a doctor

“It shows you what private enterprise can do!”
a doctor who trained at Lutheran General Hospital

This report is part of a consultative service provided by Dr. Vaux to the formative project at Lutheran General Hospital entitled "Human Values Forum." Dr. Vaux is Professor of Ethics in Medicine at the Abraham Lincoln School of Medicine, University of Illinois.

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Table of Contents

	Page
Introduction to the project: its inception, methodology, prevailing issues, anticipated results	v
I. Originating Values	
A. The history of Lutheran General Hospital	1
B. The religious foundations	3
1. Elements in the religious heritage	3
2. The deaconesses	4
3. The Hauge Reformation	4
4. Church and home	5
5. Church councils	5
6. Reflection	6
7. Analysis of Lutheran social ethics	8
a. Luther on medicine	10
b. Luther on death	11
c. Luther's last words	11
8. Characteristics of the Lutheran ethic	12
9. Implications of the religious foundations for LGH	13
C. An ecumenical concept: Human Ecology	15
1. The development of the concept	15
2. Suggestive paradigms for the Human Ecology concept: biology, sociology, theology	16
3. A view of persons in wholeness and sickness	21
4. The healing team	21
a. Pastoral care, social, psychological service	23
b. The medical service	25
c. The nursing service	27
5. Appraisal of the philosophy of Human Ecology	30
a. The concept: ecumenical or empty?	30
b. The science: specialized or impersonal?	31
c. The practice: everyone or no one	31
D. A man with a conviction	32
E. A man with a concept	34
F. The pioneers	36
II. Assessment of Current Problems	
A. Moral issues dealing with the life cycle	40
1. Issues at the start of life	40
a. Newborn Intensive Care Unit	41
b. Sterilization	42

Table of Contents

	Page
c. New modes of fertilization, embryo transfer, and gestation	43
d. Abortion	43
2. Mid-life issues—human research	44
3. Issues at the conclusion of life.....	46
B. Institutional commitments	47
1. Patient care vs. teaching/research.....	47
2. Business vs. benevolence	49
3. Responsibility vs. regulation	50
 III. Future Directions: Recommendations	
A. Clarifying concepts	52
B. Initiating a process of moral reflection	54
C. Inculcating values	54
D. Sustaining an atmosphere that builds morale.....	54
 Appendices	
A. Originating memo	57
B. 1971 statement of policy	58
C. 1972 policy	59
D. World Council of Churches (WCC) Consultation.....	60
E. Lutheran Institute of Human Ecology (LIHE) report to the American Lutheran Church (ALC) (1979)	63
F. Human genetics	64
G. Abortion.....	67
H. Codes of ethics.....	70
I. Norstad: “The University”	82

INTRODUCTION TO THE PROJECT:
its inception, methodology, prevailing issues,
anticipated results

May 16, 1979, in his first action as President of Lutheran General Hospital, George B. Caldwell called for the establishment of a Human Values Forum. This action, reflecting an earnestness of purpose that has always characterized this institution, brought to fruition two efforts already in progress. Earlier that year the Division of Pastoral Care had envisioned a program whereby awareness of ethical and human value issues might be heightened. To accomplish that end, a course in the theology and ethics of medicine had been taught at the hospital during the winter of 1979. In this same spirit, the leadership of Lutheran General Hospital, pondering the need of a forum in which human values are explored, had initiated preliminary conversations on this subject both within its body and within the larger hospital community. I was consulted concerning the inception of this effort, as Vice Presidents Leigh Rosenblum, M.D. and L. James Wylie, together with Pastor Lawrence E. Holst, directed the project. During the spring and summer of 1979 I was retained to do some groundwork for the Forum. The following report, end product of the initial phase of that consultation, will chart some possible directions for that Forum when it is convened.

In his authorizing memo, Mr. Caldwell proposed that the Human Values Forum “provide a structure for dealing with ethical and human value concerns which our people encounter in the course of their day-to-day activities.” The word “forum” was carefully selected to indicate that this would be an open, inclusive program embracing “any of our activities and all of our people.”

The forum’s activities will include the sponsorship of conferences, discussion groups and formal study papers to explore emerging ethical questions in our society. . . . It will be available as a resource to hospital management, medical staff, board of trustees, and to individuals (sic) (Caldwell memo, Appendix A).

Specifically, the Forum is to serve as a place to provoke and articulate continually the great moral questions facing those institutions which minister to persons in sickness and health.

In short, this project is but another expression of a uniquely self-conscious institution, a hospital which asks itself what it should be about. What is the guiding purpose of LGH? What present challenges call for response? What issues appear on the horizon? In addition to providing a searching mandate for this one project, the president identified again the unique “conceptual base” on which the entire institution rests. He probed the meaning and currency of a philosophy of human ecology. He sought to affirm and strengthen the viability of organic association with the American Lutheran Church. He inquired what unique bearing Christian ethical principles might have on the endeavors of this institution.

Aided by the president’s orienting counsel and guided by Holst, Rosenblum, and Wylie, I first probed the history of the hospital, then began to discern both its present activities and its future directions. Initially I interviewed dozens of hospital personnel, administrators, medical and nursing staff, patients, relatives, and students, seeking to define the way history, problems and prospects were being perceived by those who worked in the institution. These persons—patients, care providers, onlookers, sponsors—daily create value by what they believe and how they act.

As I began to reconstruct the hospital's early history, searching to understand that vision which had impelled its foundation, I first studied original documents, then fleshed out the originating vision with extensive interviews: Naurice (Doc) Nessel, Fredric (Fritz) Norstad, Holst, T.L. (Ted) Jacobsen, A.N. (Al) Ruggie—some of the founders. I next conducted a hospital-wide survey, asking what each person saw to be today's impending concerns. Documents and policies issued by the hospital further illuminated its current concerns and commitments.

As I sifted through and analyzed this data, formulating possible areas for study and action, I was taken back again and again to the work of H. Richard Niebuhr. This great theologian, steeped in the Germanic Reformed tradition and educated in nearby Elmhurst, Illinois, continually asked how a theological and moral vision could be translated into a secular manifestation. How does the work of Christ, pursued by His people in the culture, interpenetrate that order? Is this work undertaken in tension with and in opposition to society? Does it seek to witness to an alien, uncooperative environment, knowing its values and visions will never be perfectly realized? Alternatively, does the Christian community attempt to transform culture (the salt and leaven analogy); or ought it seek to conform culture to Christ's kingdom? LGH seemed to be an institution concerned in an intentional way with translating faith into culture. Quite in contrast to most other American mainline Protestant hospitals (which have long since abandoned anything except a nominal affiliation with a religious ideal or structure), LGH seemed to say: "This place will live by its values, or it will not exist at all!"

The brief history of LGH encompasses a commendable effort to sustain a religiously-rooted moral purpose. LGH is an organization with a magnificently obsessive conscience about its destiny. Working in a secular university hospital and a large public institution serving the indigent, I find this pervasive introspection awesome and instructive. I consider it a privilege to offer this summary and reflection as a prelude to an ongoing affiliation which can only be thrilling and edifying because of its intense moral quality.

As the conversations ensued a wide spectrum of issues surfaced. There were personal moral issues, those that focused on habits and behaviors: what might be called questions of etiquette. "Everything I like is either illegal, immoral, or fattening," reflected one cynic who operates within this tradition of morality. Smoking, drinking, lying, cheating, subsidizing, and all other breaches of piety-rooted moralism were seen as reprehensible. Within this perception, an eroding moral degeneration was felt when divorced nurses were seen sitting smoking in the cafeteria. It was a scandal to hear questionable language by doctors who probably didn't even go to church on Sunday. "What a shame that some employees covered the cross on their name plates," one person said. While one might be tempted to ridicule this moral orientation, it should be remembered that some of the most influential ethical theory of our day focuses on character (Hauerwas) and character development (Kohlberg). Personal moral habits form the bedrock of any moral culture. They are the foundation on which other dimensions can be built. However, a strictly personal understanding of ethics involves but one dimension of our life together.

Other commentators stressed the interpersonal moral dimension. How do employees treat each other? Does one find the "milk of human kindness" as nurses and doctors relate to patients? Is this a place where you like to work because of the friendly, affirming atmosphere? Or has growth and bureaucracy forced it to become a factory where you punch the clock, ritualize tasks in cold formality, and endure the day until the final

release to happiness in the clock punch at day's end? Moral language used to address this kind of issue includes "dehumanize," "personal," "someone listens," "they care about me," and so forth. The way persons treat others as persons, not things, not means to an end, forms a substantive essence of all morality. These issues are rightly stressed by many persons who are serious about LGH's ethical environment.

Another range of issues recognized by provider and recipient alike were concerns of cost, equitable care, access to services, and distributive justice. That issues such as cost containment, regulations, insurance, charity work, and the like, were seen as moral problems and not just manipulable economic factors, reflected the ethical maturity of the institution. One day, if the planner's projections are realized, LGH will be located at the core of the inner city within the Chicago megalopolis. If this indeed is the case, issues of social justice will become more and more paramount.

Many people interviewed perceived pressing ethical import from the range of issues now described under the rubric of "Biomedical Ethics" (see Vaux, Biomedical Ethics, Harper & Row, 1974). Those concerned with the moral roots of LGH that reach into the soil of Lutheranism and theological ethics; those who see moral reflection focusing on the great principles of life's dignity; and those who find significant moral transaction occurring in the medico-legal arena—all asked the Forum to consider the problems of medical ethics. The use of genetic knowledge and therapy; sterilization; fetal diagnosis and abortion; informed consent; organ replacement; investigative therapy; termination of treatment—all these issues unprecedented in our day are seen to be vitally significant.

As the process of analysis began, the wide scope and range of problems became apparent. When the Human Values Forum actually begins, it will need to guard against a scattershot approach, limiting itself instead to selected, manageable questions. This report deals with vital issues, set against a background of the values which informed the founders of LGH and culminating in guidelines for future directions when confronting these issues. It is the hope of advisory panel (Holst, Rosenblum, Wylie) and author that this study will provide both a framework of meaning and a panorama of possibilities within which the Forum might undertake its urgent and important task.

Kenneth L. Vaux
Riverside, Illinois
February 15, 1980

I. Originating Values

A. The History of Lutheran General Hospital

As with the American nation, Lutheran General was founded as much on an idea as a necessity. While it was true that a large community was developing in the northwest sector of Chicago, a community needing health services, it was not a demand for services that brought LGH into being: it was an idea, a vision, a religious impulse, a concept that bore an irresistible power and excitement—a calling, one might say.

Just as America in the eighteenth century was the creation of Scots-Irish and German immigrant culture fashioned on the foundations provided by the English and Dutch *Vorganger*, so in the nineteenth century middle America, particularly the Great Lakes and Central North West areas, became the soilbed for the planting of Scandinavian immigrant culture. On May 22, 1897, Lutheran Deaconess Hospital was created on the near Northside of Chicago by the coalesced concern of Norwegian deaconesses, pastors, doctors, and laymen as they witnessed the needs of their fellow countrymen. In 1917 Lutheran Deaconess Hospital became a formal part of the Norwegian Lutheran Church; a church convention elected the Board of Trustees. What do we know about these pioneers: their faith, their moral commitments, their hopes, as they created this institution?

I met one afternoon with the Deaconess Hospital sisters who live in the residence at Lutheran General Hospital. Sisters Esther, Hilda, Nellie, Anna, Mette, and Bertha reviewed the background of the deaconess movement. Originating in Germany in the 19th century, the diaconate quickly extended its witness to Scandinavia, the United States, and the new world. Responding to the acute needs of people who were victims of wars, infectious disease, immigrant poverty, and the like, the sisters traveled to the far corners of the world establishing clinics, hospices, and homes for the sick. Two impulses activated their work: first, the evangelical spirit, to witness to the truth of the Christian Gospel that there is salvation in life and death through Christ. Hospitals were founded to succor and save the soul, while God healed the body with the help of doctors and nurses. The hospital was a place where suffering people came face to face with the tenuousness of existence and the fear of death. This was a place where one asked about life's meaning and the rightful allegiance of one's soul. As the deaconesses prayed, counseled, and sang through the hospital corridors, they witnessed to their faith in the truth of God and held forth to the sick an invitation to faith.

A second motivation was the pastoral imperative to care for one's own religious and ethnic family. Norwegian and German immigrants had newly arrived in New York, Chicago, and other great cities. The new land was strange and their lot was tough. As these family members experienced childbirth, executed the passages of illness and recovery, and approached suffering and death, the deaconesses extended the shepherding concern of home and congregation.

Reasons noble and not so noble prompted the move to the suburbs. On the one hand Norwegian compatriots were now living further west; and the inner Northside was populated by Catholics, Italians, and blacks. The strong moral impulse to serve one's own people pulled commitment away from the inner city. On the other hand some were committed to stay and serve those new families, even though they looked different, spoke another language, and worshiped in ways that seemed either pagan or primitive. T. L. (Ted) Jacobsen, Executive Vice President, recorded the comment of a hospital consultant brought in during 1953:

There were considerable number of Scandanavians, particularly Norwegian Lutherans, in the Humboldt and West Town area as far back as the turn of the century. These areas arrived at maturity approximately fifty years ago and since that time there has been a steady exchange of population. The Germans and Scandanavians were moving further west and further north while taking their place have been the Poles, the Russian Jews, the Italians, and a small but consistent influx of colored

(T.L. Jacobsen, Symposium on Hospital Affairs,
University of Chicago, April 1970, p.28).

A sometimes bitter debate ensued, with opinion finally favoring the suburban relocation.

The moral equivocation of this transition from Deaconess to LGH makes it even more obvious how redeeming and indeed morally necessary the initial vision of LGH was. The presence of other motives to start anew, expediency and sectarian interest, to say nothing of religious prejudice and racism, meant the new departure had to be morally grounded. A transcending radiance had to light up this new move; indeed it did. On Christmas Eve, 1959, an estimated one million persons viewed the opening of the Park Ridge facility, the "Inn of Many Rooms." The Bethlehem theme of stars, songs, and silence was taken to another theological depth as a cross on the top of the building illuminated the Chicago horizon. This was fitting, since Luther reminded us that a cross was the meaning of Bethlehem. It also foretold the story of this hospital. It would be a place where joy and serenity would lie behind and beyond the pathos, the tragedy, the suffering that are found in any hostel for the sick and dying.

The inception of LGH is inextricably bound in the conviction and conception of Drs. Nessel and Norstad. In 1956, after serving five years on the Deaconess Board, Nessel became Board President. The American hospital enterprise had entered a period of dramatic growth and change. Federal programs such as Medicare and Hill Burton began not only to change the funding and founding customs of American hospitals, they also transformed the underlying values, regulations, and priorities from a *laissez-faire* entrepreneurial model to a more regulated one.

Doc Nessel and his colleagues on the Deaconess Board did some soundings and some dreaming. Dempster Street, they were told by demographers, would one day be the center of the Chicago megalopolis. O'Hare Airport was already a major crossway of international travel. Acreage, adequate and affordable, was available in the Park Ridge area. All forces and factors seemed ready, at least to the venturesome and imaginative Doc. His sense of timing and his business wisdom, but most of all the bedrock of his uncanny religious faith, shaped a pattern of conviction that was convincing to the others he enlisted in the cause. Perhaps the wisest intuition came in Doc's awareness that an idea man had to be found. Enter Fritz Norstad, stage right, a professor at Luther Seminary, St. Paul, Minnesota, pastor, philosopher—but most importantly for this moment, a man of rigorous and expansive conceptual power. Fritz, once convinced that it might be possible to conceive and build a church-related hospital (a possibility he initially doubted), fashioned in long hours of dialogue with Doc the philosophy of human ecology that would form the living ideology of LGH.

In the Spring of 1961 Doc, Fritz, and Larry Holst, the new colleague in pastoral training, and some LGH trustees, met with officials of the Lutheran Church in Rainbow

Springs, Wisconsin, to consolidate a new seriousness in the relationship with the church. At this meeting the point was made that profound moral issues such as abortion, sterilization, and death and dying were now facing health care institutions. These issues, it was argued, could best be addressed by a hospital that had a vital, organic association with the church. It was concluded at this meeting that the church alone could serve as adequate moral guide to a health care center in these challenging times. Reciprocally, what better way was there for the church to express its ministry of compassion and healing than through a hospital located in the midst of one of America's great cities? The covenant was established.

It was a community hospital; yet it was "in," not "of," the community. Community support was welcomed. Physicians and patients were enlisted from the neighborhood. But the hospital had a higher calling. It would express higher values: it would be theologically rooted and ecologically elaborated, guided by universal values shaped by administration and board, staff, and benefactors whose reason for being there was more than just nominal conventional Christianity or community spirit. It was *vocatio* in Luther's full meaning of that notion: a task undertaken under a vision, within a set of circumstances and resources called into being by God.

Recent history has articulated that founding vision and design. Several developments bearing on the moral issues must be mentioned. In the 1960's the hospital intensified its educational thrust, adding medical education and training in allied health professions to its existing nursing program. In 1972 an affiliation was made with the University of Illinois, making LGH a central part of the Metro Six, the network of teaching hospitals in the Chicago area where the university trains its physicians. Residencies in numerous fields expanded; and the hospital was well on the way to becoming one of the major medical teaching centers in the metropolis. This choice of direction produced some new strengths, some new challenges.

At this same time LGH also committed itself to dramatic expansion. It is now one of the largest and most complex hospitals in the Chicago region. Specialty services, high technology utilization, extensive use of computers, thousands of employees—all these new factors slowly fashioned LGH into a different kind of institution than it had been before. Some cried that the soul was gone, the communication impeded, the community impersonalized. Some said that new pharaohs were on the throne who "knew not Joseph." Personnel felt and expressed nostalgia and skepticism as well as excitement and optimism. It was a time in the hospital's history when the originating values needed to be remembered and reaffirmed, their relevance and implementation reassessed.

B. The Religious Foundations

In its essence that originating vision had sprung from a religious impulse. The roots of Deaconess, as we have mentioned, lay in the Norwegian Lutheran Church. For Nessel and Norstad, too, the primal value was theological and ethical, arising from their spiritual heritage. The renewed affiliation with the American Lutheran Church further intensified this spiritual dimension. Only in understanding those religious impulses which constituted LGH—brought it into being—can one undertake the tasks of reappraising and reaffirming its current corporate life and mission.

1. Elements of the Religious Heritage

Robert Morrison, former director of Biological Sciences at Cornell University, has noted that the religious ideal of John Wesley, which inspired people to pursue

cleanliness as next to godliness, did far more for public health in nineteenth century England than all the physicians did together. Similarly, as the Methodist tradition shaped the modern secular world, so also the power and the enigma of what has been called the "Lutheran Ethic" has informed LGH as it has emerged as an institution. That driving force is seldom articulated, seldom written down; but as with Wesley's revolution, the Lutheran substance and style forms the moral architecture around which the bricks, mortar, and programs of LGH are constructed.

2. The Deaconesses

As we isolate the various moral elements that have gone into the fashioning of this institution, we note once more the Norwegian Lutheran deaconesses. While it would be another major research task to reconstruct the moral commitments of the courageous sisters who expended their lives in service in this new land, it is possible to discern the roots of their piety and morality and gauge the efficacy of their moral witness. It can be unequivocally stated that without these roots there is very little chance that LGH would have begun with the moral seriousness that marked its inception and follows it to this day.

Lutheran theologians of the nineteenth century often spoke of a *Gesinnungsmoral* (moral disposition) that marked the religious piety of that era. This was particularly pronounced in Scandinavia and intensely embodied in the religious orders. This moral posture, focusing more on manner than on specific ideas, very likely formed the essence of the commitment that motivated the sisters who started Deaconess. There has always been a "worldly-wise" quality to this moral posture. As in the Lutheran social ethic, a great emphasis was placed on secular wisdom: customs, law, business acumen. It seems evident that finding a Doc Nasset to give fiscal and strategic direction to the old hospital was part of this wisdom. This "moral disposition" very likely fashioned an atmosphere that was both pious and strict, and joyous, kindly and well-managed. It showed deep respect for suffering people and accorded dignity to all persons who worked, visited, or were treated in that place. Yet the compassion and esteem were not effusive and evocative of feeling, but rather reserved, controlled, and formal. Just as Lutheran ethic chastened and honored the "natural moral law" and baptized Stoic and Aristotelian virtues such as fortitude and justice, so the moral habits and behavioral traits (love and trust, faith and hope) likely constituted the moral milieu.

This moral "style" formed the character of the hospital more than would any detailed casuistry of rules dealing with every particular situation. The deaconess ethic very likely affirmed the central themes of Lutheran faith concerning medicine, sexuality, and suffering. As the family was affirmed as the primal order given for the preservation of human life, strong emphasis would be placed on procreation. There were no misgivings about the size of population; no toleration for artificial restrictions to the process of bringing children into the world; and infinite respect for child life. An overriding faith in providence subsumed all events—illness, pain, suffering and death—into a pattern of meaning, making them bearable, indeed redemptive.

3. The Hauge Reformation

Fritz Norstad has said that, in order to understand the moral founding of LGH, we must know not only the Deaconess tradition but also Hauge Synod in the Norwegian Lutheran Church. His own roots and much of the moral heritage of other Norwegian-American Lutherans spring from the convictions of this reform movement. As with all protestantism on the continent, in the eighteenth and nineteenth centuries Norwegian State Lutheranism had become static, arid, and inculturated. Just as Kierkegaard had

to dissent radically in order to refresh theologically Danish Lutheranism, so also did Hans Nielsen Hauge seek to reform the Norwegian Church. Hauge, a farmer's son, had studied Luther as a youth and in 1796 received a call to become a lay preacher to "arouse" his sleeping countrymen. He preached in his own town and environs and then sailed along the coast and preached from town to town. Since itinerant preaching was forbidden by law, he was arrested ten times. The State church and local pastors were upset by this "enthusiast." When he helped poor people start businesses and factories, he became a threat to the privileged merchants. This Norwegian lay preacher left a deeper mark on Norwegian religious life than anyone since the Reformation. Particularly was his impact felt on those Norwegians who ventured to this new land.

As in the American colonies the tea tax drove the sorely-pressed colonists to rebel at last, similarly in Norway, a salt tax designed to make the rich richer and the poor poorer further alienated State and Church from the people each purported to serve. The pastors of the State church were forced to become enforcing agents of the government to insure citizen compliance. Not only did the church succumb to being an instrument of secular power, it did so on the side of oppression, not justice; the wealthy, not the poor.

The Hauge reformation was a puritan resistance to such a perversion of power. It combined an emphasis on moral purity with iconoclasm and anti-clericalism. Smoking, drinking, swearing, and dancing were forbidden. This moral puritanism was formed in opposition to both the formalized, ritualized immorality in high places and the crudity of common life (*Wusten Rotterei und Buberei*, wild disorder and knavery, Luther). The spirit of this movement, in its distrust of the imperialistic; its discomfort with the formal and officious; its stress on personal as opposed to public morality; and its deep sense of moral outrage at injustice and the willful infliction of suffering, undergirded the moral life of many who would in turn weave threads into the fabric of LGH.

4. Church and Home

In addition to the contributions of the deaconesses and the vestiges of Haugian reform, a major element constituting the moral climate at LGH was the simple religious devotion and moral example of the people who drew together to start the institution: Doc and Fritz, the doctors, the first nurses, Holst, Wylie and the first pastors, the trustees. Coming from various parts of the country, from homes where beliefs and values were inculcated, reared in a Lutheran parish church, educated at church-related schools—this body of commitment, thoroughly religious at its heart, shaped the moral character of LGH. Its influence cannot be dissected or even clearly delineated. But it remains the enduring moral substance of this institution.

5. Church Councils

A final element within the religious heritage of LGH has been the cutting edge of Lutheran theology as expressed through the denomination and the world councils of Lutheran Churches. We will later review a consultation of the American Lutheran Church on abortion and sterilization to illustrate this growing tradition. Some themes developed in world Lutheran conferences in the 1960's also added to the heritage that became LGH. The insights of these councils were mediated into the developing moral tradition of LGH through Holst and other pastors whose theological education was steeped in this era of reflection; through Jim Wylie and Fritz Norstad who directly participated in the consultations; and through numerous lay leaders, church officials, professionals, consultants, and others who in one way or another introduced ideas and values that became part of LGH.

The era of Lutheran General's birth and development has been called in church history "the era of ecumenical theology." The invigorated theological investigations of the European churches, together with the vital congregational life in the United States and Canada and the dynamism of Christian witness expressed in the new and developing world, came together in the 1960's to form a multifaceted jewel-like expression of Christian faith and life. The ecumenical movement, the World Council of Churches, the World Lutheran and World Reformed Associations, the new contacts of Roman Catholicism with Eastern Orthodoxy under Pope John XXIII, the entrance into the WCC of holiness and evangelical churches together constituted a lively ferment within which reflection as to the nature of Christian belief and action occurred.

In 1964, under the joint auspices of the World Council of Churches and the Lutheran World Federation, the German Institute for Medical Missions in Tübingen, West Germany, hosted the first significant consultation on the healing ministry of the church. In 1967 a second consultation, under the same auspices, examined the theme "Health and Salvation."

The Tübingen I Conference, "The Healing Church," lifted up the principle that all healing is of God, expressing the Lord's ongoing redemption in the world. The practice of medicine should therefore be related to a theological foundation.

Health is not solely a private concern of physical well-being or equilibrium. 'Health,' in the Christian understanding, must embrace the whole personality, and is realized in its fullness only when the individual is committed to sharing in the redemptive purposes of God in the community. Faith, social responsibility, and the creative experience of maturing are at the heart of health. If the Christian community is true to its calling it must promote health in the most comprehensive terms—individual, community, and at world level as an expression of its very nature. . . . Every Christian can and must contribute to the health of others (The Quest For Health, 1979. World Council of Churches).

At Tübingen II, however, the profound difficulty of further delineating that relationship became apparent. The first consultation (1964) discerned from the biblical tradition and the Church's historic witness an imperative to inform human health with religious insight. But moving in 1967 to a deeper analysis of the "biblical" understanding of health and the meaning of health proved difficult, indeed impossible. The appended document "The Missions and Service of the Church in Sickness and Health Care" was the only statement of consensus that the consultation was able to generate. This inability on the part of conference members to articulate problems or policies concerning the interaction between religion and health care prompts a concluding reflection.

6. Reflection

Clearly the inability to reflect on the biblical, theological understanding of health and disease and the contemporary meanings of health results from a period of religious malaise, combined with an ignorance of the developing currents of biomedical thought. The theological impasse (what one churchman has called our "theological amnesia") exhibits a painfully evident weakness of the church in our time. Surely we cannot appropriate theological wisdom to secular concerns if the theological ideas themselves are unclear and uncertain.

But one cannot force clarity. The modern world has demanded that the Christian witness come clean from its obfuscation of language, its assimilation into cultural thought and life forms, its moral reticence when confronted with grave social crisis. We are in a hermeneutical crisis, a crisis of interpretation. Biblical scholarship has impressed us more and more with the historicity and reliability of the Bible. As the civilizations of Sumer, Egypt, Phoenicia, the Dead Sea communities, and Macedonia have been unearthed, we have come to know the life situation of scriptural teaching. Within the last decade we have discovered the character of ancient Near Eastern covenants, Jewish didactic and apocalyptic, Gnosticism, and many other forms of belief and morality that clarify the meaning of our inherited understanding of God and moral response to the divine covenant.

Yet we cannot appropriate this insight to the problems that confront us. We are intimidated by agnostic secularism: that modern way of being, thinking, feeling and acting as if God did not exist. We are ashamed to own our faith and make moral claims because we wish to be modern, eclectic, syncretistic, and liberated; furthermore, we know the split in our spirit and conscience. In our desire to be ecumenical and responsible to the pluralistic qualities of our society, we slide into relativism. In other words, the theological malaise involves a genuine eclipse of ability to see, know, and do the truth. This failure of vision inevitably marks the passage of humanity into a new age. This combines today with our failure to think critically and live decisively out of an experience of disciplined commitment.

Secondly, the church has not sustained a dialogue between the faith and its ethic and the developing issues of biomedicine. Our churches have condoned, if not caused, the schizophrenia of perception whereby our lay persons can be distinguished biological scientists, physicians, psychologists or policy makers—all devout Christians—regular at worship, kind to their families and upright citizens, yet illiterate as faith relates to work. If accused of being a Christian, there would not be adequate evidence in their thought, speech and action on the job to convict them. Their two worlds never interpenetrate: knowledge of God is unrelated to knowledge of the cell. The call to heal and mediate divine miracles into life is disassociated from using respirators and insulin injections. One hears of Paul's healings and exorcisms at Ephesus (Acts 19:11) at worship on Sunday and on Monday of third party payments and treatment of pneumonia with Amenopheline and Penicillin. The two worlds never meet. In Sunday School we joyfully hear of Christ rescuing the perishing but curse the Vietnamese refugees who ask us to rescue their boats and resettle them in our neighborhoods. Because we are intellectual schizophrenics conducting our life within two realms, the "sacred" and the "profane," we abandon the worlds of biological knowledge, biomedical technique, and science policy to its own relentless, value-less, autonomy.

We need to find ways to stimulate active Christian reflection on the job, about the job. What does it mean to be a Christian nurse, a Lutheran pathologist, a Jewish psychiatrist, a Presbyterian geneticist? Perhaps we will wish to appropriate our theological and ethical prerogatives from the secular sphere. There is a strong tendency in this direction in Lutheran theology. We will examine this matter in a brief analysis of the Lutheran social ethic. If we do accept secularism as our world view, then, we need to recognize the variant philosophy we have adopted: its view of man, its epistemology, its value structure. We also need to know that at each point there is a divergent notion in the Christian philosophy we have disclaimed.

In addition to delineating our secular stance, we also need to convene the different belief groups, giving each the opportunity to reflect on its respective theology of health

and disease and on its medical ethics. Let us convene ten symposia over the next several years, calling together the best minds in the various religious groups to address these critical issues. From such an exchange a volume could be prepared to which adherents to those respective faiths could turn as they faced decisions in these realms.

Judaism
Roman Catholicism
Eastern Orthodoxy
Islam
Lutheranism
The Reformed Churches
Anglicanism/Methodism
Black, Hispanic and Native American folk religion and healing
Sectarian - and new evangelical faiths
Other religious groups: Christian Science, Mormons, Jehovah's
Witness, Seventh Day Adventist

When moral decisions are made in the homes, hospitals, communities, and public forums of this land, they are not made on the basis of deontological or teleological theory. As we face questions of meaning in birth and death, suffering and healing, we evaluate experience in a religious way, from the context of faith and ethics. The symposia would help us articulate an ethical response within the context of a newly-examined faith.

Four elements have helped constitute the religious heritage of LGH: the deaconess faith; the Hauge reformed spirit; the simple life commitment of Lutheran men and women; and the denominational and conciliar reflection of the church. Now we must analyze critically those aspects of Lutheran ethics which, while they contribute to the moral strength of LGH, also may limit seriously the range of the hospital's ministry. Analysis leads to insight and insight to action.

7. Analysis of Lutheran Social Ethics

What is the character of that "Lutheran ethic" which has so decisively moulded the moral life of this great urban hospital? In The Social Teaching of the Christian Churches, his great sociological study of the Reformed Churches, Ernest Troeltsch suggested that the Reformation created two types of religious organization: Church and Sect. The Lutheran Reformation, though primarily a church-type reformation, bore certain affinities with the sect type. In this sectarian pattern, according to Troeltsch, "grace means the calling and election which separates the Christian from the life of this present world, and insures the pure gospel ethic (subjective) with knowledge and power" (Harper Torchbook Ed. v.2, p. 462). In centering an entirely fresh restoration and renewal of primitive Christianity on grace, Luther and those who followed him have always vacillated as to whether they passively accepted the world as it was or set about to change it.

The Lutheran reform built upon the intellectual work of the late Middle Ages often associated with the name of William of Occam and characterized by the movements of nominalism and mysticism. In Occam, and later in Luther, the medieval Catholic identification of reason and revelation was being dismantled. In the Thomistic synthesis, the moral and spiritual will of God was identified with the ecclesiastical and political administration of thought and life that was the Roman Catholic Church. In the

nominalist and mystic reactions within medieval Catholicism, religious interest began to withdraw from secular and political concerns as the seeds of autonomous nation states began to grow.

In Roman Catholic thought, the natural law constituted the moral regulation of human existence. The natural law fused two codes. The first was the decalogue, with Old Testament amplifications of the Mosaic law. Here, as later in Luther and Calvin, the natural law expressed God's mandate to us concerning how we are to live since we have corrupted the primeval innocence and state of natural goodness. This biblical revelation, culminating in the law of Christ, formed the first constituent of natural law. The second source was human reason as expressed in the wisdom of the philosophers (particularly the moral philosophy of Aristotle and the Stoics) and extended through the moral exposition of Roman Canon Law. Together these two sources were fused into one codification and promulgated, taught, enforced, and held in perpetuity by the Roman Catholic Church.

Luther's revolution, which returned to Augustine and Paul, reasserted the biblical understanding of grace. Grace gave law a different meaning.

Grace is no longer a mystical miraculous substance, to be imparted through the sacraments, but a Divine temper of faith, conviction, spirit, knowledge, and trust which is to be appropriated. . . . Religion thus steps out of the material substantial sphere, which was merely accompanied by thought and feeling, and enters into the intellectual, psychological, spiritual sphere (Troeltsch, pp. 468, 469).

Within grace the moral life began to be reconceived: no longer did one act according to the clearly defined dictates of a substantive moral tradition which was evident to reason and sustained by dogma, catechetics, confession, and sacrament. Now the moral life became interior and spiritual: an act of faith, a direction of will, a disposition of life. This was the fundamental ethical shift implicit in the theology of Luther. When we search for a detailed list of guidelines for specific problems, such as a Lutheran position on abortion or test tube babies, we find nothing. This silence reflects Lutheran resistance to law and codification. The terrible tension arises because there is such intense conscience on these and other issues, yet there are no ready-made guidelines telling us what to do. The question is: Are we thus abandoned to antinomianism—complete loss of any norms? To this question we shall return.

Troeltsch went on to suggest that this univocal accent on grace in Lutheranism leads to the positing of a purely spiritual ethic. Since there can be no "ecclesiastical, authoritative, moral law," the only rule for conduct is the impulse of the individual conscience (p. 471). But this concentration does not call into critique the natural moral law; rather it accepts that rule of life which is stabilized in "the decalogue, the natural law." In Troeltsch's phrase, Luther assimilates the "intra-mundane" ethic into the Christian ethic, just as it has been assimilated in the "patristic and medieval ethic" (p. 471). The standards for moral activity are not therefore radical values that call secular standards into question. In its finest form a worldly ethic recognizes basic moral wisdom, those natural philosophical and Hebraic qualities that have always made up the essence of western morality. Unfortunately, there is often a passive acceptance of the standards and norms of a world gone wrong.

When Luther severed the ligature binding the religious and moral life to supernature as

mediated through the sacramental grace of the church, he freed it to a new worldliness. It is within the sphere of service to this world, Luther wrote, that the Christian is called to live responsibly. Our love is extended not up through the ascending substantive hierarchy, but out through the network of our worldly life. The stations (*Stand*) and callings (*Beruf*) of life bring order and control, saving it from chaos and disorder. Marriage, family, servants, lords, work, the state are all God-given structures to restrain sin and regulate life. In vocation one accepts the ravages as well as the joys of life in the world. The reality of God's glory is so overwhelming when compared to the sufferings of this world (a drop and spark compared to a mighty ocean and blaze of fire, Luther) that one finds in Luther almost a taunting, a teasing of the evil one. It is as if our safety in grace enables us to laugh at the devil. One senses here a passive resistance to pain and evil which may be both the glory and the tragedy of Lutheran theology.

The Lutheran way of thinking and acting "Christian" may not be as devoid of content, or as divorced from the secular realm, as one might think. In Luther's writing and elsewhere, there is a substantive teaching that can be used in all modalities of moral edification, inspiration, and guidance. Luther reflected, for instance, on health, medicine, suffering, and death. Later we will examine a spectrum of medical moral issues that might be addressed by the Lutheran ethic.

a. Luther on Medicine

The physicians in sickness consider only of what natural causes the malady proceeds, and this they cure, or not, with their physic. But they see not that often the devil casts a sickness upon one without any natural causes. A higher physic must be required to resist the devil's disease; namely, faith and prayer, which physic may be fetched out of God's Word. The 31st Psalm is good thereunto, where David says: 'Into thine hand I commit my spirit.' This passage I learned, in my sickness, to correct; in the first translation, I applied it only to the hour of death; but it should be said: My health, my happiness, my life, misfortune, sickness, death, & c. .stand all in thy hands. Experience testifies this; for when we think, now we will be joyful and merry, easy and healthy, God soon sends what makes us quite the contrary.

When I was ill at Schmalcalden, the physicians made me take as much medicine as though I had been a great bull. . . .I do not deny that medicine is a gift of God, or do I refuse to acknowledge science in the skill of many physicians; but, take the best of them, how far are they from perfection? A sound regimen produces excellent effects. When I feel indisposed, by observing a strict diet and going to bed early, I generally manage to get round again, that is, if I can keep my mind tolerably at rest. I have no objection to the doctors acting upon certain theories, but, at the same time, they must not expect us to be the slaves of their fancies. We find Avicenna and Galen, living in other times and in other countries, prescribing wholly different remedies for the same disorders. I won't pin my faith to any of them, ancient or modern. On the other hand, nothing can well be more deplorable than the proceeding of those fellows, ignorant as they are complaisant, who let their patients follow exactly their own fancies; 'tis these wretches

who more especially people the graveyards. Able, cautious, and experienced physicians, are gifts of God. They are the ministers of nature, to whom human life is confided: but a moment's negligence may ruin everything. No physician should take a single step, but in humility and the fear of God; they who are without the fear of God are mere homicides. I expect that exercise and change of air do more good than all their purgings and bleedings, but when we do employ medical remedies, we should be careful to do so under the advice of a judicious physician. See what happened to Peter Lupinus, who died from taking internally a mixture designed for external application. I remember hearing of a great law-suit arising out of a dose of opium being given instead of a dose of opium

(Luther, Table Talk, Thomas Kepler, ed.
[New York: World, 1952],
pp. 318, 319).

b. Luther On Death

One's 38th year is an evil and dangerous year, bringing many heavy and great sicknesses. Naturally, by reason, perhaps, of the comets and conjunctions of Saturn and Mars but spiritually, by reasons of the innumerable sins of the people.

It were a light and easy matter for a Christian to overcome death, if he knew it was not God's wrath; that quality makes death bitter to us. But a heathen dies securely; he neither sees nor feels that it is God's wrath, but thinks it is merely the end of nature. The Epicurean says: Tis but to endure an evil hour.

We read St. Vincent, that, about to die, and seeing death at his feet, he said: Death! what wilt thou thinkest thou to gain anything of a Christian? Knowest thou not that I am a Christian?

So many members as we have, so many deaths have we. Death peeps out at every limb. The devil, a causer and Lord of Death, is our adversary, and hunts after our life; he has sworn our death, as we have deserved it; but the devil will not gain much by strangling the godly; He will crack a hollow nut. Let us die, that so the devil may be at rest. I have deserved death twofold, first, in that I have sinned against God, for which I am heartily sorry; secondly, I have deserved death at the devil's hands whose kingdom a lying and murdering through God's assistance, grace and mercy I have destroyed; therefore he justly wishes my death. The school of faith is said to go about with death. Death is swallowed up in victory. If death, then sin. If death, then all diseases. If death, then all misery. If death, then all the power of the devil. If death, then all the fury of the world (Luther, Table Talk, p. 320).

c. Luther's Last Words

One of the most moving passages in the Luther literature is the diary prepared by those

followers who accompanied him on his last journey to Eisleben. When congestive heart failure finally took his life, he whispered:

Ich bitte dich, mein Herr Jesus Christe, lass dir mein seelichen bevolen sein. O Himmlicher Vater, ob ich schon diesen Leib lassen und aus diesem Leben hinweg gewissen werden muss. So weiss ich doch gewis das ich bin dir ewig bleiben und aus deinem Handen mich niemand's reißen kann.

(Justus Jonas, Michael Coelius, et al., The Last Days of Luther, Doubleday, 1970, pp. 72-3).
pp. 72-3).

(I pray thee, Lord Jesus Christ, call up my little soul. O heavenly father, now that I must depart this flesh and leave this life behind, I know well that I remain yours forever and nothing can tear me out of your hands.) (Vaux trans.)

8. Characteristics of the Lutheran Ethic

As we return to our analysis of the social ethic of Luther, we note that it is an existential and not an evolutionary ethic. In our decisions, Luther wrote, everything is complete in a moment. The act bears its own moral integrity. There is no moral development lifting one from immorality to goodness; and certainly there is no gradual moral improvement of the race. The emphasis is on freedom, spontaneity, and conscience, not guidance, training, and regulation.

The Gospel message of Jesus is sanctification of the self for the love of God, and love of the brethren for His sake. As law, the moral law disappears entirely, and he again exalts the free purposive character of ethics, which knows only an absolute aim, that of self-surrender to God in faith. Luther then claims that out of this supreme end (which alone is valid) the whole Christian Ethos with a great variety of motive will evolve quite naturally (Troeltsch, p. 494).

This emphasis on freedom leads as expected to a variety of equally tenable moral positions on a given issue.

Luther frequently described the ethic of love, anchored in the Sermon on the Mount, as characterized by gentleness, non-resistance and peace. This ethic opposes the ethic of struggle, with its concern for power, influence, prestige and retribution. Here we see the passive character of the ethic taken to its extreme. As with Jesus on the cross, one submits to the malice of others rather than resisting, as one indeed could. This point becomes one of the very controversial aspects of this system. Do Christians resist Caesar? Do Lutherans oppose Hitler? One of the moving parts of my own education in a Lutheran University faculty in Germany was the recounting of the decision by Lutheran pastors, Helmut Thielicke, my *Doctorvater*, among them, to assassinate Hitler in the July 20th movement. As Bonhoeffer, Dobhyani, Niemoller and others pointed out, this decision forced them to come to grips with the core “non-resistance to evil” element in the Lutheran ethic. “Resist not evil—love your enemies,” counseled the Sermon on the Mount.

Non-resistance can quickly deteriorate into a complicity with evil. First one says, "I cannot resist evil," then, "There is nothing I can do to rectify evil," then, "It must be all right." The transition is subtle but profound in its moral significance. The overriding weakness of the Lutheran ethic lies in its compliant acceptance of the secular institutions: reason, law, might, compulsion, property, regulation. It remained the task of the more socially transformative ethic of Calvinism to gain cultural and political efficacy for the Reformation in Europe. In America the Lutheran and Calvinist spirits have blended to form a unique new faith and ethic, a total energy and sense of life that Troeltsch calls "Americanism."

In summary, the purely Lutheran ethic is dualistic. That is at once its genius and its besetting weakness. It emphasizes the will and spirit; it acknowledges that ethics are rooted in a person's relation to the eternal God. It is an ethic of the inner life and the life beyond death. It does not take this world, this time, with ultimate seriousness. It distrusts the intentions of man, even the benevolent intentions; it doubts the possibility of utopia, perhaps even of making this world a better place. It is a dualism often tinged with apocalyptic. There are two realities: this world, matter, sin, death, a transient realm ultimately doomed to some "vast extinction" (Bertrand Russell); then there is a realm of truth, God, spirit—an eternal realm. Here we need to place our heart, our treasure. In this system there is a religious consecration of natural conditions, natural duties (p. 506).

The Lutheran religious ethic is idealistic and conscientious, celebrating the secular, and inclined towards dualism. The love ethic of the Sermon on the Mount anchors an intense, spiritual standard. It is a view of life's meaning activated by a grace which denies in man any competence to goodness, his only rightness and justification found in the crucified and risen Christ. As one finds forgiveness in Him, one also locates conscience in that relationship of grace and sanctification; the less rigorous standards of common sense, utility, expediency are replaced by a psychologically vibrant sense of "ought." The world's order and arrangements are celebrated, that the common tasks of life may be dignified. In a Lutheran hospital one can speak of the ministry of floor sweeping and window cleaning.

Finally, there is a tendency towards resignation and passivity as injustice, malevolence, or bureaucratic dehumanization set in. The relevance of these observations will be noted later. Troeltsch summarizes:

From the political and social point of view the significance of Lutheranism for the modern history of civilization lies in its connection with the reactionary parties; from the religious and scientific standpoint its significance lies in the development of philosophical theology, which is blended with a religious mysticism and "inward" spirituality, but which, from the ethical point of view, is quite remote from the problems of modern political and social life (p. 577).

Recognizing the sheer transcendence of things spiritual and the ubiquity of evil, there is a temptation to "put up with it," even chasten it.

9. Implications of the Religious Foundations For LGH

What does it mean to be a Lutheran hospital? Fritz Norstad said "no" to Doc Nessel's

initial overture because he doubted there could be such a thing as a church-related hospital. This refusal and subsequent willingness clearly show that Norstad is either a corrupted or a reconstructed Lutheran. He came to believe that the idea was worth trying.

One can look at the nominal expressions of a church relation. A certain number of trustees must be Lutheran. Employees are given name tags with the cross (which might be taped off by objectors); prayers are uttered at meetings and convocations; a cross is planted on the top of the building.

At another level a judgment has been made that the religious identity not be expressed by proselytizing. An ecumenical pastoral care department may extend ministries in the custom of the particular religious communions, but the pluralism of constituency (staff and patients) and the church/state separation clause accompanying federal and state funding precludes this. How then is the religious commitment expressed? The answer is an ingenious and powerful philosophy called Human Ecology. We will examine this in meaning and implementation in the next section.

Several motifs emerge from the religious tradition that serve to guide its activity. Initially, and most importantly, is the motivation to be a caring person in whatever way one serves. A large complex institution tends toward the rote, mechanical, efficient, and impersonal. Only a sense of personal care inspired by a religious faith can overwhelm this and make this hospital a kind and fair place to be.

The servanthood notion is imbedded in the religious heritage. The technical, business, professionalized mentality that has pervaded the health care system in recent years has stressed qualities like rights, professional competence, wages, rules and regulations, forms and schedules, all of which blur the fundamental covenant of what must transpire in a caring institution, serving in the presence of pain and suffering. The professions have their roots in a religious vocation. They are callings to the side of one's fellows bearing a particular gift, a service. When the hospital is seen as an arena where one does his research, or practices one's skills, or puts in hours to earn a living, this primal purpose is obscured. The time may have come when we need to authorize new callings into the ministry of the church, those callings extended to men and women who will serve as nurses, physicians, counsellors, and other healers that will minister in our hospitals.

Finally, there may be a unique understanding of suffering, pain, illness, and death, conversely of birth, growth, maturation and health that can be articulated within the religious faith. The moment in the history of medicine in which we find ourselves seems uniquely open to such an expression. As we discover that health is related as much to belief, behavior, and life style as it is to germs, surgery, and technology, we may be ready to entertain some fresh notions of what constitutes health and what forces predispose and dispose persons toward health.

The reason churches found hospitals is to attend persons as their lives are drawn into the profound depth of suffering and dying. Here the understandings of life's meaning are addressed adequately only by religious faith. To accompany persons with compassion into these profound reaches of life, to attend their needs with sophisticated medical treatment, expert nursing care, and tender pastoral concern, is the primary task of an institution that would take its religious foundation seriously.

C. An Ecumenical Concept: Human Ecology

Before LGH was built, Fritz and Doc sat day by day in the Park Ridge office and pondered the Christian witness they sought to express in a new hospital. They were drawn to several central convictions. In the Synoptic Gospels they met Jesus's disciples doing good works: teaching, healing, and redeeming the common life of people. This simple pattern of service left its imprint. This idea was enriched by the notion in the Apostle Paul that the life of faith is fruitful, no longer marked by frantic works in search of justification, but with the fruit of the spirit (Galatians 5:18-22). Paul's correspondence to Colossae also captured their attention. The great hymn in the first chapter of the letter spoke of the whole creation in all of its magnificence as the manifestation of Christ into our world. He was the Person in whom all the wonders of creation cohered; in Him they held together (Colossians 1:16-19). This passage became a symbol, explicitly Christian, yet one that could gather together and undergird a range of values, a plurality of efforts, a spectrum of services and ministries that might constitute a sophisticated, ecumenical health care center. The concept grew slowly, but miraculously. It took shape, sharpened as the theological acuity of Fritz was refined by the practical wisdom of Doc.

1. Development of the Concept

In the years 1957-1961, as Lutheran General was being planned and built, those who had the unique privilege of fashioning a design had several questions to ask themselves. They pondered the forces that made for health or illness in our contemporary world. They asked what the church had at stake in the arena of health care and how a church relation could contribute to a unique kind of institution. It was a rare opportunity to start from scratch. There were no existing buildings, programs, or traditions that had to be reconstructed, altered, or struggled with.

During one of these brain-storming sessions Doc and Fritz were struck by a discussion of "ecological medicine" by environmental allergist Dr. Ted Randolph. Speaking from the point of view of allergic and hypersensitive reactions, Randolph pointed to the importance of interface between a pathogen (a disease-provoking agent), an environment, and a patient with variable resistance and responsivity. This analogy made sense to Doc and Fritz. Doc had been a biochemist and pharmacologist, serving in previous years with Baxter Laboratories. As a life scientist and an executive, Doc knew the principles of interactivity and interdependence that governed any living system. Fritz from his side found this notion resonant with what he was learning in social theory, biblical studies, and the new personalism in philosophy and psychology.

The leadership that was recruited was schooled in the concept. The trustees were introduced to it. Doc and Fritz continued to expound and elaborate the idea in conversations, talks to various groups, and study papers. As teaching programs developed and other hospital departments were formed, the concept of Human Ecology became a guiding light.

HUMAN ECOLOGY IS THE UNDERSTANDING AND TREATMENT OF THE HUMAN BEING AS A WHOLE PERSON IN LIGHT OF HIS RELATIONSHIP TO GOD, HIMSELF, HIS FAMILY AND THE SOCIETY IN WHICH HE LIVES.

2. Suggestive Paradigms For The Human Ecology Concept

Several understandings of ecology were drawn on in forming the concept. For decades biology has presented a model of how organisms function and interact that can be called ecological. Garret Hardin, the great California biologist, has used the phrase "Human Ecology" in speaking of man's interaction with the natural world which is his environment. Ever since Darwin dealt the final blow to Aristotelian biology, showing on his Beagle voyage that animals and plants developed in evolutionary patterns and existed in interdependent networks, the ecological assertions began to take hold. Aristotle and the medieval Christian thought bequeathed through his disciple Aquinas contended that creatures of the earth were created at the beginning in their present forms. They went into Noah's Ark two by two, static species that had forever been and would forever after be the same. While it is true that Hebrew creation theology and Hippocratic medicine were holistic and ecological systems long before the modern age, even though all they knew of the history and context of natural life was impermeable species existence, it remained for the modern biological revolution to remind us how inextricably we humans are related to all other creatures in the web of life.

Recent biology has driven even deeper, showing that we are not only interdependent beings linked with all nature and rooted to the dawn of life by our chemical structure and DNA tapes, but indeed are made up of several different forms of life.

A good case can be made for our non-existence as entities. We are not made up, as we had always supposed, of successively enriched packets of our own parts. We are shared, rented, occupied. At the interior of our cells, driving them, providing the oxidative energy that sends us out for the improvement of each shining day, are the mitochondria, and in a strict sense they are not ours. They turn out to be little separate creatures, the colonial posterity of migrant prokaryocytes, probably primitive bacteria that swam into ancestral precursors of our eukaryotic cells and stayed there (Lewis Thomas, Lives of a Cell: Notes of a Biology Watcher [Viking, 1974], p. 3).

We are interdependent and symbiotic creatures. As interdependent creatures, our survival hangs on the activities of chloroplasts in plants and plankton in the sea and on the spectrum of creatures from beef cattle who awkwardly supply our minimal need for animal protein to the microbes that constantly recycle life, concealing from us the pervasive death and decay that is nature's way. We abide in a precarious envelope of life. The sea around us, the food cycle, the ozone shield are part of that sustaining and protective membrane that makes life possible.

Ecology is a rich and multifaceted concept. It is derived from the Greek word *OIKOS*, which forms the root of three words, each of which partially connotes its meaning. Economy, ecumenism and ecology are different facets of the one jewel. The biological paradigm reminds us of the intricate web of life where man must relate to the rest of nature with care, with frugality, with reciprocity. If humankind comes on too fast or too many, it may disrupt the ecosphere and activate chaos and devastating feedback. To disrupt this balance is to invite disequilibrium and destruction. Thomas reminds us of this burden:

It is a despairing prospect. Here we are, practically speaking twenty-first century mankind, filled to exuberance with our new

understanding of kinship to all the family of life, and here we are, still nineteenth century man, walking boot-shod over the open face of nature, subjugating and civilizing it. And we cannot stop this controlling, unless we vanish under the hill ourselves (Thomas, Notes, p. 123).

Even the biological paradigm of what human ecology might mean drives toward the theological. In an ecological setting, what is appropriate subjugation? What is responsible dominion? We are driven to speak of our proper role on the earth as God's ambassadors, as gardeners, as handymen (Thomas). (See Vaux, Subduing The Cosmos, John Knox Press, 1970.)

To summarize the insight received from the biological understanding of ecology for LGH's philosophy of Human Ecology, we again draw on the wisdom of the New England Journal of Medicine's Biology Watcher, Lewis Thomas. He speaks often in Notes and The Medusa And The Snail (Viking, 1979) of the communication between creatures. "The life of this planet sings a majestic variety of songs from the rhythms of insects, the long, pulsing runs of the bird-song, the descants of whales, the modulated vibrations of a million locusts in migration, the tympani of gorilla breasts, termite heads, drumfish bladders to Beethoven's 14th Quartet. One grand canonical ensemble in music of this sphere" (Lives, p.28).

Not only in song and speech but in vibes, odors, pheromones, and all the subtleties of movement and feeling, we communicate with each other. The genius of Human Ecology is open, reciprocal communication. A nurse told me what Human Ecology at LGH meant to her. "It means being heard; there is someone here to listen!"

Norstad claims that he has drawn most of his concept of Human Ecology from social analysis formulated late in the nineteenth century and associated with the names of Max Weber, Toinnes, and the like. Seeing social groups as functioning ecosystems, Toinnes spoke of two styles of binding group cohesion. One kind of society was organized by the functions of production, efficiency, and mutual provision of goods and services. This kind of social configuration functioned best with anonymity and minimal disruption by either deviance or emotional distraction. Buber would call this the I-It dimension of the social fabric. Toinnes called it *Gessellschaft*.

Another quality of social life was *Gemeinschaft*. The "congregation" in old German is called the *Gemeinde*. In this community personalized, liberating, value-infused intercourse allows different human possibilities to surface and different needs and expectations to find expression. Social, political, and economic theory in the nineteenth century looked at the way the *OIKOS*, the house of our common life, could be ordered and organized. Those sciences helped us understand the way that social entities were brought into being; how they could be conceived with some purpose; how moral and exploitative forces came into conflict; how undergirding value eventually became unconsciously transmitted, even when the original sustaining impulses had waned. Within this mode of analysis, Max Weber spoke of the spirit of Protestant culture. Here religious ideals and ideas took secular form and gave shape to economic and political character.

The lasting contribution of this thought is that configurations of people can be brought into being by some value, but not without value conflict. Institutions can be ecologically derived, i.e., conceived in moral purpose and ordered by shared, communal concerns

and reciprocity; but the sustained vitality of such a group is contingent upon forces such as authority, homogeneity, coercion, compliance, and enduring commitment. Any institution like LGH, being at once private and public, religious and secular, personal and corporate, intimate and bureaucratic, accessible and expansive, will experience perpetual challenges to its identity, its character. The rich knowledge base we have received from social theory may be instructive to LGH as it seeks to sustain some elements of *Gemeinschaft* in the midst of *Gesellschaft*. Simply put: can ecological, value-infused qualities endure in an institution that becomes committed to big business?

Two great theologians, Joseph Sittler and Paul Tillich, have expressed what might be called a theological concept of human ecology. Sittler's ideas are found throughout his writing, particularly in his *Essays on Nature and Grace* (Fortress, 1972). Tillich's essay "The Meaning of Health" (*Perspectives In Biology and Medicine*, Autumn 1961) and David Belgum (ed., *Religion and Medicine*, Iowa State University Press, 1967), summarize this viewpoint. Theology has always been concerned to draw the big circle, to expand our picture of reality to its far reaches. Human beings cannot be understood exhaustively by noting their molecular-mechanistic characteristics. Even the social, cultural, and environmental contexts of life do not present an adequate framework. Persons are created by God; and therein they share certain qualities that transcend space and time, that are eternal.

Tillich claimed: "It is the destiny of the philosopher and the theologian. . .to envisage the whole of life." Surely the concept of ecology implies precisely such a comprehensive search. The quest for this depth is incumbent on any institution that seeks to respond to the dimension of Spirit. The unity of human life is expressed in six dimensions—physical, chemical, organismic, psychological, mental and historical—which functions in the vital tension of self-identity and self-alteration. Within this dialectic the self reaches out, adventures, and returns in a perpetual process of growth and consolidation.

In every creative process of life a destructive trend is implied; in every integrating process of life, a disintegrating trend. . . .These ambiguities of life produce the concrete causes of disease. . . .The ambiguities of encounter of being make destructive accidents unavoidable, be it bodily injuries or psychological traumata. The ambiguities of assimilation of elements of the surrounding world—in food, breathing, communication—make unavoidable the destructive intrusions of strange bodies as in bodily or mental infections; the ambiguities of growth, that is bodily growth or the development of one's spiritual potentialities, make unavoidable the appearance of imbalances (p. 5).

Disease, then, results inevitably from the tension between creation and destruction—life's universal ambiguity. "Life," Tillich continued, "must risk itself in order to win itself."

A multi-dimensional unity of life in persons makes necessary a multi-dimensional concept of health, disease, and healing. Using language both ancient and contemporary, there must be a holistic understanding of persons and a multiphasic and multifaceted therapeutics. LGH responded to this kind of underlying philosophy when it formulated its ecological concept of "the human person in sickness and health" and its health care team.

Tillich's elaboration of this concept is helpful as we flesh out what might be called a Lutheran theology of human ecology. Just as Helmut Tielicke's theological ethic of health care will later be cited as the finest expression of Lutheran thought on this theme, so also has Paul Tillich devoted profound attention to the notion of ecology. Some might object that Tillich does not express orthodox Lutheran theology. It is true that he had been shaped not only by the Reformed and Roman Catholic religious heritage, but also by the traditions of secular philosophy. But it is precisely the secular richness of this thought that makes it instructive for our considerations. He was fascinated with human life as it unfolded within secular culture and thus devoted much attention to art, literature, science and politics. His reflection in health, medicine, psychotherapy, and pastoral care were minor but rich motifs in his thought.

In discussing the physical dimension of life, Tillich accepted the demarcation made by Descartes between matter and mind which had provided at one level that man could be seen as a body machine. The human body, he saw, is a constellation of organs, each functioning in patterns discernable by mathematical models and replicable (theoretically, at least) by mechanical counterparts: the eye is a camera, the arm a lever, the heart a pump, the kidney a purification plant, the liver a factory, the brain a computer. The arts of surgery and transplantation, orthotics and prosthetics, electronic monitoring and use of mechanical devices all are born in the Cartesian principle, as are the new hybrid sciences of biomedicine such as cellular biophysics and molecular genetics. The day-to-day work in our great modern hospitals like LGH is, for the most part, medical manipulation, surgical intervention, and rehabilitative maneuvering. The physical being forms the crucial and necessary substratum for the higher reaches of existence to build upon. One of the great lessons of modern life has been seen in the spectrum of disease-inhibiting, mending, and function-restoring ministries of diagnostics, physical medicine and surgery.

The ministries of physical medicine are of divine origin and power. With spittle and mud Jesus touched the eyes of a blind man and he could see (Matthew 20:29). Healing and salvation in the Gospels were often described by the same words used to describe mending a tear in the fishing net. Fritz Norstad once described what he thought the liturgy (work offering) at LGH should be. He envisioned a procession through the hospital with colorful vestments and banners blessing with holy water and incense the divine instruments of each station: the hyperbaric chamber, the electronic microscopes, the SMA 6 machinery, the CAT scanner. Mechanical ministrations, the work of our hands, have always been established in our Maker.

Many of the processes of life are biochemical processes. Metabolism—the energetics of life—itself is a chemical process. Growth, development and much mental and physical response are mediated hormonally. There is a limited truth to Feuerbach's dictum: "*Man ist was er isst*" (One is what one eats). Nutrition plays a critical role in health maintenance and an increasingly important role in medical treatment. But it is the wide range of chemo-therapeutic agents that provide the powers of medicine in the chemical dimensions of life.

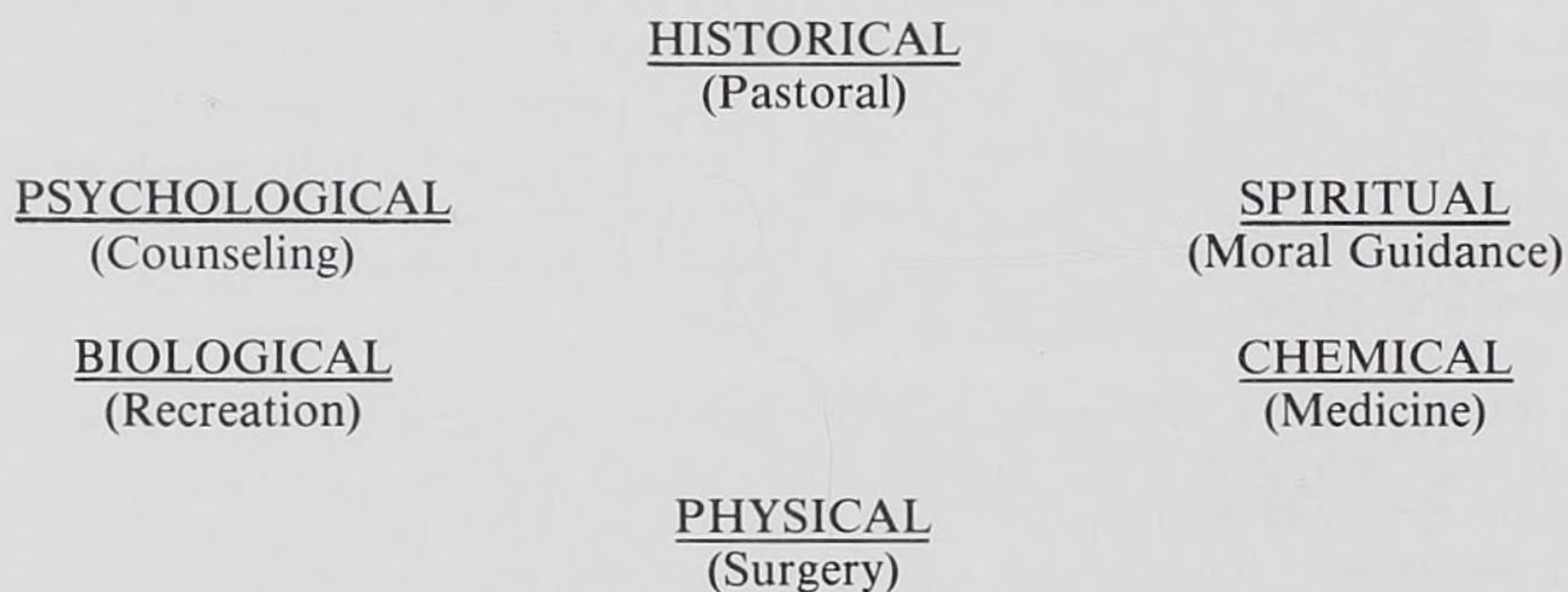
What drugs can do to relieve and heal, to distort and destroy is well-known. With the advent of DNA engineering, the promise and threat of chemical modification of life is awesome. When Gerard quipped: "Behind every twisted thought is a twisted molecule," he reminded us that the chemical dimension of life blends into the physical on the one boundary and into the psychological on the other. A most intriguing theme in modern medical literature is the study of how emotions interplay with

physiochemical processes. The chemical pathways of stress response have been known since the work of Cannon and Selye. Can we now speak of the chemistry of salutary emotions—hope, love, peace? Can we trace the chemical alterations induced by shame, fear, rage, guilt? (See Vaux, “Religion and Health,” Preventive Medicine [December 1976]; and Norman Cousins, “Anatomy of An Illness,” New England Journal of Medicine [December 23, 1976], p. 145.) It may be new knowledge of the biochemical dimension of life that will make ecological health care and multifaceted team ministry no longer a luxury but an imperative. It will no longer be seen a quackery or homeopathy but the normative medicine of our time. If so, the final transvaluation of Descartes’ polarization will have occurred. Matter will have yielded insight into spirit.

At this level we view the total organism in the environment. Much of our disease is organismic, with only symptoms being specific. Socio-biology has accented the familial and even populational traits that make us what we are. We are organisms tied to a great web of life, rooted in a distant ancestry, and open to amazing adaptive potential. It is within the biological dimension that Tillich introduces the notion of recreation as the revitalizing impulse which keeps life creative and rescues it from stagnation. This dimension approaches the essence of human ecology.

In the psychological, spiritual, and historical dimensions our existence is lifted to the transcending levels of awareness, conscience, and hope. The possibilities for disease and healing are intense at these levels. Tillich summarized: “In order to be healed the spirit must be grasped by something which transcends it which is not strange to it, but within which is the fulfillment of its potentialities” (p. 9). The theological approach to human ecology makes it evident that it is necessary to think about persons, particularly the sick, in a new way, and as a result of this enriched perspective, treat persons differently.

Tillich’s six dimensions of human life, each of which gives rise to a particular ministry of maintenance, repair, and restoration, may be paired as follows:



These healing ministries must always function in a holistic and not fragmented way. When a patient asks the surgeon, “Am I going to die?” it is a question requiring a deeper response than a description of the resected colon. When after a stroke a rehab patient tells the nurse, “It’s not worth working this leg any more,” she is invited to respond with more than descriptions of muscular atrophy. The way LGH has responded conceptually and procedurally in terms of the idea of Human Ecology and the process of a total health care will be discussed in a subsequent section.

We have taken note of analogous renditions of human ecololgy in the biological

sciences, in social theory, and in theology. All three have made their imprint in the unfolding concept and operation of LGH. We now turn our attention to three specific characteristics of the philosophy of Human Ecology as it is manifested at LGH.

3. View of Persons In Wholeness and Sickness

As one listens to the voices of LGH, reads founding documents, interviews its leaders, and talks to patients and care-givers, it becomes clear that an undergirding idea exists about who persons are and what disease and health mean. This is the first feature of what Human Ecology means at LGH. Since persons are unified psychosomatic beings expressing their life within dimensions described by Tillich, they find that the dialectics of existence, order and disorder, integrity and brokenness, creativity and stagnation, affect their total being. Mental anguish has physical effect. Physical trauma bears down on the spirit. Family pathology expresses itself in the bodies and minds of family members. In a moving essay written by LGH Trustee Norman O. Olson to his fellow trustees, this concept was noted:

We believe there is an essential unity about a healthy, happy man. He respects himself; he loves and has a sense of oneness with his fellowmen; he feels as one with God and is in tune with the rhythm of nature; he adopts one central philosophy of living for all his actions whether at home, at work, or at play. He is not three persons, body, mind and soul; he is all three of these in one integrated unit.

This philosophy views much illness as a disruption of this essential unity—as brokenness, reflecting man's personal fragmentation or his disassociation from others, from his family or from nature. It is within this basic belief that at Lutheran General we feel a major emphasis in healing must be in curing the brokenness and fragmentation of life. While the specialty of those serving the patient may cause them to concentrate on differing aspects of illness—the surgeon on the physical aspects; the psychiatrist on the emotional; the clergyman on the spiritual; and the social worker on social maladjustments—there is and should be an indivisibility to these disciplines. The know-how in all fields must blend and be brought to bear in the interests of individual persons ("Trustees: Stewards Of The Commitment and Guardians Of The Mission").

In a 1972 paper Norstad stated: "A new view of man has been emerging and we have contributed to it. The new view of man states that he is unified and healthy if whole—and that illness is brokenness." This view of personal life, fragmented and unified, broken and whole, is an ancient image found in primitive cultures. The Navajo Indian health rituals, for example, see disease as a force that breaks a person and fractures his solidarity with the community. In elaborate rituals of isolation and reintegration, this brokenness and restoration are expressed.

The imagery is also found in post-World War II existentialist philosophy and theology. Writers like Sartre and Camus and the theologians of crisis like Karl Barth and Eduard Thurneysen spoke of the conditions of existence under sin, disease, and death as alienated and broken and the renewal under grace bringing salvation, health, and reconciliation.

These expressive metaphors give rise to a very different therapeutic style than say the adjustment/maladjustment concept of human disease and well-being. The images of brokenness and restoration have been corroborated by recent medical studies. In studies that are now widely disseminated, Holmes and Rahe have shown the way that onset of illness follows life changes and crises. If one experiences enough disruption, both happy (marriage) and/or sad (death in the family), physico-mental strength, immunological surveillance, and disease resistance are compromised. Next to the constant variables of genetic inheritance, environmental pathogenicity, and the sheer unpredictability of accidents, this quality of vulnerability appears crucial in terms of how people stay well, get sick, or get better. The metaphor of brokenness and wholeness applies aptly here.

Another way to view the person in sickness and health ecologically would be to acknowledge that we are all broken and imperfect creatures. Some of those conditions of brokenness can be corrected by the efforts of medicine; others we must learn to endure. A caring health ministry based on human ecology might accent the fact that we must learn to live within the confinements and constraints of disease and debility. Our moral response might therefore consist in being with and caring for one another under these conditions of existence. As Cicero claimed: "We are all dying persons caring for the dying." In a searching statement Pastor Larry Holst reflected: "Human Ecology. . . is the attempt to listen to the quality and nature of people's responses to life." Both Christian theology and a philosophy of Human Ecology stress the limitation, boundaries, and built-in frailty of our existence. The manias for health, perfection, pain-free existence, and physical immortality are utopic ("no place") and dangerous.

One basic theological question surfaces here. Should a health care institution activated by a philosophy of Human Ecology be concerned with accepting and accommodating the human condition; or, as prevalent medical philosophy more often stresses, should our work seek to intervene and alter the human condition? The initial dimension of Human Ecology provides a notion about the meaning of health and disease and an idea of who persons are.

4. The Healing Team

A second dimension of the philosophy of human ecology is the practice of comprehensive health care by a healing team. Tillich developed a health model with six valences. The LGH model, formulated by Nessel and Norstad, has five sides.



To minister to these five dimensions the professions of medicine, nursing, social work, psychiatry and psychology, and pastoral care were enlisted.

The integrating strength of this ministry and the corresponding dangers of fragmentation were noted early by Norstad.

If we add (to a concern for the physical and spiritual in man) an active attention to his intellectual, social and emotional aspects we

may be simply adding to the confusion and contributing to his brokenness. The presence of various disciplines working together in cordiality and mutual respect. . . .The patient is in danger of feeling like a ping-pong ball played on a pentagonal table.

This danger has further intensified since Fritz made these observations in 1972. Today the specialization of the five health professions—medicine, nursing, psychiatry, social work and pastoral care—has led to a situation where autonomy of knowledge and technique in each field has further fragmented patient care. The doctor finds himself capable of only shallow theological-moral knowledge and thus feels inadequate to offer any soul-care. The pastor knows so little medicine that his ministrations often seem detached from the sick person. Likewise, other coprofessionals in health care have become so concerned about their own prerogatives—their “rights”—that they have lost sight of the total care of the patient.

Building on the Lutheran doctrine of the priesthood of all believers and the dignity of all work, the hospital articulated at its inception a view of health care delivery that included all the professions. In the 1972 document framed together by LGH and Deaconess it was stated: “Our purpose is. . .to serve each person in need, with maximum attainment of selflessness as a being of inestimable value to God in the full realization that all who serve in this house are instruments of his healing powers.” This doctrine, which expressed the potency of divine healing through the instrumentality of different healers, underlies the team concept.

The New York Times (Sunday, September 9, 1979) reported that a hospital in Winnipeg, Canada, has recently hired an Indian medicine man on the staff. Dr. Torrie, the medical director of the hospital stated: “Indian culture has a more holistic approach to health and spiritual problems than we would have. Traditional healers treat their patients as more of a whole person.” Mr. Counsellor, the medicine man, said: “I’m healing people with my powers with which I have been blessed by the Great Spirit.” Although Doc Nasset occasionally spoke favorably about faith healers and medicine men, the Lutheran tradition has contended that such powers are neither magical nor isolated in some few holy persons. All persons can facilitate the divine healing power. The health ministries—medicine and surgery, nursing and the other allied therapies, social work, psychology and psychiatry, pastoral care—all must strive to manifest healing power, enlisting both the knowledge of fellow health professionals and the natural healing impulses (*vis medicatrix naturae*) of the patient himself.

Let us look more closely at the various healing professions as they constitute the health team at LGH.

a. Pastoral Care, Social, Psychological Service

The religious ministry was present at LGH before the hospital existed. As we have noted, Fritz Norstad was a partner in the brainstorming and arm-twisting that brought the dream into reality. Fritz was also charged with developing a program in pastoral care. The roots were established. The ministry exercised at Deaconess clearly anticipated the modern hospital-based pastoral care movement. Some sisters were nurse-counselors; others were pastoral visitors. Their interactions with patients were identified as *sjolesorge* (soul care). They would enter the room of the sick, console and listen, read the scriptures and pray, drawing forth the spiritual resources of the patient.

In addition to the diaconal service of the sisters, a pastor was assigned to the hospital.

He conducted services, presented sacramental ministry, provided general pastoral oversight to both patients and staff. Several of the pastors who have given continuing leadership to the distinguished department at LGH were trained in this work at Deaconess: the transitional supervision team with Dr. Norstad, Larry Holst, Jim Wylie and Harold Nasheim were among these pastoral pioneers. Careful thought and conviction led the founders of LGH to locate a pastoral care team at the heart of the health care enterprise. In the trustees' minutes (1972) we find stated the rationale for locating the ministry in a pivotal position:

. . . [T]he term ecology implies the study and treatment of the whole man in relation to his total spiritual, emotional, physical, and intellectual needs and his relation to his family and socio-economic environment. Modern science and medicine have tended to take the human being apart in order to treat his various disorders separately, while the concept of man created in the image of God requires that he be treated as a whole. Being dedicated to this purpose LGH. . . utilizes the best scientific knowledge and technical skills in the practice of medicine, and adds to this the services of theology, psychiatry and social service. . . . As a first step in unfolding and implementing this theory of human care, the trustees have established a Division of Pastoral Care.

Within the concept of Human Ecology, then, disease was seen as a phenomenon rooted in and affecting one's total being. It related to family, to environment, to one's relationship with God. Norstad wrote: "The illness from which man must be healed is his brokenness, with its resultant agony, sickness and death. It flows from the Fall as a river of pain and suffering, pouring out its destruction and death upon all men. Into this chaos, God reaches His redemptive hand to save and heal" (The Healing Church, p. 2). Healing of body and mind must take place in an atmosphere where the need for divine, cosmic and interrelational reconciliation is recognized. It is this starting point, this presupposition about health, which provides the rationale for placing pastoral care at the strategic center of the health care process.

At LGH we find a mandate that the pastoral service be chaplain not only to patients but to the institution. In other words, the activities of worship, spiritual ministry, moral inquiry, theological and ethical education, and service are to be shared with staff as well as with patients and their families. The service is expected further to contribute to the moral tone of the institution. Ministry seeks to strengthen the relationship of persons with God and with one's fellowmen. Within this second imperative the pastoral service inevitably becomes involved in staff relations, employee interactions, and patient policies. In the same manner, it cannot fail to be committed to the virtues of honesty, kindness, fairness, and justice at all levels of life in the hospital. In A Statement of Philosophy: The Division of Pastoral Care one of the goals of the department reads: "To help one clarify. . . ethical values and commitments."

We find three ways that the Division of Pastoral Care is involved in the ongoing development of moral consciousness at LGH. There is first of all the notion that all persons in the hospital—patients, families, friends, staff—are potential pastors. Rooted in the Lutheran conviction of the priesthood of all believers, the ministry of caring is commended to all. Secondly, we find at LGH specific provision made for clarification of ethical values at the levels of patient and family decision, in the decisions of health care-givers, and in hospital policy. Finally, Pastoral Care is called on to

communicate that moral seriousness within the Institution in which all interactions and interventions are viewed not as mere techniques but as ethical acts. When the medical student does his first spinal tap to extract cerebrospinal fluid, when the nurse brings news to the expectant father, when the cashier receives payment for a bill, these are all actions fraught with moral significance. In addition to the pastoral service, basic human ministry is extended through the Pastoral Counseling Center, through the new section of Parish Relations, the Division of Social Service and the Section of Psychology.

As it becomes more evident that both illness and well-being involve the total fabric of one's life—family, community, environment, work—then it will be recognized that healing and prevention involve social service, mental health, indeed a new "life style in the world." LGH is reaching out beyond a limited, organismic approach through programs such as those in alcoholism and geriatrics; and as it does so, new knowledge concerning both the prevention and the treatment of the disease will be discovered.

The limits of this report do not allow extensive discussion of the divisions of social psychological, and psychiatric service as these play a crucial role in the unfolding moral design and ecological purpose of LGH. These ministries will become more prominent as the spectre of disease facing our society inevitably shifts towards the frontiers of behavior and the environmental, as Dr. Olga Jonassen, the great transplant physician, has suggested.

Before passing from the pastoral, social, and mental services, mention must be made of a contribution that rightfully should stand at the heart of this story of an institution and its values. In quiet and unassuming but awesomely significant ways, the Service League typifies the deepest values of LGH. The deep moral purpose of LGH or any house signalled by that sign of Christ's self-giving, a cross, must be pure-hearted, disinterested benevolence, with no expectation of reward. The Service League embodies that value. In this sense they are the conscience of the institution. They remind all of ancient precedents and transcending meanings that are almost lost in the modern contractual structure of health care. The legacy of the early Jewish refuges; the Christian hospices where no payment was expected; the thousand mission clinics like Schweitzer's Lambarene where sheer benevolence, not profit motive, gave shape to the ministry—the spirit of all these is sustained in the Service League.

b. The Medical Service

Physicians are principal actors in the creation of any hospital. The hospital is the house they staff. It is the system of information analysis, administrative accommodation, and ancillary service that provides context for their work. Some physicians from Deaconess Hospital were involved in the early developments at LGH. Other doctors residing in the Park Ridge area were instrumental in encouraging the project. Doctors create values and set tenor and tone for an institution. While their influence in creating the mood of a house is not nearly as pervasive as the nurses', they do influence the policies of governance and the procedures of treatment. It is their workshop. At its worst moments the hospital becomes the theatre where they play bit parts in the drama that illness brings to a person's life. It can be the shop where they sharpen their tools. At best it is an artist's studio and a curative temple. It is the place where images of beauty and wholeness are fashioned from color fragments on distorted canvases. It can be a place of healing where listening ears, salvific balm, and mediating touch restore pilgrims to some power to cope and live with whatever disability nature has given.

Paul Ramsey, in his Yale Lectures, The Patient as Person (New Haven: Yale University Press, 1974) noted that no profession in history has been so concerned as medicine to monitor ethically its activity. While this is true, recent research into the documents of medical ethics from Hammurabi down to the nineteenth century has shown that these oaths and codes are as much self-serving devices as they are patient-protecting devices. When the Hammurabic or Hippocratic physician is counseled to shun surgery, it is to protect the physician from malpractice proceedings as much as it is to protect the patient from injury. Just as any craft or guild protects its prerogatives and seeks to enhance its status, even the noble profession of medicine has constantly articulated etiquette rules whose main purpose has been in the words of one early AMA Code of Ethics, to “maintain the honor and prosperity” of the profession.

To trace the changing values of a hospital, it would also be helpful to see the way the doctors have changed during the history of medicine. The science on which their art is founded has undergone dramatic changes in the modern world. For millennia the physician could do scarcely anything except provide natural remedies and salutary authority by his presence while the patient cured himself. With the Renaissance, a new era began where one could separate the body-machine from the person and treat ailing parts. This led to the early modern notion of diseases and disease entities. One could speak of diseases as distinct from persons. “Come and see a classic case of tuberculosis,” said the senior physician to his entourage.

The germ theory of disease in the nineteenth century intensified this notion of objectivity in medicine. Diseases were caused by specific pathogens. One caught a cold; one was exposed to typhoid. Now diseases came to be seen as things that happened to persons: distinct entities that could be isolated, warded off through immunization, attacked with antibiotics, cut out with surgery, and the like. This way of thinking about disease has prevailed until only very recently, when the ancient wholistic, organismic, environmental notion has begun to reassert itself. But that prevalent nosology (conceptualization and classification of disease), when joined to the armamentarium of modern technological instruments, has fashioned a way of dealing with sick patients that is qualitatively different from traditional health care. Diagnosis is for the most part mathematical, biochemical, and radiologic. Physicians have to work hard to retain their traditional diagnostic powers: listening, palpating, observing. The primary therapeutic relation—doctor to patient—has been intervened by a thousand intermediaries, instruments, other professionals, policies, guidelines, economics, bureaucracy, and the like. The values of a qualitative relationship or covenant have been superseded by a quantitative contract. Both patient and physician suffer.

As an institution attempts to assess its values, numerous other factors relating to the medical service deserve careful analysis. The introduction of medical education and medical research brings new goals which sometimes collide with fundamental values. Economic considerations, insurance payments, employee unions, welfare payment mechanisms—all bring new ingredients to the moral process of a hospital.

Many of the central issues of medical ethics pertain to physicians. How does conscience inform clinical judgment? Does one order tests that have the possibility of injuring the patient? Does one honor a patient's autonomy by fully disclosing all of the risks attending a treatment regimen? How does one balance the paternalism necessary to trust and the affirmation of patients' autonomy necessary to freedom? Does a physician disclose with full candor diagnosis and prognosis? Does he tell the patient he has cancer? Does he indicate that one will likely live only 48 hours? The retreat of the modern medical

profession into private knowledge, intense guild protectiveness, and obsession with affluence are all responses to the profound trauma of our times. Doctors embody manias, obsessions and defenses that we all share in those eras Toynbee called "Times of Trouble." We are changing ourselves; a deep transformation of the human being is occurring in biological and socio-cultural evolution. We desperately need to ponder, assess, and reform our fundamental values in order to preserve those virtues that give life meaning. Only these enduring visions can adequately guide us into the challenging future that draws near.

The hospital will continue to look to the medical service for vision and leadership in inculcating the ecological philosophy. Success or failure will hinge on the ability of the medical staff to divorce itself from the prevalent avaricious milieu that characterizes American medicine; to dissociate itself from the fear-ridden defensiveness fostered by the malpractice environment; and above all, to give renewed vitality to the classic ethical impulses of a noble profession.

At the practical level we need to work on the day-to-day tactical problems that mitigate against an ecological approach. Pastor Larry Holst listed these challenges in a 1976 paper entitled "The Implementation of Human Ecology on Medical/Surgical Units":

- The lack of coordination (the doctor is torn between offering on the one hand occasional interventions with sick persons, a quick visit here, a test there, then leave the rest to the nurses, and on the other hand the more sustained guidance of the entire health team, patient included, towards a salutary program of therapy.)
- The lack of consistent ecology orientation and re-orientation. (How is the concept inculcated in the medical staff?)
- The pressure of time
- The lack of space
- The mobility of the private-practicing physician
- Tunnel vision (Specialization: "I need a consult on the liver in Room 123")
- The tension between the Physiological and Psychological
- The increased emphasis on medical education
- The malpractice crisis
- The integration of family and community resources in patient care

C. The Nursing Service

Just as the basic wisdom of life is expressed in its balance between adventuring and conserving, so the genius of health care provision is found in the historic joining of nurse and physician. When nursing is able to sustain its attitude of accepting, communicating, and caring and is able to ward off the temptations to technophilia (love of

skills), idolization of professionalism, and the "Big Nurse" syndrome, it is then able to provide the humanizing essence of health care.

The nurse at LGH attempts to bring the philosophy of Human Ecology to the bedside. One of the most noble statements deriving from the philosophy of Human Ecology is the "Statement of Philosophy" of the Division of Nursing at LGH (1976).

The Division of Nursing at Lutheran General Hospital shares the philosophy of Human Ecology: The understanding and treatment of the human being as a whole person in light of his relationship to God, himself, his family and the society in which he lives.

We believe the patient is the primary focus of all nursing actions and is entitled to individualized care. To this end, we believe in a concept of care in which the nurse, in collaboration with the patient, the family and allied health disciplines, formulates and implements a comprehensive plan. This plan is based on an assessment of immediate and projected physical, intellectual, spiritual, emotional, and social needs.

As advocates of the rights of patients, we acknowledge their right to participate as much as possible in decisions regarding nursing care. We accept the obligation to provide the patient with the necessary information and knowledge for such decision making. We recognize their need for safety, confidentiality, individuality, and dignity.

We believe our scope extends beyond the geographical boundaries of the hospital, and recognize our responsibility to participate in meeting the health and educational needs of the community we serve.

In a climate conducive to learning, individual growth, and self-fulfillment, we will endeavor to increase our knowledge to a level which will enable us to initiate, evaluate and accept changes in the delivery of nursing and health care. We accept the challenge to be creative, to monitor our own efforts, and to contribute to the growth of our profession.

The nurse, then, embodies ecological care. She is available around the clock. She provides the primary access of patient to the hospital and hospital to the patient. Because of her closeness to the family and her awareness of the gifts of other health professionals, she becomes an ideal instrument to draw supportive care to the needy patient. She is the team coordinator. As I have talked with nurses and watched them in action, I have felt that here are the persons who genuinely seek to translate values into the care of the patient.

The nurse, as with women called to vocation within the Roman Catholic Church, is in a peculiar position. She is given tasks she is not authorized to perform. She not only senses a calling for the primary care of people, but actually assumes this obligation in day-to-day activity. Formal recognition of this role, however, is withheld. Legally and contractually, the nurse is subordinate to the physician in the same way the female

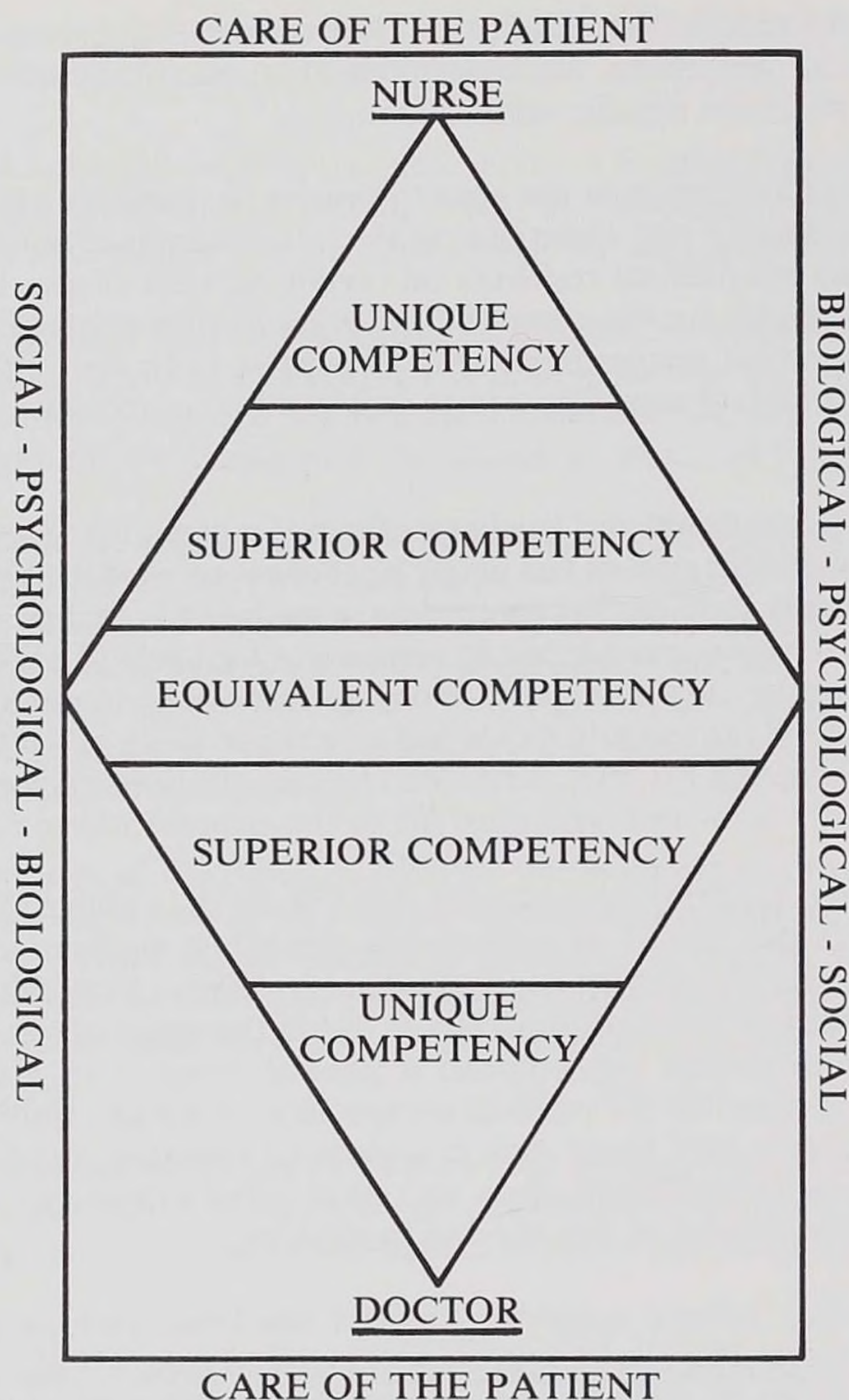
Religious is subordinate to the male priest. She may exercise the full-orbed ministry—administering the sacrament, teaching, preaching, pastoral care—yet in name and place within the structure remain subordinated.

The problem of subordination is not easy to resolve. A sensitive physician can handle the situation by affirming and undergirding the full competence and prerogative of the nurse. I have observed medical residents on certain services of our hospital who have such an enduring respect for the nurse and the other helping professionals that they are able to fashion a *modus operandi* wherein all express fully their gifts in the patient's service and there is no jealousy. There is no insubordination because, in reality, there is no subordination.

To remove those institutional and legal impediments which make this cooperative style nearly impossible remains one of the major challenges of modern health care. For example, a major moral problem in contemporary medicine is that of following medical orders. When the decision is made not to resuscitate a gravely ill patient, does the doctor write a DNR order into the chart? Does he informally communicate this to the nurse? What is done if (as recently happened on our service) a patient finds a DO NOT RESUSCITATE order on his own chart when he had not been partner to the decision? The nurse frequently is the one who must act in the vacuum where no guidelines exist.

There is an honored tradition which holds that the nurse is obliged to break an order that is wrong, as in the case of an erroneously-prescribed medication. Like the physicians, she is under the Nuremberg stipulation not to follow, at penalty of prosecution, an order that breaks the "laws of humanity." But in the midst of this moral and actual authority she has to remain subordinate, a passive receptor of directions from the physician. We must upgrade the medical competence of nurses, follow the example of the Nurse-Practitioner, and foster new processes of mutually responsible reciprocity within the health care team. Then again we can give full expression to the tenderness, power, and inherent dignity of the nursing profession.

A major contribution toward achieving this end has been made in a chapter by Dr. George Engle (General Hospital Psychiatry, [Elsevier Press, 1979]). In formulating a biopsychosocial model of therapy, he developed a diagram of physician and nurse mutuality in the service of patients. It is an axis chart that shows zones of peculiar competency:



Such a model deserves study and reflection as we work toward a goal of cooperation between doctor and nurse. The patient will be the beneficiary.

5. Appraisal of the Philosophy of Human Ecology

a. The Concept: Ecumenical or Empty?

The concept of Human Ecology commends itself to a modern, pluralistic, comprehensive health care center for several reasons. The first strength it possesses is its ecumenical quality. Even though LGH takes its *raison d'être* from Lutheran theology and ethics, it transforms that moral commitment into a philosophy that all can share. Christian, Jew, Muslim or secular humanist can affirm and contribute to this eclectic philosophy. It invites all who share a moral earnestness about medical care delivery to accept the commitments and offer their unique gifts toward its enrichment and implementation.

This strength can also become a weakness. Frequently during my interviews of personnel at LGH I asked the question: "What does 'Human Ecology' mean to you?" A wide spectrum of responses, some contrasting, some even contradictory, were forthcoming, e.g., "It is a place where the poor will receive compassionate care regardless of their

ability to pay.” Or, “The philosophy guards against the welfare malingering and protects the free enterprise system.” One person summed up the problem clearly, “Human Ecology can mean anything you want it to.” This strong philosophy cannot be allowed to deteriorate into a vapid “do your own thing” ideology or, worse yet, the theology of a former president: “It doesn’t matter what you believe as long as you believe something.” Therefore, continual effort will have to be made to bring substantive content and continual reform and refreshment to the concept.

b. The Science: Specialized or Impersonal?

A second line of appraisal uncovers another strength and potential weakness. The genius of modern medicine is its high degree of specialization, which has insured quality care and a significant offer of recovery for persons with problems that formerly could not be treated. Radiology, nuclear medicine and computerized tomography have held forth amazing new prospects of diagnosis. But the high specialization required to administer this instrumentation and the many and varied personnel needed to deliver and interpret the service have served also to fragment care and diffuse direct responsibility. The patient often is not sure who his primary caretaker is. One can never be sure that everyone knows what everyone else is doing.

In another common transaction of medical care, a specialist, perhaps a surgeon, is called in. His work is undertaken while one is under anesthesia. Now one is brought back under the care of the internist. Perhaps he knows the full details of the surgical intervention, the prognosis, the status of adjacent tissue, and so forth; perhaps he does not. He may have conservative dispositions and counsel against surgery. The surgeon may be inclined in the opposite direction and recommend surgery in one of those countless instances when it is not required. One of the amazing paradoxes of medical care is found when we have a diagnostic test or a surgical procedure. The test comes back negative. The lesion is benign. We breathe a sigh of relief, thank the doctor, and pay our three hundred dollars. Perhaps we should be angry, not elated, as we discover that the cost, the inconvenience, the injury of that test was unnecessary. Hyper-specialization is a gift, a great healing gift borne in ecological medicine’s commitment to quality care. It is also a two-edged sword, conveying as it does the dangers of distance, anonymity, and morbid and mortal mistakes.

Lest we be too quick to condemn, an article in the Chicago Tribune (October 9, 1979) pointed up the extreme moral vulnerability of health professionals. They are frequently “damned if they do and damned if they don’t.” In an excerpt from his book, How to Choose a Good Doctor, George LeMaitre lists the common errors doctors make: treating non-diseases (symptoms)/not treating disease, undertherapy/overtherapy, recommending surgery too early/recommending surgery too late. We ask doctors to preserve life, yet sue them for “wrongful life” (being born when, it is contended, you should not have been), or “wrongful prolongation of life” (not being allowed to die when, it is contended, you should die). As long as we persist in this pharisaic moralism we are heaping up impossible moral burdens that are “millstones.” We ourselves, even real gods, could not bear them.

c. The Practice: Everyone or No One

Doc Nasset had a sign in his office paraphrasing John 3:16: “God so loved the world that he didn’t send a committee!” This simple statement, rhetorically affirming the rugged individualist penchant of Americans, lifts up another critical issue of Human

Ecology. Since this concept is based on the multi-faceted nature of the healing arts, it would seem best implemented through a "team" approach. As through learning a foreign tongue a scholar distances himself from his native thought forms and thus humanizes himself, so also can a team of healers learn from each other, measuring powers and limitations. Rather than being merely a front to mask an actual *Fuhrerprinzip* of authority and subordination, the team concept is grounded in participation, mutual respect, engagement with the patient, fairness, and care. The teamwork within "Human Ecology" can insure competence by limiting pretensions and evoking powers.

If good teamwork can yield insight, its perversion can produce further ineptitude. No one is responsible, because everyone is. No one is willing to search out those profound depths of existence where all dimensions (body, mind, spirit, and culture) flow together. Each person retreats to that little corner one calls his own competency, that little fragment that one feels can be captured in a still photo or a frozen section and dealt with. Health and illness, suffering and healing, living and dying cannot be domesticated and managed in that way. The unruly, unfathomable, unpredictable mysteries of life should keep anyone who is a healer open to any event at anytime. Each nurse, doctor, respiratory therapist or pastor, cleaning lady or security man, president of the hospital or passing visitor needs to be ready to meet the terror, the pain, the wonder that is a person whose shell has been cracked. Here a healer has the privilege of being escorted by the suffering one into the Beneath and Beyond of life.

D. A Man With A Conviction

Doc is a man with a conscience—a deep and brooding conscience, one activated by a profound gratitude for life. He is possessed by an awe and sometimes terror-filled sense of responsibility, an uncanny intuition of action balancing risky leaps of faith and careful conservative management. One interpretation of history views political change as effected not by economic or social forces or great ideas, but by the influence of certain "world historical" individuals. Surely Doc has exerted this kind of force in the history of LGH. In quiet but conclusive moves and decisions, in vision and direction given the Board of Trustees, in selection of key leaders, Doc has given the institution the clear imprint of his values.

He was born and raised on an Iowa farm. While it would be inappropriate to speculate on formative forces in his childhood, we can assume that he was steeped in rural Lutheran values: hard work, honesty, discipline, and an abiding concern for and helping disposition toward those who suffered. Somewhere along the line he became a serious Christian. Some experience drew him from that position of nominal, conventional religion into a place where faith was the one pervasive all-embracing fact of life. Perhaps he is a "twice-born" soul; perhaps he was one of those rare souls for whom faith and moral sense came as naturally during development as breathing and moving. Whatever his story, as soon as you meet Doc it is evident that here is a man stricken by a conscientious obligation to give his life in service to human need.

He set out to do it well by preparing himself carefully. Educated in Iowa and St. Olaf College, he then proceeded to Wisconsin for the M.S. and Ph.D. Completing his studies in biochemistry, he worked in that compelling new field at Baxter Laboratories. All of the senses necessary to found and establish a new health institution were nurtured during these years of education and occupation: the managerial sense; the understanding of complex systems; a gentle suspicion of, tempered with sympathy for, physicians.

Service within the health care ministries of the Lutheran church gave Doc the chance to assess the strengths and limitations of such programs. In serving on the Board of the Lutheran Home Finding Society, he helped guide the efforts of this agency to serve the needs of unwed mothers and their children. Here the imperative for total health care was felt. The chronic apathy of staff and the demoralization of all helpers in the face of tragedy led Doc to see that health care givers had to sustain strengths in one another through team effort in order to be able to help others. In 1951 he joined the Board of Trustees of Lutheran Deaconess Hospital.

Doc sensed both the frailty and the promise of this inner-city hospital. In 1956, as Chairman of the Board, he may have anticipated that a good seed planted would bear fruit: that from the ashes of a troubled Deaconess, a new general hospital would rise. The plans unfolded; and in 1968 Doc became president of the Lutheran Institute of Human Ecology and in 1970 the first president of the hospital.

Among the many values that Nasset has implanted in the life of Lutheran General, three stand out. They are the notion of transcending purpose and accountability, the delicate blending of the values of excellence and efficiency, and the good sense to enlist Fritz Norstad to collaborate with him in formulating the Human Ecology design.

Lutheran General will always be an exhilarating and frightening place to be; for, unlike most hospitals, it has a transcending purpose that was proclaimed at its inception. There will always be an overriding constellation of values holding forth a vision of what the institution should be as over against what in actuality it is. There will always be distance between the "is" and the "ought." This tension will always create a restless and uneasy feeling as well as inspire vision. It is not that this hospital seeks to be special or has higher ideals than others; it has a charter that transcends human inventions. Like ancient Israel, Lutheran General might wish that it had a calling and destiny like everyone else, but it doesn't. It is founded in moral purpose. It is brought into being as a divine beacon and not purely a business venture. It is created as a mission instrument of the church. Every time penultimate values are lifted to prominence—economy, entrepreneurial practice of doctors or nurses, or prestige—these overriding values should call the lesser goals into question. In his prayer (composed on a scrap of brown paper in the kitchen), Doc wrote:

You have given us knowledge and wisdom and power over all things on earth. To each of us You have give special talents.

We who here use your gifts to serve those who give birth and are new born, those who are sick in mind, body and soul, we ask for strength to conduct ourselves as to be pleasing in Your sight and to walk with dignity among men.

If, as many predict, our health care system in America falls on very hard times, LGH, like all hospitals, will be cast back on its fundamental values. Some will fall back upon a triage policy selecting those with special illnesses or patients' ability to pay as the selective criteria. Others may restrict the array of services they offer. We can believe that Lutheran, because of the transcending moral references established by Doc Nasset, would respond differently.

A second value that will endure into Lutheran's future after Doc's retirement is the careful equipoise between excellence and efficiency. From the beginning it was clear

that LGH was to be a class institution. The best of facilities, the most sophisticated equipment, quality professionals, and dedicated trustees and lay volunteers were brought together to provide superb health care. This search for excellence, combined with a fiscal generosity, enabled the hospital to build a distinguished administration, a competent medical and nursing staff, and the largest and perhaps finest Division of Pastoral Care in the world. At the same time there has been an attempt to exert frugality and careful stewardship of every dollar entrusted to the hospital. The question for the hospital's future now becomes: is the approach of Human Ecology dependent upon institutional affluence? Is a 10 - 15% annual expansion of fees and total budget necessary to sustain the richness of service? Can simplicity and frugality contain cost but yet not restrict quality of service? The creative tension between excellence and efficiency that Doc nurtured in the hospital's administration will help LGH meet this challenge.

This observer attributes great wisdom to Doc as he identified gifted colleagues, especially Dr. Fritz Norstad. Nessel himself agreed: "You never do things by yourself. I've been fortunate to surround myself with effective leaders and workers who are helping the hospital realize its potential" (*Human Ecology*, Spring, 1979, p. 3). In recruiting competent and morally committed people both in the background of administration and front line of services, fortune smiled on Doc.

E. A Man With A Concept

Fritz Norstad was one of the pioneers of modern medical ethics. He came up from roots in pastoral ministry, seminary teaching, and Clinical Pastoral Education. Though gifted and distinguished in these competencies, there is something in this man that keeps breaking out into new and creative directions. He is a founder of the contemporary movement of medical ethics because he sought to bring the excitement of imaginative value concerns into the heart of the clinical enterprise. Not content merely to provide pastoral care to patients or to supervise pastors in training (although he exercised these important functions well), Fritz wanted to make a difference within the corridors of power of this great institution. He wanted to find lively conscience and humane sensibility in the labs, in policy decision-making, in medical science and training, in bill-collecting, in nurse education and clinical service—indeed at all levels of the hospital's life. He was able to invoke this not so much through his skill as an administrator or human relations facilitator (as indeed he could and did), but as a thinker, a philosopher. When Nessel, the pragmatist, was joined by Norstad, the philosopher, powerful electricity was generated.

Following education in Chicago and St. Olaf and Luther Seminary, St. Paul, Fritz became a pastor in Iowa, then a Navy Chaplain during WWII. Returning to civilian ministry, he directed the chaplaincy services of the Lutheran Welfare Society of Minnesota. In 1956 he became Professor of Practical Theology, Psychology, and Counseling at Luther Seminary. In 1959 he began what has become a 20-year involvement with LGH, first as consultant in planning the hospital and Pastoral Care Director, then as Vice President and Program Director of Lutheran Institute of Human Ecology. In recent years he has been a valued friend and advisor to the hospital.

When one has the difficult task of drawing some singular thread from the rich tapestry of Fritz's influence at LGH, he could lift up the theme of sanctification of the worldly. Fritz celebrated life in all of its secular manifestation. His enduring moral contribution at LGH has been the positing of profound value in every phase of the hospital's life and

his affirmation that each person is, in his or her right, an important moral agent. The nature and significance of this theme undergirds the entire healing enterprise to which we are all committed.

Of the Norstad *Werke* that are found in the hospital archives, one of the most fascinating is a biographical document entitled "The University," written before his retirement. (This document is presented in full as an appendix.) In 1932, as a 20 year-old university student in Chicago, Fritz decided to take a pause in his "university" training to see if there really were a universe, a coherent and wonderful realm which one could understand and embrace in some unified way. He particularly sought to take bearings on the world to discern its grandeur and intentionality, that he might assume a responsive and responsible posture within it.

He first took the microscope and studied, not only the amazing complexity, but also the awesome, inspiring symmetry and beauty. In studying spun urine slides with crossfield refraction or snowflakes, one studies micro art, handiwork of One who designs the cosmos and places perceiving and appreciating receptors in man.

After probing the microcosm, Fritz took a telescope and stack of books which might have included Koyre's From the Closed World to the Infinite Universe and took a glimpse of the macrocosm. This excursion as an astronaut filled him with the same awe, wonder and thankful moral response as did his intranaut adventure.

He then spent some weeks at Cook County Hospital witnessing birth and death. He analogously studied seeds and plants.

The second chapter set up another set of contrasts and had to do with beginning and ending. It had to do with human birth, springtime, germinating seeds and shoots pressing through the ground. It had to do with human death and falling leaves, decaying stumps, things returning to the ground from which they had come. The mode of the search was. . .to experience, to contemplate, to meditate, to be confronted. I spent more than a month at Cook County Hospital watching babies born and striving to pick up the weakening pulse of dying persons. At 9:30 I may have watched a baby come into this world and heard its first cry, and watch it take its first breath and at 10:30 called the nurse's attention to the fact that the old man with whom I was sitting was no longer breathing. The jarring contrast between life and death, between being born and dying, carried me far beyond those two extremes. The genes in the body being born could be traced to Adam, and faith in the concepts of immortality and eternity were wrapped up in the experience of the moment. Once again the bottom line was a sense of awe based not only in the facts of life and death but in the unitary nature of even these extremes and opposites. To live is to be dying and to die is to live (p. 5).

Next he visited the museums and attended the magnificent musical concerts of Chicago. The aesthetic experience of art and music and reading the Gospel of John was coupled with the field work of riding at night in vice-squad cars in crime-ridden sectors of the city. Through this experience Fritz sharpened the antinomies of the beauty and the sordid, of good and evil.

In this very remarkable exercise we find a person who is asking himself, "What is worthwhile?" This, of course, is the same question as "What can I worship?" or "What in this world shall I morally give myself to?" The words of Paul to a church at Philippi come into focus:

Whatever is true, whatever is honorable, whatever is just, whatever is pure, whatever is lovely, whatever is gracious, if there is any excellence, if there is anything worthy of praise, think about these things (Philippians 4:8).

This search of a young soul in Chicago for that which was of worth characterizes the career of Norstad. At Lutheran General he constantly witnessed to the inestimable value of each act. The opening of a door, the handing of a flower, the pathological analysis of a frozen tissue section, a CAT scan: all were gestures of worth. This experience generated in Fritz the notion that each person was a highly competent and responsible moral agent. The day-to-day life of the hospital was a panorama of activities and actions that were ethically significant. Each work, each gesture, each ministration, each decision, had the power to degrade or ennoble. Today, if you take the pulse of LGH, you find behind the unexplainable rhythms of kindness and consideration, behind the formal philosophy of Human Ecology, behind the impressive morale of the place, the heartbeat of this primal sense of worship. It is very much like the primitive religious sense of awe, wonder, and moral responsiveness that Rudolf Otto described in his study of the idea of the Holy: *Das Heilige*. The conceptual legacy of Dr. Fritz Norstad is indelibly imprinted on this place.

F. Other Pioneers

Several other persons who saw LGH come into being, some serving to this day, have silently woven their beliefs and values into the life of Lutheran General: Ken Lund in administration; Al Ruggie, Harold Shafter, and others in the medical field; Ilene Schloatman and Marilyn Tanner in the nursing department; Larry Holst, Harold Nasheim, and Jim Wylie in the pastoral care and church relations field. Space precludes mentioning all of the dedicated persons whose lives have deeply touched and given direction to the institution: persons in the Service League, Maintenance, Housekeeping, and Security departments. Those in the nerve centers of the hospital—switchboard, records, the labs—all have inextricably woven themselves into the moral fabric of Lutheran, making it what it is today.

The outside observer who searches out the value history of LGH cannot help but mark the footprints of one other person, Norman Olson, Trustee. Mr. Olson was an accountant and businessman and a tireless advocate and supporter of the hospital. He served as President of the Board during the critical years of development. His own life was chastened by lingering and painful disease. Through this and his churchmanship he became one of the authors of the doctrine of Human Ecology. An address to his fellow Trustees discloses to us his insight.

The church's guidance is also needed in wrestling with the baffling ethical questions that pervade health care from birth to death, including such crucial modern-day problems as those of abortion, "death with dignity" and transplants. The problems of ethics in health care are further escalated as medical know-how and technology search ever deeper into the mysteries of life's processes.

But the biggest search is the one in which the church is involved and where progress is probably agonizingly slow for the majority of us. And it is this search, the search for meaning in life, that will contribute in more than any other way to healing and to the maintenance of good health. For as a person finds meaning and purpose in his life, he acquires the essential unity of which I spoke earlier. The result is a deep desire and zest for life from which flow the energies for recovery from much illness and for the maintenance of good health. This is the church's domain and nowhere is the question of life's meaning asked more clearly and poignantly than in the hospital room, and in no place is there a greater opportunity to present satisfying answers.

In all of these matters I speak as neither physician nor theologian but strictly as a layman. Yet the experiences of life, including that of serious and distressing personal and family illness, convince me beyond all doubt that we have the right idea. Its implementation may be extraordinarily difficult at times and can never be perfect. But progress will be made toward the goal as the concept of Human Ecology becomes a pervasive attitude or state of mind in all our contacts and relationships with patients and their families and with one another.

This document discloses more than any other the strength of the moral purpose undergirding LGH.

We have dealt at some length with the originating values of Lutheran General Hospital. This analysis has been extensive because of the fact that only someone who knows who he is can know where he is going. The past cannot be idolized, especially since it is only 20 years old. We now move to assess current moral problems in the light of this tradition.

II. Assessment of Current Problems

The full spectrum of moral issues in modern medicine takes effect in the day-to-day life of Lutheran General. Issues relating to advanced clinical practice, caring for the disadvantaged, and informed consent to innovative treatment appear because of Lutheran's commitment to be both a sophisticated therapeutic center positioned at the heart of Chicago's megalopolis and a teaching hospital for a great medical university. The following two tables survey the moral issues reflected in the documents of LGH and the issues perceived by present employees.

TABLE I: MORAL ISSUES REFLECTED IN DOCUMENTS OF LGH*

Personal Moral Issues

- Chemical Abuse Among Employees (Jan. 1978)
- Alcohol Rehabilitation (1972)
- Employee Benefit Plans (1974)

Interprofessional/Professional Issues

- Racial Prejudice (1964)
- Conflict of Interest (1973)
- Discrimination Policy (May 1960, Apr. 1970)
- Employee Relations Policy (1975)

Social Action Issues

- Alcoholism Treatment Center (Nov. 1978)
- Aging (1978)
- Ambulatory Care Center (Dec. 1978)
- Bank: Investment Policies (1973)
- Notification of Rate Increase to Blue Cross 15% 1977, 20% 1978
- Clinica Christiana (Overseas Project)
- East Africa Mission Project
- Energy Conservation Policy (Oct. 1976)
- Cost Containment Policy (Apr. 1978)
- Joint Programs with Lutheran Welfare Services (Apr. 1978)

Community Issues

- Community Health Center
- Pastoral Counseling Center (1971)

General Bioethical Issues

- Abortion Policy (1974)
- Sterilization Policy (1976)
- Brain Injury Program (1971)
- Clinical Research Policy (1974)
- High Risk Nursery (1974)
- Institutional Review Board (Apr. 1978)
- Teaching Hospital Policy (1974)

Vision (Futuristic Issues)

- Dr. A. Ruggie - "Present and Future Concerns" (Apr. 1977)
- Dr. F. Norstad - "A Crisis in Opportunity" (1972)
- "The Healing Church" (1967)
- Goals for LGH (1966, 1971)

*The spectrum of issues is gleaned from the archives of LGH. These archives house Minutes of the Board, Policy Documents and various working papers. The hospital has confronted these issues and in most cases has formulated a response or policy statement. It is interesting that only rarely is the moral response explicitly based either on Lutheran Ethics or Human Ecology. Dates given are to hospital archives.

TABLE II: ISSUES PERCEIVED BY HOSPITAL PERSONNEL SURVEY CONDUCTED FALL, 1979

Patient Issues

- Parking
- Visiting hours*
- Caring for patient and family as whole persons**
- Human rights to determine treatment**
- Privacy*
- Counseling, especially bereavement*
- Cost of care**
- Prolongation of life**
- Patients as "numbers," "diseases," "cases," pathology focus**
- Ethnic sensitivity, i.e., increase Spanish-speaking staff
- Program on death and dying*
- More charity care**

Staff Issues

- Determination of time of death
- Do not resuscitate procedures, policies
- Value of High Risk Nursery to individual, family, society*
- Empathy for patient's values, culture, faith*
- Fragmented care
- Employee relations*
- Professional conduct, dress code, eating, smoking, alcohol use
- Malpractice crisis*
- Respirator decisions
- Understaffing

Institutional Issues

- Allocation of scarce resources, i.e., transportation, dialysis*
- Meeting the needs of staff
- Quality care and research*
- Commitment to expansion, building, order, regulations
- Managerial elite: top-heavy administration*

Community Issues

- The Aging Population
- VD, Drug Abuse, Abortion: preventive measures
- Assessment of community needs*

*occasionally mentioned

**frequently mentioned

A. Moral Issues Revolving Around The Life Cycle

1. Issues at the Start of Life

The range of issues gathered under the theme of perinatal or nativity ethics are found at LGH. Though rooted in a different theological tradition, LGH has struggled with the issues of sterilization, abortion, and care of defective newborns with the same anguish as has the Roman Catholic community. There are but a few of the poignant exemplary issues of a spectrum of present and future issues at the beginning of life.

Genetics

Genetic Counseling

Genetic screening policies, i.e., Tay-Sachs, sickle-cell

Eugenics: improving the genetic quality of future offspring

Euphenics: correcting deficiencies

Recombinant DNA

Birth Control and Abortion

Contraception - male and female - new modes: i.e., vaccination

Abortifacient measures

Sterilization

Forensic abortion (by reasons of rape, incest, danger to mother)
abortion under Roe V. Wade Supreme Court decision

Public funding of abortion

Fertilization and Gestation

Artificial insemination (husband donor) AIH

Artificial insemination (donor) AID

In vitro fertilization and embryo transfer IVF

Surrogate mothers

Cloning

Genetic Medicine

Amniocentesis and selective abortion

Fetal diagnosis (fetoscopy, sonar analysis, etc.)

inborn errors of metabolism

single gene disorders

sex-linked diseases

sexing (determining a male or female fetus)

chromosomal defects: Trisomy 21 (Down's Syndrome) XYY, etc.

neural tube effects: Spina Bifida, etc.

frontier areas: fetal markers for diabetes, cancer, heart disease,
sickle-cell disease, mental illness, etc.

Fetal research

Fetal monitoring

Newborn screening, i.e., PKU screening

Care of Newborns

Down's Syndrome - children with lethal anomalies, i.e., operable heart
or other organ problems

Hydrocephalus - shunt?

Care of defective newborns

Infant Medicine

- Informed consent
- Investigative treatments/Human experimentation
- Cancer chemotherapy in infants - refusing treatment
- Child battery and child abuse
- Sexual assignment and reassignment

The church affiliation and the philosophy of Human Ecology have assisted LGH in the examination of these issues. The church has issued a series of study papers and moral position statements on issues at the start of life. Like most denominations, the Lutherans have pondered the questions of abortion. They have grappled with the sometimes conflicting values of sanctity of life (in the fetus) and freedom of choice and conscience (in the mother).

In the field of genetics a task force on Ethical Issues in Human Medicine of the Office of Research and Analysis (ALC, Minneapolis) has raised crucial issues in that field. The document lifts up three themes in Lutheran theology as the architecture of the moral exhortation: 1. Dominion and Stewardship, “. . . [As] each human being is the sole trustee and proprietor of his or her own genetic resources typified by sperm and ova, he or she is then the steward of that genetic material and responsible to God and society for its use.” 2. Grace and Forgiveness, “Christian life still renounces the act of this sacrifice (abortion), laments the conditions leading to the act, and stands in need of the grace of God.” 3. Marriage and Family, “It remains to be proved that human worth, dignity or quality may be enhanced by any scheme of procreation at variance with God’s plan for a man and woman to make a commitment to each other in love . . .”

In the light of these overarching values the following practical issues are addressed: abortion on demand, sperm and ovum banks, surrogate gestation, genetic engineering, birth control, hedonistic sex practices, artificial insemination, fetal diagnosis, genetic counseling, eugenics (deterioration of the genetic pool). This document provides a good working paper to begin a careful analysis of the searching moral questions at the start of life. However, it falls short in two ways. It fails to come to grips with the real issues that occur in the clinics and hospitals. Then, it states very general principles but offers little in the form of concrete guidelines or policies. In the future, places like LGH will have to provide the setting for in-depth reflection on these issues. In a rich clinical environment like this hospital, the best minds of the church can come together with the leading scientists, clinicians, and pastors to formulate both guidelines for present actions and policies for future concerns.

Indeed, the hospital has already developed provisional policy on the problems of sterilization, abortion and Newborn Intensive Care. LGH has convened a consultation that has explored the shape of Christian counsel on abortion. All of these promulgations lack the thoroughness, the theological depth, and the relationship to a philosophical position that one might desire. They do, however, break the ground and initiate an inquiry that can and must go deeper.

a. Newborn Intensive Care Unit

Lutheran General was approved in 1974 as a regional perinatal center. This center will deal with issues of gestation, delivery, pregnancy, and the new-born child, as well as the high-risk mothers. It is anticipated that the range of moral quandries at the start of life

will be confronted. Do we perform routine fetal monitoring in at-risk pregnancies? Do we initiate Cesarean section deliveries and technical support in the face of risks present in the extra-uterine environment? What if the state drops the law requiring mandatory PKU screening for all newborns? It costs \$300,000 to discover one PKU infant (one in 15,000 are affected). Those female babies who had their diet corrected 20 years ago when they were found to have the disorder now give birth to children who are sometimes profoundly retarded at birth. Do we sterilize these identified newborns? Do we set in motion educative or counseling efforts to help parents select other modes of having a family?

Down's Syndrome is probably the most widely discussed concern when the topic of amniocentesis is raised. On the horizon appear other possibilities. It is now possible to discern whether a fetus is affected with sickle-cell disease. What are the moral responses appropriate to this new capacity? Some sicklers will be quite ill most of their lives with repeated sickling crises. Others may have only a few episodes and lead quite normal lives with relatively average life-expectancy. Should fetal screening be streamlined and mass-produced so all foeti at risk will be identified? Should public policy mandate such screening? This paradigm issue exhibits all of the features of most amniocentesis/abortion issues.

It has been said that the values of a society can be gauged by the concerns evidenced for future generations. The considerations we bring to the perinatal realm of life and the moral commitments we exhibit at this threshold may determine whether we shall survive as a people. If the Deuteronomic theologian is correct that God sustains or brings down nations, and if America is in some sense a messianic people, (as defined by their moral obedience to the covenants of life), then this moral failure might forfeit the destiny of our nation. Even if that biblical understanding of history is not true, our own moral commitments at the start and finish of life may determine whether or not we should survive or will leave anything of value to future generations.

Science is slowly but certainly acquiring the power of predicting the unborn child's future. When something "wrong" is discovered now, diagnosis is joined with abortion. What will be our ethical stance when we are able to foretell predispositions to cancer, heart disease, and other disorders both disabling and expensive? Will our crystal ball turn to curse us, as we are forced to choose whether to allow the birth of a child whom we know is doomed to suffer?

b. Sterilization

This issue, so perplexing for Roman Catholic institutions, now will plague LGH. A Lutheran hospital shares some of the Catholic convictions about the sanctity and inviolability of procreative powers. At the same time the hospital is committed to family life and responsible parenting. For years an unwritten policy has existed at most institutions which, like LGH, have some scruples about sterilization. If a 30 year-old mother has had six children or a 40 year-old mother has had four children, tubal ligation will be licit, perhaps desirable. The person must request the procedure in writing and be concurred in by gynecologists other than the woman's doctor and another counselor (chaplain or social worker). This stringent policy serves to underline the serious, irreversible nature of such a decision. It seeks at once to serve the value of human procreation and yet foster personal responsibility in control of conception.

c. New Modes of Fertilization, Embryo Transfer, and Gestation

With the birth of Louise Brown in Great Britain a new age has dawned in terms of our options for making babies. In vitro fertilization (IVF), conceiving a human organism outside of the woman's body by fertilizing ova in the laboratory, is now with us. It joins the procedures of the AIH and AID, artificial insemination with the husband's or donor's sperm. Do we impose moral guidelines on these procedures? The National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research has pondered this question at great length. The technique of IVF now has been authorized in this country; requests to fund projects are being considered by the National Institute of Health (NIH). There are at least two moral questions: should the procedure be done in the first place? (Is it morally licit to keep many embryos viable, then discard most of them?) Secondly, should there be some restriction on the persons to whom the procedure would be extended? Should it be limited to families? Do single parents or homosexual couples qualify?

d. Abortion

In March of 1976, the Board of Trustees formulated the following policy on abortion:

RESOLVED, that administration be instructed to establish a panel consisting of social workers, psychologists, psychiatrists and chaplains who will be available to persons seeking termination of pregnancy for the purpose of acquainting them with the possible emotional, social, legal and ecclesiastical complications or concerns. The members of this panel are to be selected by a committee consisting of the President of the Medical Staff, the Chairman of the Department of Obstetrics and Gynecology and one person designated by the Office of the President. These selections should be made from a roster of qualified personnel from the above indicated departments as provided by department heads.

BE IT FURTHER RESOLVED, that the attending physician shall refer each patient requesting termination of pregnancy at Lutheran General Hospital for consultation with at least one representative of the aforementioned resource panel and this referral be noted on the patient chart.

It is to be clearly understood that the panel members are resources to the patient and her doctor. Decisions will be left with the doctor and patient.

The moral problem of abortion seems to be infinitely complex. It is neither a simple nor a singular problem. There are at least four types of abortion; each may carry a different moral significance. Abortion because of rape, incest, or other form of injurious or violent conception is one problem. Abortion when the health of the mother or fetus is involved is a second kind of abortion. When fetal health is extended to cover the range of diagnosable anomalies *in utero* previously cited, this becomes a wide-ranging concern. The issue of aborting a fetus because it is male or female should be mentioned at this point. Thirdly, there is abortion for the sake of birth control or terminating an unwanted pregnancy. If one evaluates actions in terms of personal will and intention, there may be some moral distinction to be made even within this category. Finally,

there are the agonizing cases for the young and the poor. Do we provide public funds for abortions or do we, by implication, make this available only to those who can pay?

At this point it can be noted with pride that in 1974 the American Lutheran Church convened a consultation on abortion. This consultation formulated a policy statement which became a guiding document for the whole church (see Appendix). The counsel stops short of taking an absolute, unequivocal position on abortion. The normative principle of sanctity of life establishes a pro-life bias in the document. Other positive principles such as responsible parenthood and freedom of conscience are then proposed. These, along with the absence of specific biblical injunctions, allows (the report claims) a latitude of moral possibilities within the general pro-life position. Finally, the report counsels careful consideration of each abortion case. The decision to terminate a pregnancy is one of profound religious, moral, and emotional consequence. It should not be undertaken lightly or in isolation. Competent and concerned medical, psychological, and moral consultation should be available to all who ponder "this terrible choice."

Abortion stands today as one of the most agonizing personal, institutional and political questions of our time. The Roe V. Wade Supreme Court decision has not resolved the ambivalent national conscience. The failure of public agencies to match the legal judgment with funding mechanisms reflects the lack of resolution and consensus. LGH is in an ideal position to pioneer some creative work on this issue. What programs in the community would diminish the need for abortions? Do we continue to accelerate the incidence of abortions at 12-15% per year? Will abortion come to be seen as the major modality of birth control in our society? Moral progress on the issue will require imaginative scientific, religious, and policy work. LGH can help do it!

How might Lutheran ethics or the ethics of human ecology speak to this question? In an important study of Lutherans in the Detroit area (The Lutheran Ethic: The Impact of Religion on Laymen and Clergy, Wayne State University Press, 1970) Laurence L. Kersten discussed the Lutheran ethic of abortion and the discrepancy between the orthodox ethic and the operational ethic in the lives of people. Orthodox Lutheran moral teaching counseled passive acceptance of what God has given through natural process and affirmed sanctity of life doctrine extending protection to the fetus. Conservative laymen and clergy adhere to the 80% level to this moral stance. However, the higher one rises in social class, the more likely one is to allow abortion (80% lower class, 75% middle class, and 62% of the upper class oppose abortion. Kersten, p. 114ff). Surprisingly, women are also more opposed to freedom in abortion policies than men. This points to the way freedom of choice and latitude of conscience, also deeply historic Lutheran values, vary with certain cultural variables, i.e., sex, socio-economic status, education, and the like.

The Human Ecology doctrine, as an extrapolate from orthodox Lutheran moral wisdom into a secular pluralistic milieu, presumably would accent these notions of choice, free conscience, and intense pastoral forgiveness and care rather than restrictive prohibition.

2. Mid-Life Issues—Human Research

Of the numerous bioethical issues appearing during life's course, human sexuality, dialysis and transplantation, the use of drugs, behavioral therapy, truth-telling, allocation of scarce resources and moral issues in informed consent and human experimentation are most frequently mentioned. Let us lift up the issue of human research as

representing this spectrum of concerns and briefly note both its moral dimensions and the response of LGH.

Medicine has always needed to try new treatments and refine existing ones. Indeed, in one sense of the word, all medical treatment is medical experimentation, since that treatment has never before been tried with that person at that point in his life. After the horrors of medical investigations in Hitler's Germany, vigorous and thoughtful codes of ethics were articulated to insure that persons would never again be treated as guinea pigs, as innocent victims of morbid and lethal experimentation. These codes, especially relevant to research and educational centers where new treatments are pioneered, insure that risks will not outweigh benefits; that adequate laboratory and animal testing will have gone before; and that informed consent will be secured. The Nuremberg code, the Helsinki code and all the codes of the World Medical Association and American Medical and Surgical Associations follow the moral stipulations promulgated at this time.

At LGH an Institutional Review Board (IRB) has been established under conditions required by the Department of Health and Human Services of the national government and in connection with the teaching affiliation with the state University of Illinois Medical School. The following policy statement issued in 1972 for the protection of patients who cannot give consent reflects this concern as applied not only to innovative, but to regular treatments.

INFORMED CONSENT AND PATIENTS UNABLE TO PROVIDE INFORMED CONSENT

It is difficult to arrive at a uniform policy which will cover all conceivable circumstances under which legitimate research projects may be conducted under the above conditions. It will be necessary for the Research Committee to carefully review each such proposal with due consideration for the significance of the research and the balance of potential benefits and risks to any patient. In so doing, the following policy guidelines will normally be followed:

- 1 . Initial studies requiring the participation of patients unable to give informed consent either because of unconsciousness, other change in mental status, or minority status, may be performed only on patients for whom consents can be provided by a responsible relative. Subsequently, preliminary results obtained from such subjects may be presented to the Research Committee for review and approval of the extension of such studies to patients unable to provide informed consent under circumstances in which a responsible relative is not available to provide such consent.
- 2 . Human research on patients unable to provide informed consent should be of such a nature that probable immediate and/or long term benefits to the patient significantly outweigh probable risks. Similarly, such procedures which are essentially substitutions for established procedures with known benefit risk ratios must, in the judgment of the Research Committee, offer a substantial probability or better outcome than the established procedures for which they are substituted.

- 3 . In all circumstances involving research in patients unable to provide informed consent under circumstances in which informed consent of responsible relatives is not available, investigators are required to obtain agreement to such procedure from two staff consultants who are not involved in the performance or evaluation of such research.
- 4 . Whenever possible in the design of research procedures to be performed on patients unable to provide informed consent, protocols will require the performance of all normal procedures prior to the institution of the experimental procedure.

“Informed consent” is anchored upon that same value of human reason articulated during the Enlightenment which provided (at least in part) the ethical architecture of our national Constitution and Bill of Rights. More fundamentally, the right of persons to understand their disease and consent to proceedings involving its treatment is rooted in the theological value of a free and responsible conscience. This value, basic to Judaism and Christianity, is reaffirmed in Luther. When in the name of paternalism (“It’s better that you not know”) or scientific intrigue (“We need to develop this information and a little compromise of your freedom won’t hurt”) people are treated as means to an end and not autonomous ends in themselves, a fundamental betrayal of human freedom has occurred.

Other issues involving informed consent and truth-telling remain to be explored. It may be that many people do not want to know their diagnosis—or the mechanics of their surgery—or the possible secondary side-effects of their treatment. Too much knowledge may collapse, not heighten, the body’s power to regenerate itself. Again, simple answers do not serve: the problems must be probed from all sides.

3. Issues At The Conclusion of Life

“Life stinks from the smell of the diddy to the stench of the shroud,” wrote Robert Penn Warren in *All the King’s Men*. Numerous moral quandries face us at the other threshold of life when terminal illness overtakes us and death draws near. Issues include the termination of treatment, living wills, “Do Not Resuscitate” orders, natural death acts, death with dignity practices, hospices, the high cost of dying and many others.

LGH has expressed its sensitivity to this constellation of concerns in a variety of ways. Let it be noted initially that a hospital having religious roots should be able to deal with the issues at the conclusion of life more easily than a hospital having no philosophical orientation. Theology and the Church remind us that physical life is not the ultimate value. This reminder brings into perspective the vitalistic excesses of health care professionals and hospitals. When death is found as an acceptable and natural part of life, helping people to die well can become a legitimate ministry of a hospital.

Earlier this year, a patient at another university hospital illustrated this issue. He was an older black man who had suffered frostbite in the winter cold. Gangrene set in along with vascular problems, and surgeons felt the leg had to be amputated. The man refused surgery and asked simply to be kept comfortable while he died. The surgeons were thrown into confusion. What should they do? Should a court order be sought? Should a psychiatric opinion be sought to designate him incompetent? Neither of these solutions seemed wise, since the man was of sound mind. “Everyone has to die sometime,”

he said. "But we can't have him on the surgical floor," the doctors said. "Can we transfer him to Medicine or a prolonged care facility?" But then they thought better. "No, he is our patient and it is just as much our job to care as to cure. We'll attend him in his needs in these last days of his life." They did—with real class; and surgeons discovered afresh what it is to be physicians.

LGH has a policy on service to the aged. A marvelous working paper launched the effort, blending medical, social, and pastoral perspectives. The paper, entitled "Comprehensive Health Care for America's Aged: A Call to Respond" anchors a rationale for sophisticated and human progress in geriatric health care not so much on economics or assessment of medical needs, but on human values. Our elders have provided for our life, have invested in our growth and learning, have tried their best to secure us a better world. We are obliged to them not only in reciprocal responsibility but in simple justice. They have special and formidable health care needs. We are careless with them to our peril. We lose the benefit of their wisdom, not so much on occasional and technical knowledge which may indeed have passed them by, but in insight into life's meaning, into enduring values.

LGH also has a rich tradition of looking at care of the terminally ill. A thanatology (for lack of a better title) committee has functioned for many years. Concerns of "living with death," grief counseling, cancer support groups, "Make Today Count," a bereavement group of widows and widowers—all have been addressed. The values of hospices and more humane care of the dying in main-line hospitals are also being considered by this committee.

B. Institutional Commitments

Corporate ethics and behavior, it is said, often differ from the values held by individual participating members. The science of human ethology has further asserted that indeed, organizations often function according to priorities disclaimed or even disowned by its constituting members. The nationalist German state, Stalinist Russia, perhaps even some modern corporations would exemplify this. The New Testament addresses this moral phenomenon in terms of the "Principalities and Powers" which seem to take on a measure of malevolence that is greater than the sum of its parts.

An assessment of those moral concerns immediately affecting LGH would reveal that here, too, tensions exist among differing modes of assessing priorities. To which set of values will the hospital be committed? In health care institutions as in corporations or in the state that mode of valuing which informs the life of the hospital must be examined—dissected—constantly; and those who work in that institution must assert their individual responsibility for determining what that informing value system will be.

1. Patient Care vs. Teaching/Research

A teaching hospital takes on three responsibilities. In addition to providing patient care, it is now concerned with the education of health professionals and the advancement of knowledge. It may be asked legitimately whether these three values are completely compatible, one enhancing the other, or whether in some ways they come into conflict. The question is not easy to answer, since no hospital, however far removed from a university, is totally without learning and investigation. All clinical care of patients is a process of cumulative experience; each patient encounter with illness is an experiment in the sense that it hasn't happened to this patient, at this point in life, ever before.

It must also be noted that even the hospital that has no association with a medical college, that undertakes no sponsored research (e.g., from pharmaceutical companies)—even this institution has value conflicts. Community physicians may be more concerned with their investment portfolios, summer homes, and golf scores than they are with nurturing health in the community or even caring for patients. Nurses, social workers, and pastors may be more concerned with professional advancement and community prestige than they are with the patients under their care. In short, the view that a morally pristine health center can exist free from the seductions of teaching and research is misleading.

Lutheran General's primary mandate is from the Church and from the patients who come there to seek care. Patient care, intentionally personal and founded on humanistic principles, is the primary value. But in the contract with the University of Illinois, LGH takes on another mandate. The hospital is now in one sense an agency of the State of Illinois, joining the University hospital system in a commitment to train new generations of health professionals.

This commitment inevitably entails another mandate. If LGH is to be a teaching center, it must have teachers. The doctor now becomes more than a physician; he is called on to fulfill the primary etymological meaning of his title *Doctor*: teacher. To be a medical teacher requires that one be a scholar about one's practice. This means that the doctor is often involved in clinical or basic research. Now the third mandate of research comes into focus. LGH, in committing itself to be a teaching institution, has inevitably invited the new requirement of organizing and furthering that knowledge without which one has nothing to teach.

Predictably, these three values—patient care, education, and advancement of knowledge—can conflict. Does research interfere with patient care? Will patients be directed to research projects which may render their hospital experience different than it would be if there were no projects going on? This tension flared up recently in brilliant, ugly relief when a doctor commented to me that "these patients [indigent browns and blacks] should realize that they owe us something in return for our provision of charity care." That "something" he had in mind was consent to being teaching objects and subjects of research. The consciousness that these men, women, and children were sick human persons requiring care had become lost: "patients" had become "objects," "things," conveniently distanced in his mind. If there is pressure on doctors to fill up research cohorts or "publish or perish," will such a priority compromise the basic value of concerned patient care? When students have to learn new techniques, will abuses such as ghost surgery, erroneous lab work, and bungled procedures occur?

Ideally, the presence of research and teaching should incline an institution toward excellence, stimulating critical awareness and scrutiny. Perhaps incompetence cannot flourish as easily here as it does elsewhere. Perhaps patients get not only the most advanced treatment but also the most intensified concern that nothing go wrong. Some have argued that investigative medicine is the best medicine. Whether one is pessimistic or optimistic about the benefits, teaching and research do change the hospital's ethos, its atmosphere, its priorities.

Specialization, too, exists in tension with patient care, being both necessary to and the enemy of good care. In pathology one cannot be a generalist; one is hepatopathologist. In ENT it is becoming difficult for one to be expert in both the ear and nose. Internal

medicine is presently undergoing profound self-examination. Responsibility demands that one not be a dilettante with a little knowledge in a lot of areas, but a sub-specialist. One is a cardiologist, an oncologist, a hematologist. Yet society looks to internal medicine to train its generalists, its primary care physicians, its general practitioners. This dilemma is generalized in the health care system. Can we concentrate on in-depth knowledge in small areas and still expect knowledge of the whole? Can we develop splendid competence in very restricted parts of the organism and still retain that sense of interactivity that is essential to render therapy and yet understand health and disease?

Teaching responsibility might be seen as a vital instrument for LGH to inculcate and disseminate its unique philosophy of health care. As the hospital becomes more and more a teaching center where nurses, doctors, pastors and other health professionals are being trained, perhaps philosophical concern can be brought to enrich scientific and technical competence. Then perhaps we can begin to rescue ourselves from the ravages wrought by decades of amoral training in the health professions.

LGH has a superb learning center. Programs in patient education, community education, professional and continuing education hold great promise. If offerings in health maintenance and disease prevention can be joined with those in disease treatment, then the genuine health needs of the community, as well as the patient, will be served, and the poles of teaching/research vs. patient care will be harmonized.

2. Business vs. Benevolence

Two hospitals receive the bulk of medical emergencies in a large American city. One hospital is semi-private. It handles some of the city's charity work but largely operates by fee for service. The other is a pure charity hospital serving the indigent. When an ambulance or helicopter delivers a patient to the first hospital, it is said that the first procedure is a "wallet biopsy." On the basis of this test it is decided whether to keep the patient or shunt him off to charity. Probably the moral concern most often mentioned by anyone interviewed—parents, family, staff, administration, people in the community—is the issue of costs.

The historic values of LGH, rooted in Lutheran theology and ecological frugality, prompt both charity and efficiency. Some of the deepest ethical concerns at LGH are expressed by persons in the business affairs area. Can the charity impulses of the religious background be kept alive when cost-effective policies are required to keep the institution viable? How do we make the compromise choices, tempering the ideal by the real?

The hospital is not a detached economic entity. It exists in a city where employees can draw certain salaries. It exists in a society that is shaped by certain economic forces: inflation and cost of energy, for example. LGH, like most private hospitals, is neither a charity institution nor a profit-making institution. It is not significantly subsidized by either Church or State. It is not out to receive profits for stockholders. It exists therefore in a posture of economic equilibrium, forced to match costs with revenues. Economic values of cost containment, efficient use of given resources, limiting charity cases, and pursuit of unpaid accounts come into play.

In ethical deliberations, economic values repeatedly interact with other human values. Can people with chronic illness be kept in the hospital after their resources and public assistance have run out? Should expensive cancer chemotherapy, e.g. methotrexate, be

begun when the prospect for cure is slight? Do hospitals purchase CAT scanners and other expensive instrumentation when the acquisition of these might not be cost-effective, or will they save money in the long run by reducing morbidity and mortality? Hospital employees, listing their concerns, frequently touched on the same area of economics vs. ethics.

- How will changing patterns of affluence in neighborhood change the hospital?
- Can thoughtless benevolence hurt institution - staff?
- How can billing and account collection be made humane?
- How can the burden of payment and worry about ability to pay be lifted from sick people?
- How should scarce resources be best allocated? Will new programs be affected?

The list of questions continues to grow as the hospital grows.

There was a day when ministrations of care for the sick were limited to cleaning wounds, placing bandages, wiping fevered brows, and sitting, listening, praying, waiting. Now, thanks to the advances of science and technology, these traditional ministries can be enriched by specific therapeutic efforts. These often involve trained personnel, expensive substances, and instruments and places where concentrated attention can be administered. These all cost money. This means that today the basic impulses of effective caring are unavoidably economic and political. The human values, value conflicts, priorities, and moral accommodations in this realm will continue to challenge the institution.

3. Responsibility vs. Regulation

A third value antinomy oscillating within the life of the institution relates to the tension between responsible autonomy and direction from external authority. Federal and state regulations cover a range of issues: insurance payments, food and drug utilization, employee policies, cost-containment, building programs, and hiring policies. Sometimes these extrinsic regulations serve values that are noble and humane, such as freedom, non-discrimination, fairness, beneficence and non-maleficence. At other times they serve values of economic expediency, vested interest, and maintenance of bureaucracy. To welcome values which help and resist those that harm people and to work constructively to build public policy in ethical ways constantly challenges an institution.

Another range of intervening values affecting the life of a health care institution is the professional codes of health care providers. Doctors function under the guidance of the Hippocratic oath, the AMA code of ethics, and the Nuremberg and World Medical Association codes. Each specialty (e.g., surgery, pediatrics, psychiatry) has more specific codes of behavior. The nurses have the ANA code of ethics. Other co-professionals (e.g., physical therapy, medical technology), also have their codes (see appendix).

These intervening codes either enhance and strengthen or challenge the hospital's own

stated values. For example, there is a debate among code historians as to whether the sequence of medical codes, Hippocratic to AMA, primarily affirm professional prerogatives, protecting the prestige and "prosperity" of the profession, or whether they serve the needs of the patients. Not only codes but laws, licensing procedures, regulations, (such as "practicing medicine without a license" laws) are ambivalent documents. They purport to serve and protect the public. They are designed also to serve and protect the profession.

Section II has explored the spectrum of moral issues presently confronting this institution. As LGH formulates its moral posture on this range of issues, it will be wise to isolate the various strands of moral persuasion which weave throughout the fabric of this complex institution. Having identified these, we can then proceed to judge the adequacy of those values and decide courses of action on the basis of some overriding normative values which supercede any particular sets of prerogatives.

In this section the ethical problems examined have been issue-oriented rather than private and personal (Does Mrs. Jones understand that she is very sick and may die? Can Nurse X and Dr. X reconcile their differences on whether or not Mrs. Smith should be transferred?). These daily moral transactions of course make up the hospital's "real life drama," but they defy systematic analysis. As LGH critiques its institutional guidelines, anticipating the kinds of problems which indeed might confront its staff during such daily crises, the ethical life of the hospital at all levels will be refined and enriched.

III. Future Directions: Recommendations

We have reviewed the values that brought LGH into being. These also undergird the hospital as it responds to present challenges. The future moral work of the hospital will not only attempt to appropriate this perennial wisdom to new situations but also anticipate issues that the future will inevitably bring. It is imperative that we begin to work on these impending issues and not always be caught in "after the fact" moral analysis. For example, we began our intense ethical reflection on in vitro fertilization after Louise Brown was born in England. We began our reflection on the morality of controlled clinical trials after many men had suffered the ravages of syphilis long after the Tuskegee study had demonstrated the efficacy of penicillin. Lutheran General has the capacity and therefore the obligation to do some pioneering work on behalf of the general society and the Church on tomorrow's questions.

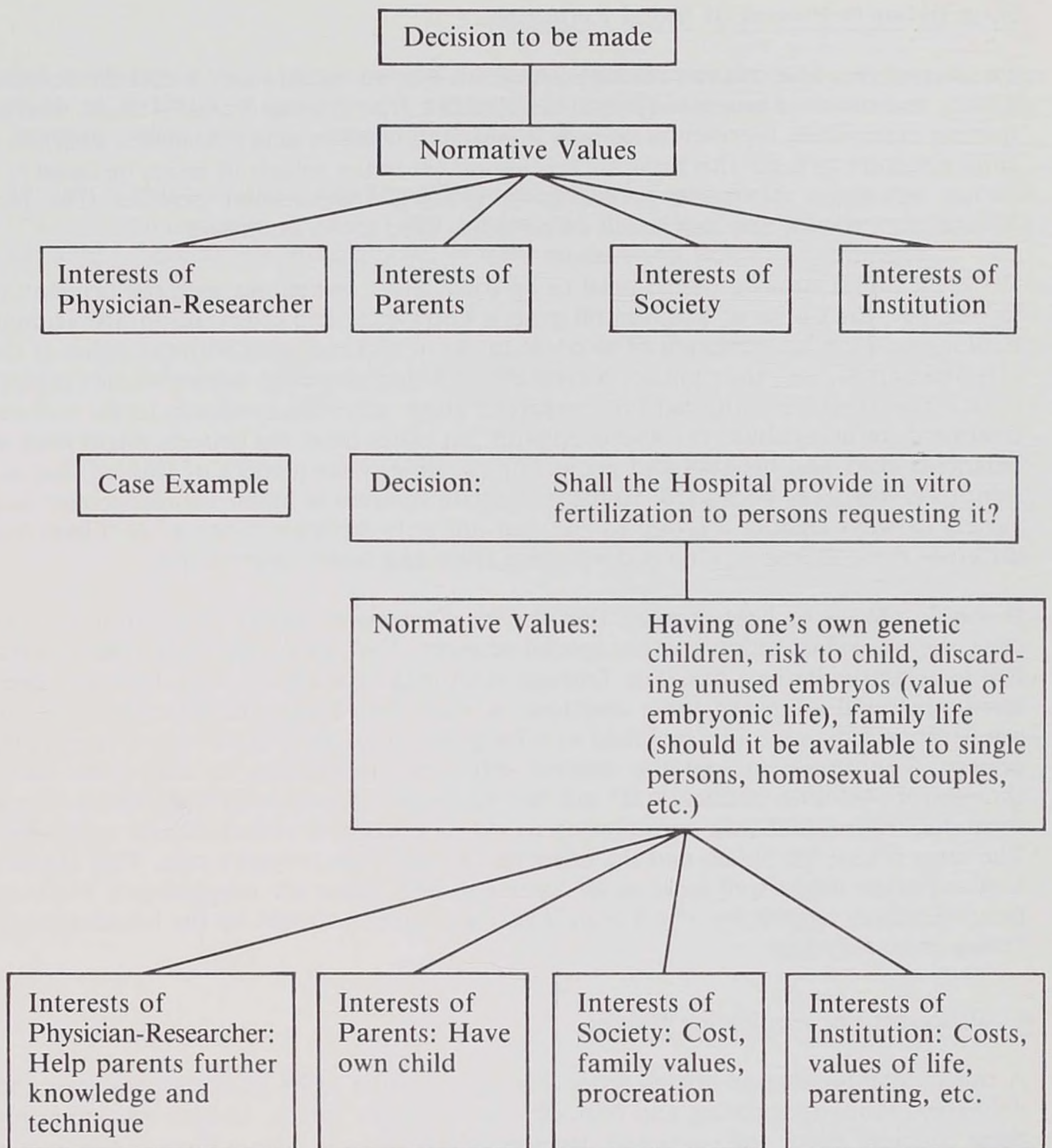
This final section of the paper will offer some recommendations about the kind of process that could serve this goal.

A. Clarifying Concepts

The first imperative will be to clarify what ethics are, how they relate to clinical decisions, how they can affect policy formulations. Some of the most exciting dialogue occurring in our day is that surrounding the theme: "The Foundations of Ethics." Dr. Edward Pellegrino, distinguished medical educator, now president of Catholic University of America, proposes that we find substantive moral content to guide modern medicine in the humanistic philosophy of the Greeks, Stoics, and great philosophers of the Enlightenment. Religious ethicists propose that we look to the great religio-moral traditions that shape our moral consciousness, reaffirm the common, ecumenical values enshrined in those traditions, and relate these to the issues we face. Others suggest that we further develop and apply the utilitarian ethics which emerged in the brilliant nineteenth century theory of John Stuart Mill and are imbedded in modern political and economic theory.

Lutheran General is fortunate to have an articulate moral philosophy that can be applied to the issues of health care. We now need to work out the applied ethics of this system. Not that this system provides all the answers. If anything, the system of Human Ecology is noted for its general principles, not for specific guidelines to particular problems. But with this starting point, the new possibilities of ethical conceptualization can be tested. We need to work toward clarity of concepts, precision in language, and discernment in the decision-making process.

Too much discussion of medical morality wanders in a bewildering desert where no landmarks or guideposts are ever found. Everyone expresses his or her own opinions and prejudices. Our democratic spirit misleads us to assume moral relativism; the dialogue ends in a moral morass of a hundred different likes and dislikes. To clean up the process of moral reflection we need to define our terms and come to agreement on which normative principles will apply. At the same time we will need to clarify the rights and responsibilities of the several parties to the transaction. A case deliberation can be lined out as follows:



The decision-making map given above illustrates one road plan to guide the deliberative process. First, facts are gathered and varying competing interests identified. At the next level the normative values are identified. If there are several values, some perhaps competing, then priorities must be assigned. Finally, responsibility is designated. The decision is made and consequences are borne.

B. Initiating A Process of Moral Reflection

The second recommendation on the basis of this human values study is that the hospital initiate and sustain a process of moral deliberation. The Human Values Forum, with its steering committee, representative task forces, and occasional symposiums, provides a good structure to begin this process. It is important that a variety of issues be faced in a variety of ways. Thematic problems (abortion), Institutional policies (Do Not Resuscitate orders), and individual case studies need to be examined.

Different moral starting points need to be tried. Start sometimes with the originating values, i.e., the Lutheran position on genetic knowledge and intervention, the Human Ecology position on treatment of alcoholism. At other times start with the rights of the affected parties, i.e., the rights of a mentally retarded person to donate tissue (kidney) or to refuse treatment, the right of parents to allow defective newborns to die without treatment, refusing shunt for hydrocephalus. At other times the process might look at balancing risks and benefits and projecting possible consequences of this on that action, then reasoning backwards to the immediate decision at hand. Handling cases in a variety of ways enables a group to contrast not only different kinds of problems but different methodologies, slowly developing tried and tested approaches.

It should always be kept in mind that the mechanisms of moral deliberation exist to serve the whole institution and not special interests. Various groups within the hospital will have particular agendas. The Trustees must make certain moral and priority decisions; they will approach these decisions in ways they find most effective. The administration will constantly be faced with judgments that quite often have a value component. The President and the cabinet will seek mechanisms to help them make thoughtful decisions. Medical staff will face issues that it must resolve internally. It will form committees and seek consultation to aid its process of reflection and resolution. The same is true for nurses and the other co-professionals in health care. This Human Values Forum might well serve as an agency to help either the hospital as a whole or these members separately. The Forum's primary agenda should be the broader issues facing the institution.

C. Processes For Inculcating Values

A third recommendation arising from this report is that LGH be more conscious and deliberate about articulating and critically examining its values, seeking ways to apply these concrete issues and cases and developing efforts to inculcate them in the people who work with the hospital. Ways might be explored to punctuate orientation processes, in-house educational programs, and continuing professional educational programs with deliberate considerations of Human Ecology and human values. Such a process would want to avoid any semblance of indoctrination, all the while encouraging all who work in the hospital to be morally serious, critical, and involved when facing these issues.

D. Sustaining An Atmosphere That Builds Morale

Finally, if an institution is serious about creating a moral tone and rigor, it must nourish an atmosphere of morale. Morale is an elusive quality, but we do know some things about it. We know it flourishes where persons are esteemed and their contributions to the enterprise highly valued. Morale flourishes under challenge. When crises and challenges are confronted and successfully negotiated, this builds morale. Further, if windows of communication are thrown open and all involved in the hospital's life

feel confidently that their voice can be heard, morale will run high. A hospital must work to establish morale among patients, their families, staff, supporters, and the broader community that gives an institution its life.

Morale is also a religious quality. It emerges when a people share a common purpose, finding sustenance in a power that transcends the immediacy of a given situation. Lutheran General has this purpose. It must sustain and extend its influence.

APPENDIX A

Management
Memorandum No. 79-15, May 16, 1979

TO: ALL MANAGERS

FROM: GEORGE B. CALDWELL

RE: HUMAN VALUES FORUM

The Office of the President has established a Human Values Forum at Lutheran General Hospital. This Forum will consist of a representative group from the Hospital, appointed by the Office of the President. It will provide a structure for dealing with ethical and human value concerns which our people encounter in the course of their day-to-day activities and is intended to be inclusive of any of our activity and all of our people. Topics and issues may be directed to the Human Values Forum by anyone in the organization.

The Forum's activities will include the sponsorship of conferences, discussion groups and formal study papers to explore emerging ethical questions in our society. In addition, the Forum will be available as a resource to hospital management, Medical Staff, Board of Trustees and to individuals.

To assist in the early development of this emphasis, we have engaged Kenneth Vaux, Dr. Theol., Professor of Ethics, University of Illinois, Abraham Lincoln School of Medicine. He will serve as a special consultant to the Human Values Forum for a period of one year beginning May 21st. Dr. Vaux served as professor of ethics and theology at Texas Medical Center in Houston prior to accepting his appointment at the University of Illinois.

The initial phase of the program will consist of individual and small groups interviews conducted by Dr. Vaux. The purpose of these contacts is threefold:

1. To provide an opportunity for Dr. Vaux to become acquainted with Lutheran General Hospital and its people.
2. To provide individuals an opportunity to identify ethical issues they see.
3. To provide content for the ongoing work of the Human Values Forum.

This phase of the program will be managed by Pastor Lawrence Holst, Chairman, Division of Pastoral Care; Dr. Leigh Rosenblum, Vice President, Medical Services; and L. James Wylie, Vice President, Human Relations and Resources. Pastor Holst will serve as Coordinator.

Your interest is welcomed—your comments are invited.

GBC:jw

APPENDIX B

A REAFFIRMATION

(First adopted as an official document on October 15, 1959)

STATEMENT OF POLICY

Lutheran General and Deaconess Hospitals is an Illinois Corporation not for profit. The operation of the corporation is delegated to a board of trustees by The American Lutheran Church.

It is the board's legal responsibility to conduct the affairs of this corporation in such a manner as to conform to statutes and interpretation of the State of Illinois governing not for profit corporations engaged in rendering health care.

In addition, the board is legally responsible for the observance of all federal statutes and interpretations as may apply to health care and the fiscal operation of the corporation.

The board regards its various legal responsibilities as minimal standards and acknowledges moral responsibilities as equally binding. The board reserves the right at all times to take such action as is necessary to properly discharge all of its responsibilities, either directly or through formal delegation of its authority. The board will at all times use diligence in arriving at its decisions.

The board regards the following as a general statement of its responsibilities over and beyond that which can be shown to be its legal obligations.

1. To the best of its ability, the board shall not cause or permit anything which violates the essential dignity of man in the operation of its institutions.
2. In addition to fulfilling the rules of the various advisory and regulatory bodies which have jurisdiction in the hospital field, the board shall take or cause to be taken affirmative action assuring the best possible diagnosis and therapy for those who come to its institutions for help.

The board accepts the principle that the best therapy involves not only the highest standards of medical practice but also requires a sincere concern for the total person and the utilization of every modality and discipline available to implement this concern.

This concept is graphically presented in the official statement of the Lutheran Institute of Human Ecology.

3. It is recognized that the board is a lay board and not qualified in all areas to unilaterally promulgate or interpret regulations involving the various disciplines. It does, however, take official cognizance of its moral and legal responsibility in all areas and shall formally delegate such of its responsibilities to such employees and voluntary associates as it deems necessary or desirable.

The board shall review all violations of policies set forth by it, and its decisions shall be final except where the law of the land provides otherwise.

The board accepts the responsibility to assist and encourage its employees and voluntary associates in every way possible in achieving the highest standards in the care of the sick as well as the general welfare of all who join their efforts and skills to make our institutions outstanding.

Rules and regulations are to be considered frames of reference and performance shall be in their spirit rather than in their letter alone.

Adopted by the Board of Trustees, March 13, 1971.

APPENDIX C

STATEMENT OF POLICY

Lutheran General and Deaconess Hospitals is a Christian institution of The American Lutheran Church existing:

1. To provide to mankind, and in particular to that geographic segment of society in which it is located, the best and most diversified health services attainable.
2. To serve each person in need with maximum attainment of selflessness as a being of inestimable value to God in the full realization that all who serve in this house are instruments of His healing powers.
3. To educate and train individuals in the various skills needed to render all types of health services.
4. To organize, delegate and supervise as to effectively and efficiently achieve these goals in a concept of total person needs—Human Ecology.
5. To accept the responsibility of expanding the parameters of patient service recognizing the usual and customary as minimal standards.

Adopted by the Board of Trustees, January 1972

APPENDIX D

WORLD COUNCIL OF CHURCHES CONSULTATION

The Mission and Service of the Church in Sickness and Health Care

(A Statement)

From the beginning of her existence, the Church has been concerned with responses to what human beings experience and understand as sickness, disease and disorder. She has done this because Christians believe that Christ came "that we might have life and have it more abundantly," (John 10:10) and that in His ministry He gave signs of this by His activities of healing and by His confrontation with the evils which hold men and women in their grip. Thus, a commitment to activities designed to assist in the healing of persons and in the treatment of diseases has always been part of the services of the Church, of her proclamation of the Gospel and of the exercise of particular spiritual gifts by her members.

The form of these activities has changed over the years. From the early preoccupation with healing as the exercise of spiritual gifts, the Church's concern began to take on a more institutional form following the Emperor Constantine's adoption of Christianity as a state religion in the 4th century. Then began the Church's long involvement in hospices and hospitals. These hospitals have tended to become, like their secular counterparts which emerged later, more concerned with the treatment of diseases than with the healing of persons. It must, however, also be remembered that the church has always maintained some form of ministry to the sick which was directly addressed to them as persons through such matters as prayer, sick-visiting, and the laying on of hands, etc., but it may be held that this became more and more separated from "medical" treatment which was more oriented to diseases rather than persons.

As more hospitals became secularized, particularly in the 18th and 19th centuries, the Church shifted its major involvement to the areas of overseas missions activity so that by 1910 the Protestant Churches alone were maintaining 2,100 hospitals, chiefly in Asia, Africa and Latin America. Yet, even today, there exist, in some European countries and in North America, a considerable number of church-related hospitals, many of them located in areas which are also served by state-owned institutions. Even in the lesser developed countries where governments are increasingly adding to the national health services it is becoming more common to find church-owned and state-owned institutions within the same locality. This, inevitably, raises the issue of comparison. What is it that makes the Christian institution different? The question becomes all the more grave when asked in the context of the very costly institutions which modern technology demands for the practice of medical care.

Both types of institutions, whether church-owned or state-owned, use the same medical model. Their practitioners are trained according to an identical curriculum. They use the same techniques of nursing and medical care. If it be argued that the distinction is to be found in the quality of service offered by the Christian institution—the unique relationship in which the patient is treated with dignity, and sickness becomes transcended in the mutual quest for wholeness, then one must ask how far the modern technical model of medical care is conducive to these objectives or whether it actually hinders or even prevents them. This is a question which the Church must face not only in relation to its own institutions but it must challenge the same model in secular institutions when it finds that it has distorted the image of health and rob men and women of their opportunity to be truly human as God intended. It is these distortions in the structure and presuppositions of medicine which obscure and even thwart its enormous achievements for good.

Of late, there has been a growing disquiet about the organized methods of responding to sickness and the means of pursuing health and healing which are dominant in Western countries

and which have been shared with, or imposed upon, the countries of the Third World. Concentration upon the science and practice of medicine as the effective means of seeking health and the sole means of responding to sickness has led to both a picture and a pursuit of human health which is dangerously narrow, makes both human beings and their communities unnecessarily dependent, and leads to a monopoly of professional power which is both exploitive of others and wasteful of resources.

The focus of this disquiet centers around those aspects of the dominant model of medical care which have resulted in false expectations which must be challenged.

Some of these are impossible expectations—e.g. health cannot be “delivered.” It is not a commodity which one individual or profession can bestow upon another. It is rather a quality which each individual and community must pursue. Moreover, the resources for health are strictly limited; human life cannot be exempted from suffering and death nor is it rendered meaningless by suffering and death.

Some are inappropriate expectations—e.g. it is not the practice of highly developed medicine which contributes most in determining the healthiness of individuals and societies. The greatest improvements in health have come from an understanding and modification of those factors in the environment which favour the occurrence of disease. It is improvements in housing and food supplies, the introduction of safe water supply and waste disposal systems and, particularly in the developed countries, the elimination of pollution and the strict observance of speed limits which have the greatest impact on our health. In short, the biggest factor affecting our health is our life-style.

Some are harmful expectations as people become greedy for scarce resources (e.g. more and more technology for a few individuals such as heart transplants and renal dialysis). These expectations lead to an addictive dependency on medical care as though it would relieve all our sickness. Then, people are depressed into additional misery when services fail or are not available.

In addition to these false expectations we recognize that the current provisions for health care have led to a gross maldistribution of resources. The adoption of high cost, technologized medicine by the Third World has served only their elite so that 80 per cent of the population are deprived of health services. Moreover, there is maldistribution among the various strata of society in some of the developed countries so that the poor can no longer afford to be sick. Meanwhile, powerful groups within the health care enterprise exercise great control and amass considerable wealth, especially the medical profession and the international drug companies.

This “domination of the medical model” (as it is sometimes called) in the human understanding and the social pursuit of health is coming more and more under challenge. Christians who are working in the fields of medicine and of health care as an expression of the witness of the church to Christ and to the Gospel have perhaps unwittingly, been caught up in (or seduced by) this medical model, together with the societies from which they come and in which they serve. Christian medical work and Christian concern for health and healing thus face the same central challenge and Christians are called to share the same disturbances and disquiets about current methods and future plans in the field of health care. The critical question for them, however, is how to perceive the hand of God and His judgment in these disturbances so that they may effectively renew their sharing in the human struggle to alleviate sickness and to develop health, as part of their service in the name of Christ and in their desire to share the Gospel.

The human pursuit of health and responses to sickness need to be set free from the domination of the medical model as it has developed. Others may and will work at this need in ways which have nothing directly to do with the practice of medicine, (for example, through developing community action or through working on social and economic conditions). We, however, choose to remain concerned with what we have called the “medical contact area” with human and social life. By using this phrase “medical contact area” we intend to draw attention to the fact that the practice of medicine developed as a way of getting into contact with the sphere of

disorder, disquiet and disease in human experience. Medicine is an applied science which gets its mandate from those who bear the burden of sickness. Yet it has grown from modest beginnings into almost a new way of life which calls the tune about what is regarded as healthy and holds the key to the pursuit and achievement of such living. A public which has been justifiably excited by the major technological breakthroughs in modern medical science is now increasingly concerned that the technology is becoming an end in itself justified by what is technically possible, rather than applied to the social mandate which gave it sanction. The medical practitioner and those associated with him have correspondingly grown from servants and carers to masters and even to substitute demi-gods. It is increasingly clear that there is very little that is health-giving about this and much that is sick-making, both for individuals and for society.

We wish to remain with this medical contact area as our sphere of operation for the following reasons:

1. Firstly, there is an immense investment, both of resources and of expectation, in medical practice as the main approach to the problems and distresses of human disorder and disease. Further, no widely accepted alternative approaches as yet exist. Therefore the medical contact area constitutes a main battle-ground for the struggle for a more realistic and a more just use of human and social resource in promoting health and happiness.
2. Secondly, as Christians we are clear that sin need not have dominion over us. We know, therefore, that abuse and distortion in a sphere of human activity need not invalidate that sphere and should not lead to its indiscriminating rejection. Commitment to and development of medicine has been an important channel of human compassion, inventiveness and service. The real achievements of this must not be lost to future and broader human uses.
3. Thirdly, the various manifestations of medical practice and attempts at the provision of health care provide us with a multitude of persons, groups and organizations who are in intimate (even if sometimes distorting) contact with men and women in the stresses and struggles of their lives. Also, there are many Christians and Christian organizations active in this sphere. Thus, there are many living opportunities available for experiment, innovation and hope.

For us, therefore, it is the medical contact area which constitutes the arena in our search for a wider health and a deeper service. We do not enter this arena with the belief that we have or shall produce fresh and good models to be substituted for medical models which have become stale and the source or sustenance of much that is bad. We look rather for ways of working with other concerned people and groups to develop a more realistic awareness of what the role of the doctor and the practice of medicine actually achieve or fail to do today. As we believe that facing up to realism and judgment is a necessary step on the way to receiving practical repentance and the renewal of opportunities for creativity and service, we expect such developing awareness to lead us also to mutual discoveries of re-interpretation, reorganization and change which are necessary if medical practice and health care are to become part of human collaboration in the struggle for more healthy living in a more just society. We do not know in advance how far these changes must go nor what demands will be made of us or what possibilities offered to us. What we do know is that God in Jesus Christ offers us resources and promises which can sustain us in facing criticisms which challenge our present identities and practices to their very roots, and can maintain us in a hopeful and joyful search in the face of all obstacles. We expect also to learn more of what faith in God through Jesus Christ means by our involvement and for our involvement in this exploration and struggle. By this learning we hope also to discover and develop hints about those forms of ministry from the Church and for the Church which will recreate, for our times and circumstances, effective mission and service in the fields of medical practice and the pursuit of health.

Thus, we are seeking to develop an analysis of what has been learned from critical involvement in the practice of medicine and the attempts at the provision of health care. We propose to relate the understanding built up by this analysis to the traditions both of human service which originally inspired the development of medicine and of Christian understanding and which has sustained the Church in confronting sickness and seeking healing. We shall attempt to put together the results of this analysis and this reflection on tradition in a practical way by seeking entry-points into the field of medical practice and health care where we find opportunities, consonant with the approach outlined above, to develop experiments, change attitudes and multiply the resources for widening the human search for health and deepening the understanding of what is implied in this and offered for it. We thus seek to be part of a rediscovery of the living links between health, community and salvation.

APPENDIX E

REPORT TO THE AMERICAN LUTHERAN CHURCH on the LUTHERAN INSTITUTE OF HUMAN ECOLOGY July 1, 1977 - April 30, 1979 -June 22, 1979-

The Lutheran Institute of Human Ecology and its operating arm, Lutheran General Hospital, has continued in a successful and joyous service involved in the serving of our fellow man.

Attached to this biannual report, you will find an annual report of Lutheran General Hospital, "The Challenge of Opportunity," which we would urge you to review at your convenience. You will note that the programs of patient care and health education are progressing well. New and expanded services in medical/psychiatric intensive care are now in place; a new coronary care/intensive care unit is now functioning; and a new chapel, auditorium and media services center were dedicated this spring.

We have also attached summary copies of the financial statements for the year ending June 30th, 1978 and the most current 10 months ending April 30th, 1979. We would also urge you to review these exhibits at your convenience. You will note that our financial position remains stable and healthy.

The Lutheran Institute of Human Ecology and its operating arm, Lutheran General Hospital, face the same concerns in regard to government interference and control that is faced by The American Lutheran Church. Federal and state regulations and controls, usurping many of the prerogatives and authority of the Board of Governors and Board of Trustees, are proposed. A number of these proposals have been enacted into law. We must be ever mindful of our prerogatives to see that they are not usurped by legislation or regulation. As such, the organizational structure of the Lutheran Institute of Human Ecology is most important and is being reviewed toward a restructuring to preserve its integrity and prerogatives to the greatest degree possible.

The Lutheran Institute of Human Ecology and Lutheran General Hospital are now in their 20th year of operation. They carry on the tradition of the founding Deaconesses who developed the original Lutheran Deaconess Home and Hospital some 82 years ago.

In these 20 years, the child has come of age. It has grown from a struggling church-related community hospital into a dynamic, church-related community health care and educational center. We stress the importance of the term "church-related" inasmuch as during the last half of the 20th century, many hospitals have drifted away from their church affiliation. The development of hospitals as highly technical and professional organizations seems to become paramount, and relationships to the church faded. Question has been raised as to why the church continues in the hospital field in the United States now that government and private industry pay most of

the bills. This implies that the need for financial support was the only justification for operation of hospitals by the church. It ignores the commitment to Christ that has motivated Christians through the centuries to serve their fellow humans in many ways, including care for the sick and injured.

Lutheran General Hospital, today, is a visible and dynamic symbol of The American Lutheran Church in its ministry of healing. Through it, the church is a valuable haven for the whole health care enterprise. Compassionate persons providing patient care, loyal medical staff and employees dedicated to its philosophy, Board members and volunteers, dedicated decision-makers—these are a substantial portion of the fiber that constitutes the haven. How well we fulfill our responsibility as a church-related institution will, to a great extent, be determined by the degree of our commitment. It is also dependent on our capability to adjust to change while maintaining our committed uniqueness.

This 20th year is a year of change. Dr. Naurice M. Nessel, a man of foresight and vision, who was President of the Board of Trustees at the time of the planning and construction of the original Lutheran General Hospital, who continued on as President of the Board of Trustees in its early days, and who for the past 9 years has been President of Lutheran General Hospital and the Lutheran Institute of Human Ecology, has retired. The facilities and program carried forth on the campus are a symbol of Dr. Nessel's vision, persistence and Christian dedication.

The foundations have been well laid. George B. Caldwell, our newly selected President, has taken over the responsibilities as Chief Executive Officer this past May. Mr. Caldwell will, we are sure, continue on with the work so ably started in the past 20 years and provide new and dynamic leadership for our corporation in the years to come.

The Lutheran Institute of Human Ecology and Lutheran General Hospital continue as agencies of The American Lutheran Church, dedicated to the philosophy of Human Ecology, "The understanding and treatment of the human being as a whole person in light of his relationship to God, himself, his family and the society in which he lives." As such, we look forward with anticipation to our institution's greater involvement as an agency of the church in a more profound type of healing and health care. In this time of great technological and professional advances, the church's guidance is needed in wrestling with the baffling ethical and moral questions that pervade health care from birth to death. The problems of ethics and morals in health care are escalated as medical know-how and technology search even deeper into the mysteries of life's processes.

Nowhere is the question of life's meaning asked more clearly and pointedly than in the hospital room; in no place is there a greater opportunity to lead persons to satisfying answers; working together to cure and to care; helping people recover a sense of purpose and worth, despite the meaninglessness and tragedy which we see around us.

It is in the light of this understanding that we look forward with anticipation and excitement to the years of service ahead of us.

APPENDIX F

STEWARDSHIP OF HUMAN GENETIC RESOURCES

A preliminary draft which expresses the general consensus of the Task Force on Ethical Issues in Human Medicine, Office of Research and Analysis, June 4-5, 1976. Address comments, criticisms, and proposed revisions to Task Force, Office of Research and Analysis, The American Lutheran Church, 422 South Fifth Street, Minneapolis, Minnesota 55415.

1. The biblical admonition to human beings "Be fruitful, and multiply, and replenish the earth, and subdue it," (Gen 1:28, KJ) has special meaning and relevance to our time in history.

Human reproduction and fertility have largely been taken for granted until this century. Change from a pastoral rural to an industrialized urban society, the emancipation of women and change of sexual roles and stereotypes, effective birth control methods, changing patterns of sexual behavior and values, and appreciation of world-wide and regional population pressures, in addition to other factors, have caused changes in attitudes and practices relative to human reproduction.

2. Looking at the present and toward the future, a thoughtful Christian must acknowledge certain realities: The acceptance of abortion on demand, the fear (reality not determined) of reproducing lives not worth living, and the recognition of the legal, moral, and religious problems implied by human sperm and ovum banks, surrogate gestation, and genetic engineering, to name a few future-oriented issues.

3. As each human being is the sole trustee and proprietor of his or her own genetic resources, typified by sperm and ova, he or she is then the steward of that genetic material and responsible to God and society for its use. Thus, while "be fruitful and multiply" still expresses the collective human obligation to reproduce and perpetuate the human species, procreation is not a personal obligation but rather a privilege and gift of God to be used responsibly, appropriately, and as a good steward.

4. Effective birth control facilitates responsible procreation and greatly enhances our ability to exercise stewardship of genetic resources. Men and women equally are responsible for contraception and procreation. The enjoyment of sexual intercourse without fear of unwanted pregnancy is appropriate. Sexual intercourse is the privilege of mature human beings who act responsibly within a context of commitment known in the Christian community as marriage. However, contraception information and assistance ought to be available to all sexually active people regardless of age, social or marital status. We affirm the primacy and sanctity of procreation and human life in the context of the stewardship of human genetic resources.

5. We deplore the dualism in our culture that allows a separation of body and soul, belief and practice, self-image and behavior. This dualism facilitates hedonism and sex without commitment and leads to sexual activity in the young without insight and without contraceptive protection. For example, a girl may avoid practicing standard contraceptive measures because she does not perceive herself as sexually active with its attendant connotations, yet she will risk pregnancy by engaging in sexual intercourse impulsively and sometimes even regularly.

6. In defining the limits of contraceptive practice one must acknowledge voluntary sterilization as usually appropriate but abortion as a means of contraception fundamentally inappropriate. Indeed abortion, the sacrifice of a fetal life, is always wrong but in some instances other than a method of birth control may be a course more acceptable than other options. Christian life still renounces the act of this sacrifice, laments the conditions leading to the act, and stands in need of the grace of God.

7. Conception occurs in a variety of circumstances. The ideal remains a married couple free of serious genetic defect both of whom desire a child and are able to provide for the child emotionally, spiritually, physically, and socially. Implicit is the understanding that both parents are willing to accept the risks and sorrows as well as the benefits and joys of parenthood. Conception must be regarded as inappropriate under some circumstances; for example when without intent to carry the child to term, when a grossly defective infant would probably be produced, when neither of the couple wants a child, when parents are incapable of nurture, when the result of rape or incest, or when induced by societal pressure.

8. Artificial insemination, conception where only one of a couple (the woman in present circumstances) provides genetic material and the other genetic material comes from an anonymous donor, may be perceived as appropriate for some married couples although there are legal and moral ambiguities. This issue of artificial insemination and the larger issues of sperm banks, surrogate gestation, and genetic engineering are in need of critical study and discussion to determine propriety and resolve ambiguities.

9. Evaluation of a pregnancy-in-progress by current imperfect and imprecise methods (mainly amniocentesis) may be appropriate for some families with increased genetic risk or children with developmental difficulties, to gain data to decide for or against abortion, and to assuage parental fears. It must, however, be questioned as a routine screening measure, to assure desired sex of offspring, when used against the wishes of a parent, and when abortion is the only option offered. There are two key questions not easily answered: (1) Is there such a thing as a life not worth creating? (2) Is there such a thing as a life not worth living? Decisions about abortion and the quality of life must evolve from answers or partial answers to these two questions.

10. The benefit of objective genetic counseling from a qualified expert is potentially great and the subsequent relation of prospective parents with a thoughtful pastor perhaps even greater. As an endorsement of responsible parenthood, the church has an obligation to foster genetic education of youth and young adults, to assist older mothers, families with genetic or possible genetic problems, and families with abnormal children in obtaining genetic counseling from qualified experts.

11. There is no hard scientific evidence presently available that would indicate that the world's human genetic pool, the genes of the four billion persons currently inhabiting our earth, can either be improved or degraded by human procreation restricted or unrestricted. The size of the human gene pool and naturally occurring mutations guarantee human variety and diversity.

12. In the past legal and societal sanctions in the name of eugenics have usually degenerated into racial, ethnic, economic, and social criteria of human value. This must be deplored by all. No thoughtful person could deny that there is real necessity to retard excessive world population growth. However, social policy should not mitigate against personal decision regarding family size unless absolutely necessary. Restraints on population growth and personal procreation are best achieved through education, debate, and example rather than by legislation.

13. It remains to be proved that human worth, dignity, or quality may be enhanced by any scheme of procreation at variance with God's plan for a man and a woman to make a commitment to each other in love and literally join their flesh in sexual intercourse to merge their own genetic resource, egg and sperm, to create a unique combination of genes and bring forth a new human life. Christians are called to live within constraints of propriety and stewardship more stringent than those of society generally. Their exercise of gifts and privileges of sex and procreation responsibly and appropriately do fulfill the biblical admonition to be fruitful and multiply and replenish the earth and subdue it. This stewardship witnesses to our Christian faith.

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APPENDIX G

ABORTION AND CHRISTIAN COUNSEL

(Revised preliminary draft of a proposed statement of judgment and conviction intended to be recommended for 1974 General Convention action by the Commission on Church and Society, The American Lutheran Church. Prepared January 1974 by Carl F. Reuss for consideration by executive committee of the Commission at its meeting on January 28, 1974. Based on comments and criticisms received on Christian Counsel Concerning Abortion and on discussions at Consultation on Abortion, Lutheran General Hospital, Park Ridge, Illinois January 16-17, 1974.)

1. The American Lutheran Church rejects the trend toward accepting induced abortion as a ready solution for problem pregnancies. An induced abortion deliberately ends a developing human life. No one dare take such a step easily or lightly. Yet, The American Lutheran Church accepts the possibility that an induced abortion may be a necessary option in individual human situations. Each person needs to be free to make this choice in light of that person's individual situation. Such freedom to choose carries the obligation to weigh the options and to bear the consequences of the decision.

2. This position taken by The American Lutheran Church is a pro-life position. It looks in awe at the mystery of procreation and at the processes through which a human being develops, matures, and dies. It takes seriously the right of the developing life to be born. It takes into account the rights of the already born to their health, their individuality, and the wholeness of their lives. It allows the judgment that, all pertinent factors responsibly considered, the developing life may need to be terminated in order to defend the health and wholeness of persons already present and already participating in the relationships and responsibilities of life. There is no simple, ready-made scale for persons to use in deciding when an abortion may be an appropriate action or when it may be a denial of another's right to life. It is a decision heavy with anguish and agony. Yet, it is a decision for the responsible parties to make in awareness of their life under God and of the imperative to love neighbor as self.

3. The American Lutheran Church acknowledges that the Bible gives no explicit word on abortion. Committed Christians differ in interpreting the meaning and understanding the relevance of the Scripture passages usually cited in discussions of abortion. Therefore, The American Lutheran Church urges the members of its congregations individually to decide their own positions and actions after prayerful reflection upon:

- a. the counsel and guidance of the Scriptures studied as a whole for the message of Law and Gospel God speaks therein to His creatures;
- b. their understanding of the meaning and purpose of human life as created by the Father, redeemed by the Lord Jesus Christ, and enlightened by the Holy Spirit for service to others and an eternity of life and fellowship with all the saints;
- c. trustworthy information as to the effects of abortion upon persons, families, and society as a whole; and
- d. human unwillingness or inability to do God's will in contrast with God's understanding and forgiveness of those who trust his promises.

4. A decision on abortion is too serious to be solely a personal decision. It is a decision which should be guided, but not forced, by church, by law, by public opinion, by family, and by other trusted persons. It is a decision toward which the Christian community ought to offer its tender, embracing, understanding, compassionate help. Pastors, church councils, auxiliaries, and key persons in agencies and institutions related to The American Lutheran Church need to give leadership toward assuring that competent counseling services are available for persons considering an abortion. In the interests of clear understanding, a fair assessment of competing

claims and rights, and an ability to give informed consent, competent abortion counseling strives to:

- a. provide reliable information concerning the possible consequences of a decision for or against abortion;
- b. help the involved persons, especially the pregnant woman and the father of the life developing in her womb, to clarify their own thoughts and feelings regarding the crisis situation in which they find themselves;
- c. take into account (1) the circumstances under which the conception occurred; (2) the maturity and the physical and emotional health of the prospective mother; (3) the present composition and responsibilities of the family, including the ages and the health of other children; (4) the economic factors at stake should the mother lose her employment and income; and (5) the effects on church membership and of feelings stemming from religious teachings;
- d. sift out and hold up for careful assessment possible notes of pride, status, self-concern, or personal comfort and convenience which clash with the interests of the developing life;
- e. point out the options and possibilities inherent in carrying the pregnancy to term, thus assuring the fetus its right to be born and the possibility of being placed in an adoptive home where it can be loved and nurtured;
- f. refer the persons, at their option, either to a competent practitioner able to perform the surgical procedure in accord with good medical practice, or to an agency with an effective program of maternity home, foster home, and adoptive services; and
- g. offer post-abortion or post-delivery assistance to deal with whatever problems or questions may develop.

5. Though an induced abortion may be an appropriate action under compelling individual circumstances, much preferable is prior action to prevent a possible problem pregnancy. Toward this end The American Lutheran Church advocates such responsible measures as:

- a. Teaching the meaning of human life and personhood, including human sexuality, as lived in Jesus Christ, in love for God, for family and neighbor, and for self;
- b. Helping parents grow in understanding of the joys, satisfactions, and obligations of parenthood, of the individuality of each child, and of the stewardship trust given them for the nurture of their children;
- c. Chastity, self-control, and consideration for the partner in the management of male and female sex drives;
- d. Comprehensive family planning services through research, development, and dissemination of information and materials for all persons who want or need such help;
- e. Effective, consistent use of reliable contraceptive measures in sexual intercourse so as to exercise responsible management of human reproductive powers;

f. Consideration of voluntary sterilization when both husband and wife are sure they should have no additional children of their own;

g. Acceptance of an involuntary pregnancy, allowing it to take its natural course, and then either accepting and loving the newcomer or releasing him or her for adoption into a home where love, care, and nurture will be given;

h. Enlarging adoption possibilities by permitting a married couple without stigma to release for adoption a child of their own when they feel themselves unable to meet the obligations of parenthood; and

i. Motivating and supporting persons as they seek daily to express in their actions the knowledge, the good intentions, and the wholesome feelings in which they have been nurtured.

6. It is undeniable that members of the congregations of The American Lutheran Church differ in their views of how civil laws should deal with abortion. Some argue strongly that laws should totally forbid abortions, no matter what the circumstances. Others divide as to whether laws should permit abortion: (a) if necessary to spare the life of the pregnant woman; or (b) for specific and weighty medical reasons related to the life or health of the pregnant woman; or (c) for specific and weighty medical or other reasons related either to the pregnant woman, the developing life, or both; or (d) within the first three months of pregnancy so long as the operation is performed by a licensed person in an appropriate medical setting, after which stricter controls are required, or (e) if and when the pregnant woman believes an abortion to be necessary. None advocate compulsory abortion.

7. The present legal situation within the U.S.A., following the January 1973 decision of the Supreme Court, can be described as allowing for free and responsible decision making. No one is compelled to undergo an abortion. The woman and her doctor are guaranteed the right to decide the question within the first three months of pregnancy. Laws regulating abortion are authorized in the fourth through sixth months in the interests of the mother's health and in the last three months in the interests of either mother or fetus. Abortions are removed from the underworld, criminal, or clandestine categories into the realm of health care and standards of good medical practice. Such freedom for responsible decision making presents perils as well as possibilities.

8. Fear that the perils will prove catastrophic moves many persons to press for a constitutional amendment which will overrule the Supreme Court decision. Thus far the proposed amendments to the U.S. Constitution fall into three major categories: (a) guaranteeing the several states their rights of "allowing, regulating, or prohibiting the practice of abortion"; (b) insuring due process and equal protection to the individual "from the moment of conception"; and (c) defining the term "person" to apply to all human beings "including their unborn offspring at every stage of their biological development." If an amendment is needed, the "states-rights" approach allows for variety, flexibility, and innovative ways for dealing with the abortion issue. The other two categories of proposed amendments appear to introduce problems greater than the abortion problem they seek to overcome.

9. The abortion issue remains deeply divisive in church and society. The American Lutheran Church pleads with the members of its congregations to show Christian love, mercy, and compassionate understanding even to those whose views and actions on the abortion issue they totally disagree. Each person bears the consequences of the decisions he or she makes in the exercise of human freedom. It is up to God, not to us mortals, to judge the rightness or wrongness of another's decisions. Our Lord's words in Matthew 7:1-5 force us to face ourselves in the judgments we would make also about another's views and actions on induced abortions.

APPENDIX H

American Medical Association

Principles of Medical Ethics

Preamble

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1

The principle objective of the medical profession is to render service of humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2

Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3

A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4

The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5

A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6

A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7

In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8

A physician should seek consultation upon request, in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9

A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10

The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

American Nurses' Association

Code for Nurses

Section 1

The nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

Section 2

The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.

Section 3

The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person.

Section 4

The nurse assumes responsibility and accountability for individual nursing judgments and actions.

Section 5

The nurse maintains competence in nursing.

Section 6

The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.

Section 7

The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge.

Section 8

The nurse participates in the profession's efforts to implement and improve standards of nursing.

Section 9

The nurse participates in the profession's efforts to establish and maintain conditions of employment conducive to high quality nursing care.

Section 10

The nurse participates in the profession's effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.

Section 11

The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.

American Pharmaceutical Association

Code of Ethics

Preamble

These principles of professional conduct for pharmacists are established to guide the pharmacist in his relationship with patients, fellow practitioners, other health professionals, and the public.

Section 1

A pharmacist should hold the health and safety of patients to be of first consideration; he should render to each patient the full measure of his ability as an essential health practitioner.

Section 2

A pharmacist should never condone the dispensing, promoting or distributing of drugs or medical devices, or assist therein, which are not of good quality, which do not meet standards required by law or which lack therapeutic value for the patient.

Section 3

A pharmacist should always strive to perfect and enlarge his professional knowledge. He should utilize and make available this knowledge as may be required in accordance with his best professional judgment.

Section 4

A pharmacist has the duty to observe the law, to uphold the dignity and honor of the profession, and to accept its ethical principles. He should not engage in any activity that will bring discredit to the profession and should expose, without fear or favor, illegal or unethical conduct in the profession.

Section 5

A pharmacist should seek at all times only fair and reasonable remuneration for his services. He should never agree to or participate in transactions with practitioners of other health professions or any other person under which fees are divided or which may cause financial or other exploitation in connection with the rendering of his professional services.

Section 6

A pharmacist should respect the confidential and personal nature of his professional records; except where the best interest of the patient requires or the law demands, he should not disclose such information to anyone without proper patient authorization.

Section 7

A pharmacist should not agree to practice under terms or conditions which tend to interfere with or impair the proper exercise of his professional judgment and skill, which tend to cause a deterioration of the quality of his service or which require him to consent to unethical conduct.

Section 8

A pharmacist should strive to provide information to patients regarding professional services truthfully, accurately and fully, and should avoid misleading patients regarding the nature, cost or value of the pharmacist's professional service.

Section 9

A pharmacist should associate with organizations having for their objective the betterment of the profession of pharmacy; he should contribute of his time and funds to carry on the work of these organizations.

Patient's Bill of Rights

(American Hospital Association, November, 1972)

Section 1

The patient has the right to considerate and respectful care.

Section 2

The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know by name, the physician responsible for coordinating his care.

Section 3

The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.

Section 4

The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his action.

Section 5

The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.

Section 6

The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.

Section 7

The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.

Section 8

The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him.

Section 9

The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.

Section 10

The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or delegate of the physician of the patient's continuing health care requirements following discharge.

Section 11

The patient has the right to examine and receive an explanation of his bill regardless of source of payment.

Section 12

The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

No catalogue of rights can guarantee for the patient the kind of treatment he has a right to expect. A hospital has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient, and above all, the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

A Living Will

(Prepared and distributed by the Euthanasia Educational Council, 250 West 57th Street, New York 10019; has also been used as a model for "death with dignity" bills introduced into state legislatures.)

To my family, my physician, my clergyman, my lawyer—

If the time comes when I can no longer take part in decisions for my own future, let this statement stand as the testament of my wishes:

If there is no reasonable expectation of my recovery from physical or mental disability, I, _____, request that I be allowed to die and not be kept alive by artificial means or heroic measures. Death is as much a reality as birth, growth, maturity and old age—it is the one certainty. I do not fear death as much as I fear the indignity of deterioration, dependence and hopeless pain. I ask that medication be mercifully administered to me for terminal suffering even if it hastens the moment of death.

This request is made after careful consideration. Although this document is not legally binding, you who care for me will, I hope, feel morally bound to follow its mandate. I recognize that it places a heavy burden of responsibility upon you, and it is with the intention of sharing that responsibility and of mitigating any feelings of guilt that this statement is made.

Signed _____

Date _____

Witnessed By: _____

Declaration of Helsinki

(Recommendations Guiding Doctors in Clinical Research)

Resolution adopted at the 18th World Medical Assembly, June, 1964, by the World Medical Association, of which the American Medical Association is a member.

INTRODUCTION: It is the mission of the doctor to safeguard the health of the people. His knowledge and conscience are dedicated to the fulfillment of this mission.

The Declaration of Geneva of the World Medical Association binds the doctor with the words: "The health of my patient will be my first consideration" and the International Code of Medical Ethics which declares that "Any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest."

Because it is essential that the results of laboratory experiments be applied to human beings to further scientific knowledge and to help suffering humanity, the World Medical Association has prepared the following recommendations as a guide to each doctor in clinical research. It must be stressed that the standards as drafted are only a guide to physicians all over the world. Doctors are not relieved from criminal, civil and ethical responsibilities under the laws of their own countries.

In the field of clinical research a fundamental distinction must be recognized between clinical research in which the aim is essentially therapeutic for a patient, and the clinical research, the essential object of which is purely scientific and without therapeutic value to the person subjected to the research.

I. Basic Principles

1. Clinical research must conform to the moral and scientific principles that justify medical research and should be based on laboratory and animal experiments or other scientifically established facts.
2. Clinical research should be conducted only by scientifically qualified persons and under the supervision of a qualified medical man.
3. Clinical research cannot be legitimately carried out unless the importance of the objectives is in proportion to the inherent risk to the subject.
4. Every clinical research project should be preceded by careful assessment of the inherent risks in comparison to foreseeable benefits to the subject or to others.
5. Special caution should be exercised by the doctor in performing clinical research in which the personality of the subject is liable to be altered by drugs or experimental procedure.

II. Clinical Research Combined with Professional Care

1. In the treatment of the sick person, the doctor must be free to use a new therapeutic measure, if in his judgment it offers hope to saving life, reestablishing health, or alleviating suffering.

If at all possible, consistent with patient psychology, the doctor should obtain the patient's freely given consent after the patient has been given a full explanation. In case of legal incapacity, consent should also be procured from the legal guardian; in case of physical incapacity the permission of the legal guardian replaces that of the patient.

2. The doctor can combine clinical research with professional care, the objective being the acquisition of new medical knowledge, only to the extent that clinical research is justified by its therapeutic value for the patient.

III. Non-Therapeutic Clinical Research

1. In the purely scientific application of clinical research carried out on a human being, it is the duty of the doctor to remain the protector of the life and health of that person on whom clinical research is being carried out.
2. The nature, the purpose and the risk of clinical research must be explained to the subject by the doctor.
- 3a. Clinical research on a human being cannot be undertaken without his free consent after he has been informed; if he is legally incompetent, the consent of the legal guardian should be procured.
- 3b. The subject of the clinical research should be in such a mental, physical, and legal state as to be able to exercise fully his power of choice.
- 3c. Consent should, as a rule, be obtained in writing. However, the responsibility for clinical research always remains with the research worker; it never falls on the subject even after consent is obtained.
- 4a. The investigator must respect the right of each individual to safeguard his personal integrity, especially if the subject is in a dependent relationship to the investigator.
- 4b. At any time during the course of the clinical research the subject or his guardian should be free to withdraw permission for research to be continued.

The investigator or the investigating team should discontinue the research if in his or their judgment, it may, if continued, be harmful to the individual.

CURRICULUM IN MEDICAL RECORD ADMINISTRATION

AMERICAN MEDICAL RECORD ASSOCIATION

CODE OF ETHICS

Medical Record Administration is concerned with the development, use, and maintenance of medical and health records for medical care and treatment, administrative, reference, professional education and research purposes. Medical record practice is a trust delegated by the medical and health services. To protect and merit the trust placed in it, the medical record profession has the responsibility of defining basic principles governing the professional conduct of its members. The American Medical Record Association has therefore adopted this Code of Ethics.

The following code of ethical conduct defines the tenets necessary for carrying out the purposes of the medical record profession, is binding upon any member of the American Medical Record Association, and upon any person, certified, registered, or accredited by this Association. As a member of one of the paramedical professions, he shall:

1. Place service before material gain, the honor of the profession before personal advantage, the health and welfare of patients above all personal and financial interests, and conduct himself in the practice of this profession so as to bring honor to himself, his associates, and to the medical record profession.
2. Preserve and protect the medical records in his custody and hold inviolate the privileged contents of the records and any other information of a confidential nature obtained in his official capacity, taking due account of applicable statutes and of regulations and policies of his employer.

3. Serve his employer loyally, honorably discharging the duties and responsibilities entrusted to him, and give due consideration to the nature of these responsibilities in giving his employer notice of intent to resign his position.
4. Refuse to participate in or conceal unethical practices or procedures.
5. Report to the proper authorities but disclose to no one else any evidence of conduct or practice revealed in the medical records in his custody that indicates possible violation of established rules and regulations of the employer or of professional practice.
6. Preserve the confidential nature of professional determinations made by the staff committees which he serves.
7. Accept only those fees that are customary and lawful in the area for services rendered in his official capacity.
8. Avoid encroachment on the professional responsibilities of the medical and other para medical professions, and under no circumstances assume or give the appearance of assuming the right to make determinations in professional areas outside the scope of his assigned responsibilities.
9. Strive to advance the knowledge and practice of medical record administration, including continued self-improvement, in order to contribute to the best possible medical care.
10. Participate appropriately in developing and strengthening professional manpower and in representing the profession to the public.
11. Discharge honorably the responsibilities of any Association post to which appointed or elected, and preserve the confidentiality of any privileged information made known to him in his official capacity.
12. State truthfully and accurately his credentials, professional education, and experience in any official transaction with the American Medical Record Association and with any employer or prospective employer.

CURRICULUM IN OCCUPATIONAL THERAPY

AMERICAN OCUPATIONAL THERAPY ASSOCIATION

CODE OF ETHICS (Adopted 4-18-77)

Preamble:

This association and its component members are committed to furthering man's ability to function fully within his total environment. To this end the Occupational Therapist renders service to clients in all stages of health and illness, to institutions, other professionals, colleagues, students and to the general public. In furthering this commitment the American Occupational Therapy Association has established the Principles of Occupational Therapy Ethics. It is intended that they be used by all occupational therapy personnel, including practitioners in all settings, administrators, educators and students. These principles should be reflected in and supported by licensing laws, regulations, consultation, planning and teaching. They are intended to be action oriented, guiding and preventive rather than negative or merely disciplinary. However, it is intended that these principles are only for internal use by the American Occupational Therapy Association as a guide to appropriate conduct of its members, and is not intended as a definition for patients or clients of a standard or care expected in any community. Professional maturity will be demonstrated in applying these basic principles while exercising the large measure of freedom which they provide and which is essential to responsible and creative

occupational therapy service. For the purpose of continuity the following definitions will support information in this document: Occupational therapist includes registered occupational therapists, certified occupational therapy assistants, occupational therapy students. Clients include patients and those to whom occupational therapy services are delivered.

I. Related To The Recipient of Service

The occupational therapist demonstrates a beneficent concern for the recipient of services, maintains a goal directed relationship with the recipient which furthers the objectives for which it is established. Services are evaluated against objectives and accountability is maintained therefore. Respect shall be shown for the recipients' rights and the occupational therapist will preserve the confidence of the client relationship.

II. Related To Competence

The occupational therapist shall actively maintain and improve one's professional competence, represent it accurately and function within its perimeters.

III. Related To Records, Reports, Grades and Recommendations

The occupational therapist shall conform to local, state and federal laws and regulations and regulations applicable to records and reports. The occupational therapist abides by the employing institution's rules. Objective data shall govern over subjective data in evaluations, grades, recommendations, records and reports.

IV. Related To Intra-Professional Colleagues

The occupational therapist shall function with discretion and integrity in relations with other members of the profession and shall be concerned with the quality of their services. Upon becoming aware of objective evidence of a breach of ethics of sub-standard service the occupational therapist shall take action according to established procedure.

V. Related To Other Personnel

The occupational therapist shall function with discretion and integrity in relations with personnel and cooperates with them as may be appropriate. Similarly, the occupational therapist expects others to demonstrate a high level of competence. Upon becoming aware of objective evidence of a breach of ethics or substandard service the occupational therapist shall take action according to established procedure.

VI. Related To Employers And Payers

The occupational therapist implements a commitment to the education of society and the consumer of health services as well as to the education of health personnel on matters of health which are within the purview of occupational therapy.

VII. Related To Education

The occupational therapist implements a commitment to the education of society and the consumer of health services as well as to the education of health personnel on matters of health which are within the purview of occupational therapy.

VIII. Related To Evaluation And Research

The occupational therapist shall accept responsibility for evaluating, developing and refining service and the body of knowledge and skills which underlie the education and practice of occupational therapy, at all times protects the rights of subjects, clients, institutions and collaborators. The work of others shall be acknowledged.

IX. Related To The Profession

The occupational therapist shall be responsible for gaining information and understanding of the principles, policies and standards of the profession. The occupational therapist functions as a representative of the profession.

X. Related To Law And Regulations

The occupational therapist shall seek to acquire information about applicable local, state, federal and institutional rules and shall function accordingly thereto.

XI. Related to Misconduct

The occupational therapist shall not engage in illegal conduct involving moral turpitude and will not circumvent the principles of occupational therapy ethics through actions of another.

XII. Related To Bioethical Issues and Problems of Society

The occupational therapist seeks information about the major health problems and issues to learn their implications for occupational therapy and for one's own services.

DEPARTMENT OF MEDICAL SOCIAL WORK

NATIONAL ASSOCIATION OF SOCIAL WORKERS

CODE OF ETHICS

Each member of the National Association of Social Workers subscribes to the Code of Ethics as a basis for professional conduct and agrees to submit to the Adjudication of Grievance Procedures of the Association. Those listed who are not NASW members but who hold a state license at a level at least equivalent to autonomous practice standard of the Academy of Certified Social Workers, are bound by the adjudication procedures incorporated in their state licensure law.

(Adopted by the Delegate Assembly of the National Association of Social Workers, October 13, 1960 and amended April 11, 1967.)

Social work is based on humanitarian, democratic ideals. Professional social workers are dedicated to service for the welfare of mankind, to the disciplined use of a recognized body of knowledge about human beings and their interactions, and to the marshaling of community resources to promote the well-being of all without discrimination.

Social work practice is a public trust that requires of its practitioners integrity, compassion, belief in the dignity and worth of human beings, respect for individual differences, a commitment to service, and a dedication to truth. It requires mastery of a body of knowledge and skill gained through professional education and experience. It requires also recognition of the limitations of present knowledge and skill and of the services we are now equipped to give. The end sought is the performance of a service with integrity and competence.

Each member of the profession carries responsibility to maintain and improve social work service; constantly to examine, use, and increase the knowledge on which practice and social policy are based; and to develop further the philosophy and skills of the profession.

This Code of Ethics embodies certain standards of behavior for the social worker in his professional relationships with those he serves, with his colleagues, with his employing agency, with other professions, and with the community. In abiding by it, the social worker views his obligations in as wide a context as the situation requires, takes all the principles into consideration, and chooses a course of action consistent with the code's spirit and intent.

As a member of the National Association of Social Workers I commit myself to conduct my professional relationships in accord with the code and subscribe to the following statements.

- I regard as my primary obligation the welfare of the individual or group served, which includes action for improving social conditions.

- I will not discriminate because of race, color, religion, age, sex, or national ancestry and in my job capacity will work to prevent and eliminate such discrimination in rendering service, in work assignments, and in employment practices.
- I give precedence to my professional responsibility over my personal interests.
- I hold myself responsible for the quality and extent of the service I perform.
- I respect the privacy of the people I serve.
- I use in a responsible manner information gained in professional relationships.
- I treat with respect the findings, views, and actions of colleagues and use appropriate channels to express judgment on these matters.
- I practice social work within the recognized knowledge and competence of the profession.
- I recognize my professional responsibility to add my ideas and findings to the body of social work knowledge and practice.
- I accept responsibility to help protect the community against unethical practice by any individuals or organizations engaged in social welfare activities.
- I stand ready to give appropriate professional service to public emergencies.
- I distinguish clearly, in public, between my statements and actions as an individual and as a representative of an organization.
- I support the principle that professional practice requires professional education.
- I accept responsibility for working toward the creation and maintenance of conditions within agencies that enable social workers to conduct themselves in keeping with this code.
- I contribute my knowledge, skills, and support to programs of human welfare.

CURRICULUM IN MEDICAL LABORATORY SCIENCES

AMERICAN SOCIETY FOR MEDICAL TECHNOLOGY

CODE OF ETHICS

“Being fully cognizant of my responsibilities in the practice of Medical Technology, I affirm my willingness to discharge my duties with accuracy, thoughtfulness, and care.

“Realizing that the knowledge obtained concerning patients in the course of my work must be treated as confidential, I hold inviolate the confidence (trust) placed in me by the patients and physicians.

“Recognizing that my integrity and that of my profession must be pledged to the absolute reliability of my work, I will conduct myself at all times in a manner appropriate to the dignity of my profession.”

The symbol for the American Society for Medical Technology is represented by the Caduceus, microscope, and retort. The Caduceus, or serpent wreathed staff, is the traditional symbol for the profession of medicine, while the microscope and retort were among the first instruments used in the clinical laboratory.

CURRICULUM IN PHYSICAL THERAPY

AMERICAN PHYSICAL THERAPY ASSOCIATION

CODE OF ETHICS

Preamble

The physical therapist member of the American Physical Therapy Association accepts this Code of Ethics as the basis for the practice of his profession. Individually and collectively, the members of this Association are responsible for promoting and maintaining the highest ethical standards.

There shall always be a Guide for Professional Conduct to assist in the interpretation of the Code of Ethics. This guide, taking reference from the code, shall be subject to monitoring and timely revision by the Association's Judicial Committee.

This Code of Ethics and Guide for Professional Conduct shall be binding on the physical therapist members.

Principle 1

The physical therapist should respect the dignity of each individual with whom he is associated in the practice of his profession.

Principle 2

The physical therapist should comply with the law and Association policies governing the practice of physical therapy.

Principle 3

The physical therapist should accept responsibility for the exercise of professional judgment.

Principle 4

The physical therapist should maintain optimal standards of professional judgment.

Principle 5

The physical therapist should respect the confidence imparted to him in the course of his professional activities.

Principle 6

The physical therapist should seek reasonable, deserved and fiscally sound remuneration for his services.

Principle 7

The physical therapist should provide accurate information to the consumer about the profession and services provided.

Principle 8

The physical therapist should not engage in any form of self-aggrandizement.

Principle 9

The physical therapist should accept responsibility for reporting alleged incompetence, illegal activities, and/or unethical conduct to the appropriate authority.

Principle 10

The physical therapist should conduct himself in all of his affairs as to avoid discredit to the Association and to the profession.

Principle 11

The physical therapist should give his loyalty and support to the American Physical Therapy Association in its efforts to attain its objectives.

(Revised June 1977)

APPENDIX I

THE UNIVERSITY

Fredric Norstad

It may be well to begin this presentation with a preamble setting forth the concept and something of the history of its development. The concept of "The University" has grown out of personal experience. It dates back to 1932 when I was a student at what is now known as Roosevelt University. In its earlier days the school was marked by a good deal of educational experimentation and was generally regarded as liberal in the extreme. Whatever else it was, it certainly provided a stimulating academic and social environment.

This spirit of freedom at the school made me bold enough to express a criticism of the whole educational process. While having lunch one day with Dr. Waldemar Junek, my professor in Anthropology, I argued that undergraduate education at least was like a smorgasbord served on a rapidly revolving lazy susan from which it was necessary to grab what you could while you could get it. My main criticism expressed that day was that little help was given to the students in establishing direction or even an awareness of the context in which his educational experience was to take place. I had told Dr. Junek that I needed to know the cardinal compass points of life—that I would like to know the smallest and the largest and I needed to know the beginning and the end of life. Dr. Junek was most cooperative in facilitating my personal search for compass points and direction.

I proceeded to drop out of school temporarily and with Dr. Junek's help managed to secure the use of a microscope, slides and other material for microscopic examination. The purpose was not so much to gain knowledge and information as it was to be confronted by this dimension of the universe. I had looked through microscopes before but always with a specific intent to learn something or to see something prescribed by a professor. Here was a different dimension entirely. The experience was more meditative than cogitative. Because I did not have to learn something specific, I was free to experience in a far more profound way the significance, at least for me, of the microscopic. In this awareness I could feel, and not simply know. It was an experience in awe.

At this point it may be well to take two short detours. First, out of this and other experiences I became aware of how impoverished is modern man in that he has taught himself to confine his interests in the direction of hard facts and the provable. Seldom does his blood warm with a stirring sense of wonderment and awe. If, for instance, it is his adrenal glands that are involved, they must be shriveling and left useful only for the implementation of his fears and hostilities (or could it possibly be that man satisfies his need for awe by associating himself directly or in vicarious experiences with violence.) Without a capacity for wonderment and awe modern man is poor indeed and something has gone out of his humanity.

Detour number two takes me to the meaning of the word university. While meditating over a microscope and while experiencing a consequent sense of awe, I became conscious of the unity and oneness of creation—that I was a part of it. This development had its roots in my own religious experience and commitment. Having discovered the wonder of this intra-world it was as though I were asking "What will my Father think of next?" I can remember spending time wondering over "hands" that could make things so small and at the same time could put the stars in their places. Even before getting at the telescopic scene I was already developing an awareness of the basic primary meaning of the universe. Until those moments the word universe called attention to those things that were far away, far-reaching and strange. My experience with the microscope and later with the telescope tended to pull it all together and I began to see the universe as unitary, total and indivisible. In using the term university to describe what I am proposing, I am simply taking its original meaning "universitas" from the Latin meaning totality. Like the Greek word "oikos" from which our word ecology has come, it proclaims indivisibility and wholeness. To apply the word university to a small and relatively unstructured

learning experience is to ignore its present reference to certain educational types and to apply the term to something more fundamental, more elementary and surely more personal. In other words, if a school develops around these thoughts and in implementation thereof, the word university will not describe a federation of "colleges" into an organized whole but will be used to call attention to the basic principle of the unity of the universe—the unity of the creator with the creation and the created with the creator.

My second two week escape from "educational reality" was to contemplate the stellar universe. I was given access to libraries and telescopes. I read and I looked. Again it was not the facts or their orderly accumulation that was primary. It was again an experience in awe. It was a chance to "eyeball" the infinite. There were times when I experienced a momentary confusion. It was as though I was back looking through a microscope. I would have to remind myself that what I was looking at was light years away and not immediate—as immediate for instance as the micro organisms I had "experienced" at the microscope. Again it was an experience in awe. It was a little easier to understand the mood of a shepherd boy who "considered the heavens." David obviously knew nothing about light years or degrees of magnitude or the fantastic velocities of space. He did know a basic meaning of stars and planets—stars and planets that succeeding generations would learn to measure and analyze. He knew or rather experienced their most basic meaning. They were out of the hands of God to whom he could direct a resultant personal question. "In the face of all of this, why do you bother about me?"

This ended the first chapter of my search and I moved on to the second. In the first I found myself standing between the largest and the smallest and felt in some way at least a part of both. The second chapter set up another set of contrasts and had to do with beginning and ending. It had to do with human birth, springtime, germinating seeds and shoots pressing through the ground. It had to do with human death and falling leaves, decaying stumps, things returning to the ground from which they had come. The mode of the search was the same, namely to experience, to contemplate, to meditate, to be confronted. I spent more than a month at Cook County Hospital watching babies born and striving to pick up the weakening pulse of dying persons. At 9:30 I may have watched a baby come into this world and heard its first cry, and watched it take its first breath and at 10:30 called the nurse's attention to the fact that the old man with whom I was sitting was no longer breathing. The jarring contrast between life and death, between being born and dying, carried me far beyond those two extremes. The genes in the body being born could be traced to Adam and faith in the concepts of immortality and eternity were rapped up in the experience of the moment. Once again the bottom line was a sense of awe based not only in the facts of life and death but in the unitary nature of even these extremes and opposites. To live is to be dying and to die is to live.

After completing these experiences which covered a period of approximately two months I had lunch again with Dr. Junek to report that now I thought I knew something about the cardinal compass points of life. I had learned as it were the north, south, east and west and supposed at least that I was ready to go back to classrooms and curriculum choices and reading assignments once again.

That turned out to be in error. If anything, I was more confused than before. At that time (these were the depression years) we could get into the top balcony of the Civic Opera House for twenty-five cents. While sitting there one evening I became aware of a deficiency in my previous quest. Here was beauty and goodness. It stood in some relationship to ugliness, inhumanity and the bad. Again I left school and for a period of two weeks went in search of the ugly and the bad, the insensitive and the cruel. The locale started out to be West Madison Street and the Halsted and Maxwell area. It also took place in police squad cars and jails. I was permitted to join the police on vice raids. The experience included a couple of nights in the "tank" where I was accepted by skid row drunks as a rather improbable addition to their fellowship. When I vomited they didn't realize that it was their vomit that caused my vomit. One fellow told me that Norwegians just don't know how to drink. It was a jolting, jarring, disturbing thing to find that these people, the poor and the prostitutes, the criminals and the drunks, these were not the worst, but were often only the symptoms of something very bad. To discover here again the indivisible oneness of which I was a part was at the very least a devastating experience. I came to

the inescapable conclusion that I was a part of the worst and in this discovery learned the meaning of Jung's suggestion that when this discovery does take place, we will "deny ourselves a thousand times before a single cock has crowed."

But one hard to define fall-out of that experience was to find that the supposedly bad of this world were really not so bad, that they did not have to be strangers, but that in them I had met my brothers. It was no longer necessary to regard them as fearsome strangers. Many years later I learned a little bit of verse that speaks to this:

"Remember the Word
The Word from this manger
It means simply this
You can dance with a stranger."

Perhaps a combination of fear and guilt had caused me to project on to the poor and the different the image of the bad. Perhaps too I had learned a little bit of what the incarnation is really all about and picked up some ability to dance with strangers and thereby to discover that I am myself not estranged.

Then of course there was the good. I had experienced much of it in all the days of my years but this present experience started while sitting on the old wooden steps of a tenement house on the near west side with children who accepted me and laughed at my stories or opened their eyes to share my senses of amazement and awe when I described the stars. I left them one evening to hurry to the Opera House where the symphony was playing Dvorak's "New World." The sheer beauty of the largo brought forth some honking sobs and some pointed suggestions from the people who objected to a person coming in late, stepping on their toes while finding a seat and then proceeding to cry. Then in the days that followed there was music and poetry and laughter and the sound of waves on the beach and the gospel according to St. John.

The four compass points in the horizontal plane had been helpful but not complete. They are meaningless without the moral. It was necessary to experience depth and height, up and down, good and bad, ugly and beautiful and again to discover the unitary principles which have made it impossible ever since to think in polar concepts about opposites. The universe is indeed universal. It is whole and indivisible. Illusions to the contrary leave us impoverished and superficial. At least to this part of the universe which I call myself, the experience had considerable meaning and significance.

Was it simply a personal phenomenon, an episode in one person's life or is it capable of communication? Can a stage be set where it can happen to others and perhaps without the complete loneliness that characterized my search? Can it be done in a "university" where, let us say, twenty people try to "put it all together" while respecting the meditation and the solitude so necessary to making this quest personally meaningful? I am convinced that one can have the personal together with the fellowship and find them enriching of each other in this experience.



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