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Second Opinion

health, faith, and ethics



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Second Opinion, as its name implies, recognizes that the complexities of modern health care make it increasingly difficult to find the single “correct” action, thought, or method. Each situation is open to a variety of apparently legitimate and appropriate interpretations and applications. But such confrontations with ambiguity need not lead to discouragement. They can instead elicit greater research, discussion, and thought.

By inviting contributions from a wide range of perspectives, *Second Opinion* stimulates interdisciplinary conversations between members of fields relating to health, faith, and ethics. While other publications deal with one or two of these concerns, *Second Opinion* distinctively seeks to address all three. The Park Ridge Center created this publication in the hope that it will help form one public out of a number of related constituencies. This public will not only wish to relate ethics and faith to health issues, but should also, through lively and enlightened interchange, be better equipped to do so.

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Living with Descriptions

Wallace Stevens, the insurance executive whose moonlighting efforts as a poet won him acclaim as America's foremost modernist, once said, "we live in the description of a place and not in the place itself." In one line Stevens had captured a fundamental theme of modernity: how people see things makes all the difference in the world. In fact, the perceptions they carry shape worlds and create structures of meaning into which the places, the situations of modern life are fit.

This first issue of *Second Opinion* is about many things—organ transplants, pastoral care, nursing ethics, new relationships between science and religion, the state of health of modern medicine. At the same time it is about one thing—the descriptions carried by those who enter the world of modern health care. Hospitals, the foremost representatives of that world, overflow with technical, professional, cultural, philosophical, and religious opinions. The people who encounter one another in these ultramodern places live in intricate webs of descriptions which shape their interpretations of what happens to them. Hospital experiences also carry modernity's citizens beyond Stevens's aphorism. Not only do people live in descriptions, they suffer and die in them, using them to shape ultimate human experiences.

In his keynote article for this inaugural issue, **Martin E. Marty**, the historian of modern American religion who doubles as president of The Park Ridge Center, reassesses old descriptions of the relationship between science and religion which have influenced health care in the modern

era. By exploring the traditions, dimensions, and issues of faith, Marty suggests that it may be possible to move beyond the old counterproductive descriptions of the relationship between health, faith, and ethics toward new ones which could, in the long run, make a difference in care for people.

The article by **H. Tristram Engelhardt, Jr.**, a physician and philosopher of medicine, shows how different descriptions of illness have consequences for people who receive and give care. Depending upon the province of meaning one stands within, the alcohol abuser, for example, becomes either sinner, criminal, or sick person in need of either prayer, incarceration, or treatment.

Nurse-ethicist **Mary-Carroll Sullivan** calls attention to the fact that an ancient calling is re-perceiving itself as a profession. This shift from pre-Florence Nightingale understandings of the nurse's place to new professional descriptions has led nurses into a complex world of ethical searching which is making fresh demands upon these essential caregivers.

Second Opinion's interview with **Arnold S. Relman** provides another angle of vision on the theme of descriptions. Dr. Relman, the editor of the *New England Journal of Medicine*, is concerned about the redescription of his own profession during these last years of the twentieth century. Convinced that the dominant cultural values of our time have provided "great inclinations to view all reality as a marketplace," Relman points to a clash of opinions about what the physician is to be.

In "Perspective," **George B. Caldwell**, presi-

dent of the Lutheran General Health Care System, also expresses concern about changing descriptions. In this case, the descriptions of hospitals are changing under the influence of sudden transitions in the health care industry. No longer healing places, these institutions have become, within a relatively short period of time, fixing places, business places, and places of moral questioning.

Don S. Browning, a scholar of religion and psychology, provides an actual example of colliding descriptions when he invites us to consider the inability of a patient and her physicians to transcend the barriers between their value-laden descriptions of the world. Browning suggests that hospital chaplains have distinctive skills and opportunities to discern the rich variety of world views present in any clinical context, to interpret them for insiders and outsiders, and then to find places where understanding can occur.

Chicago Tribune reporter **Jeff Lyon** leads readers into the problematic world of organ transplants where new surgical techniques and wonder drugs like cyclosporine have forced medical experts to redescribe death and patients to stretch understandings of the self. The complex scenario portrayed by Lyon will leave readers pondering the use of such new procedures within old descriptions of human identity.

How does one cross through this complicated landscape of descriptions which interact with, shape, and reshape each other? **Kenneth** and **Sara Vaux** trace instinctive, professional, political, and transcendent pathways followed by those who traverse the treacherous moral terrain of health, faith, and ethics. The Vauxes caution against relying on any one pathway to the exclusion of the others and suggest that within each human being

exists a variety of descriptions and opinions which vie for attention and response.

The first issue of *Second Opinion*, then, is about perspective—about awareness of the places from which people view things and the role of descriptions in determining these places. The issue attempts to provide greater perspective on how humans think and act with reminders about the wide variety of vantage points that intersect in what William James once called the “full fact” of human experience. The articles also call attention to the many other descriptions which have gone unmentioned in the charter issue—an ample warrant for many more volumes of *Second Opinion*.

One task remains before I encourage you to step into the conversation which we are beginning with the first volume. I wish to invite you to join the people associated with The Park Ridge Center in regular conversations about this great problem of perceiving, describing, understanding, and proposing courses of responsible action in the fields of health, faith, and ethics. Clearly other opinions than those offered on these pages are needed if the conversation is to be representative and if the complexity of the modern situation is to be fully grasped. That means you are invited to contribute articles, perspective pieces, and creative suggestions which can promote the quality of the conversation we are seeking to nurture. And join our family of subscribers who through their support and their criticism can help us keep the conversation open, candid, honest, scholarly, lively, and constructive.



James P. Wind, Editor

SECOND OPINION

...in Health, Faith, and Ethics

Martin E. Marty

second: other, another, additional to that which has already existed, taken place, been mentioned. . . .

opinion: the formal statement by. . . an expert, professional man, or the like, of what he thinks, judges, or advises upon a question, or matter submitted to be considered. . . .

Oxford English Dictionary

The second opinion is not necessarily the last opinion. It is another opinion, or an opinion by another. As such it may either confirm, complement, or contradict an earlier one. In matters of *health*, life or death may be at stake. In matters of *faith*, belief or doubt are at issue. In matters of *ethics*, good or evil actions can result. In all three cases, a conflict of opinion can inspire panic or probing. Little has changed since Alexander Pope wrote *Moral Essays*:

Who shall decide, when doctors disagree,
And soundest casuists doubt, like you and me?

Professionals who are doctors often do disagree. Lay people who are casuists, who soundly make decisions over cases, frequently have good reason to doubt. When a medical doctor gives an opinion, a patient or her insurer may insist on another reading of the case. When the religious leader is not satisfying, the congregant may inquire elsewhere. Garrison Keillor turned into fiction what social science surveys confirm about the religious market: "Clarence [Bunsen] is Lutheran but he sometimes drops in at the

rectory for a second opinion.” When a source that regulates conduct is unacceptable, the casuist seeks ways around the rule. Humorist W. C. Fields spoke for his kind in his culture: “I have spent a lot of time searching through the Bible for loopholes.”

I. The Need for New Strategies

Precisely because they are scientists, people who do research in health sciences actively promote second opinions. These may lead to new discovery, and, as it has been said, “Discovery is what science is all about” (Hanson 1958:352). So exciting has been the pace of modern scientific discovery that some researchers dismiss inquiries which do not go on in the laboratory. We are told that after World War II an American visitor toured the University of Göttingen. He heard the German physicist who guided his tour boast about the huge funds to be spent. They would restore the old laboratories and help produce a new scientific future. The visitor knew of Göttingen’s past glories in religious and philosophical thought. Why, he asked, did these go unmentioned when people spoke of the future? The physicist dismissed inquiry in the fields of faith and ethics: “Oh, Theology? Philosophy? *They’ll never discover anything new over there.*”

His attitude expressed what we might call the modern first opinion. In recent years, disagreeing doctors and doubting lay people have begun to promote second opinions in the fields where health and faith and ethics meet. Serious journals and popular media offer rich evidence to show that centuries-old habits of mind are now changing. Many inherited frameworks of inquiry have become obsolete. Creative suspicion within and among the three separate fields leaves experts more ready than before to revise outlooks that they once did not question. Maybe someone *will* discover something new “over there.”

One can point to several reasons for this by no means universal change in climate and outlook. Researchers find that they can follow strict scientific methods and still be open to a larger range of questions than before. This is especially the case when the destiny of human subjects is at issue. Meanwhile religious thinkers, once simply cast on the wrong side of what Andrew Dickson White called the warfare of science with theology ([1896] 1965), are now confident that faith has a bearing on health and well-being. Ethical thinkers have been even more eager to accept the challenges



“Who shall decide, when doctors disagree. . . .”

Alexander Pope



Charles Darwin, once cast, or miscast, as the villain in "the warfare of science with theology."

posed by breakthroughs in technology. They are also alert to the problems presented by a pluralistic society where diverse religious and nonreligious systems of belief coexist.

It is one thing for the three sets of people who wear laboratory coats, clerical collars, or academic robes to be open to the interests of those who are not symbolically garbed as they. It is a more difficult thing to begin to find ways to pursue these interests together. They realize that important differences among the three are not based on merely personal eccentricity or narrowness but grow out of frameworks of inquiry based on complex belief systems. These systems are sets of *"related ideas (learned and shared), which [have] some permanence, and to which individuals and/or groups exhibit some commitment."* Such systems do demand personal commitment, but they also exist partly independently of the passing opinions of those who at the moment make them up (Borhek and Curtis 1975:5).

Five recently proposed terms indicate the current ferment and offer promise that second opinions can emerge. These include the "aim or blueprint" for a science (Maxwell 1974:294); the "disciplinary matrix"; the "research tradition"; the "research program"; and the "research strategy." The first of these needs no explaining. Thomas Kuhn, who coined the second, defined a disciplinary matrix as the "entire constellation of beliefs, values, techniques, and so on shared by the members of a given community" (1970:175, 182, 187). This term could refer to a community of scientists as well as of religious or ethical thinkers. These communities develop traditions of research, our third term (Laudan 1977:81, 120). As for the fourth, philosopher Imre Lakatos claims that "the history of science is the history of research programs rather than of theories" and is, indeed, "the history of competing research programs" (1970:133, 155). The fifth term is directed less to the past, more to the future. Anthropologist Marvin Harris favored the "research strategy," as we do, because it "connotes conscious explicitness." That is, it knows something of what it seeks. Yet as a strategy it does not imply "rigid adherence to a preestablished series of observations and experiments" (1979:26).

Research strategies will permit scholars and members of the public to do more than engage in camaraderie, chatter about sharing, or pursue faddish proposals. Yet finding appropriate strategies is only the first step. Addressing questions of substance in inquiries concerning health, faith, and ethics is the next and more difficult step.

Health and Science

*The modern first opinion gave science a monopoly.
The second opinion finds science more open to
partnerships.*

The first opinion, which shaped the earlier modern research strategies in medicine, gave science a virtual monopoly. No matter what patients believed or how publics acted, to people in the laboratory or clinical worlds, issues of faith or ethics that concerned the whole person often seemed beside the point or even in the way. Witnesses are plentiful. Philosopher Ernst Cassirer was most succinct: “There is no second power in our modern world which may be compared with scientific thought.” Cassirer elaborated this point in terms that helped provoke second opinions. Science, he said, is seen as “the summit and consummation of all our human activities, the last chapter in the history of mankind, and the most important subject of a philosophy of man.” Important debate went on only within scientific circles. “We may dispute concerning the results of science or its first principles, but its general function seems to be unquestionable. It is science that gives us assurance of a common world” (quoted in H. White 1978:29–30).

Gary Gutting, a more recent philosopher, has noted that “science is the only generally recognized cognitive authority in the world today” (1980:1). Physicist and philosopher C. F. von Weizsäcker capped such comments when he observed that science and technology often took on the scope of “a universal religion” (1970:16). That is, people came to believe and trust in it as well as obey it.

Whenever science took on the guise of religion, it also naturally developed guardians of orthodoxy. They dismissed other modes of inquiry as throwbacks or upstarts. Some religious thinkers—one thinks of Wolfhart Pannenberg in Germany or Thomas Torrance in Scotland as examples—insist that theology can be a science itself. Insofar as their claim points to theology’s interest in ways of knowing or offering appropriate pictures of a world, they would appear to be challenging the ordinary use of the term *science*.

Nobel Prize-winner Manfred Eigen and Professor Ruthold Winkler, again at Göttingen, distanced a possible rival field when they asserted:

“Theology, insofar as it expresses itself as a science, satisfies itself for the most part with the transmission and explanation of an historical reservoir of thought. Contributions to the doctrines of morals and mores are today more likely to be expected from those branches of science other than theology” (1975:290). They thereby voiced the old first opinion: “They’ll never discover anything new over there.”

Some of the impulse to challenge such dismissals and promote a second opinion was at first radical and jarring. For example, moved by political, religious, and humane concerns, Ivan Illich coined the concept of *medical nemesis*: the “expropriation of man’s coping ability by a maintenance service which keeps him geared up at the service of the industrial system” (1975:160). Less radical but just as sweeping was the word of Toronto philosopher John O’Neill, who attacked the “medicalization of the body.” He saw it as part of the “bureaucratized choreography of professional heroism: one body probing another in the extension of the finest medical technology in the world.” On these terms, O’Neill claimed, “no scenario is better suited to modern society: its apparent classlessness, its obvious expertise, and its atheistic humanism are not only the very stuff of medical soap-operas; they are our elemental ideology” (1985:118).

Such provocative statements could contribute little to the task of developing new research strategies or partnerships across disciplines. All along, some scientists and philosophers had begun to find partly satisfying ways to promote new inquiry. Anthropologist Marvin Harris describes himself as a “cultural materialist” and has no mission to sound friendly to religion. Yet he was among many who paid honor to the concept that there is more than one way to “know.” He provided some space for religion, even if in a mental box of its own. Harris hinted at a second opinion when he urged that people should keep their fingers crossed whenever they held science to be a “superior way for human beings to obtain knowledge about the world in which we live.” Harris recognized that there are “domains of experience the knowledge of which cannot be achieved by adherence to the rules of the scientific method.” These domains included the ecstatic knowledge of mystics and saints, the visions and hallucinations of drug users and schizophrenics, and the aesthetic and moral insights of artists, poets, and musicians. Harris developed the theme: “One does not obtain knowledge of God and flaming cherubim or of the beauty of a Beethoven quartet by applying the rules of the scientific method to sunsets or by studying the sound waves produced by bows drawn over taut strings.”



There are “domains of experience the knowledge of which cannot be achieved by adherence to the rules of the scientific method.”

Harris, however, was careful to put limits on any new entente between science and other modes of thought. Although ready to “subscribe to the popular belief that science and religion need not conflict,” he urged that one provision be kept in mind: “Science does not dispute the doctrines of revealed religions as long as they are not used to cast doubt on the authenticity of the knowledge science itself has achieved” (1979:6).

Remarks like Harris’s at least blunted the attacks on scientific medicine that had begun to come from professed advocates of humane concerns. These critics were perhaps correct in some respects. Scientists in some centuries may have had to guard the gates of learning against misguided priests, for the sake of human good, but in more recent times it may have been the “priest” and the philosopher, the theologian and the ethicist, who raised the questions or promoted the policies that guard humans from possible abuse at the hands of misguided science. However, after points had been scored from all fields, a time came for common inquiries born of mutual respect. Perhaps novelist Marcel Proust put the case best: “To believe in medicine would be the height of folly, if not to believe in it were not greater folly still, for from this mass of errors there have emerged in the course of time many truths” (quoted in McKeown 1979:11). Many truths—not all the truth, or the only truth.

Faith and Theology

*The modern first opinion led religion to retreat.
The second opinion finds more confident religion
advancing toward partnerships with science and
philosophy.*

The primal opinion with respect to faith and healing antedates science as we know it. It is as old as recorded knowledge. Faith was the root of well-being. It was the fulfillment of creation, the base for promoting human health. Traces of the old ways remain in the modern code word that reduces the whole subject: *faith-healing*. Let it be noted that faith-healing, whether in connection with scientific medicine or apart from it, remains the prime strategy of millions if not billions of humans. Many of these live at the heart of scientific and technological culture. Efforts to connect faith with healing are themselves proper subjects for scientific inquiry, and research strategies



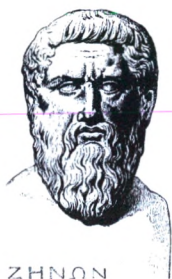
The Kresge Chapel by Eero Saarinen on the campus of Massachusetts Institute of Technology demonstrates that religion has a place even in the midst of one of the world's famous centers of science and technology.

for examining their claims have hardly reached the infancy stage. In connections where science came to be mentioned, however, it often crowded out faith. This put theologians, who reflect on faith, on the defensive. The resultant warfare of science with theology is by now an often-told, oversold, and dreary tale.

Between the assertion of first and second opinions, some religious thinkers began to notice that they were needed at the side of scientists. As theologian Langdon Gilkey noted in elegiac and almost forlorn tones, public respect for notions of reason and progress had begun to waver. Philosophers of science had ever more difficulty making their case for what scientists were doing in isolation, however awesome their achievements in their specialties were. Gilkey described the plight of the religious thinker at a time of such uncertainty. Speaking of the complex of simple belief in reason, progress, and science not as a “disciplinary matrix” but as a myth, Gilkey wrote: it is the “disintegration of this secular myth—not that of the traditional Christian mythos—that constitutes the present religious crisis of American society” (1981:24).

Religious thinkers began to seek approaches that would complement scientific thinking. Many of them, influenced by the work of Ludwig Wittgenstein, settled for a role similar to that assigned them by Marvin Harris. For these thinkers, British philosopher Keith Dixon observed, religious discourse reflects a “particular *form of life* or mode of behaviour which has its own rationale, logic and concepts” (emphasis mine). Faith could be understood only on its own terms. No scientist should try then to reduce religious thought or behavior to something else, in order to explain it away. Religious discourse, like its scientific or ethical counterparts, takes on its own character. It is unique and autonomous; no one can assail it from without. “Aesthetic, scientific, moral, or religious experience is *sui generis* and self-justifying” (Dixon 1980:41–42). Although room does exist for developing research strategies based on this “forms of life” approach, such strategies will not satisfy everyone. In the eyes of many they will lead to mere relativism.

Philosopher Robert John Ackermann was typical of those who wanted to move beyond the idea of seeing the philosophy of science and the philosophy of religion as “separate domains” which allowed only for occasional “border crossings.” The Wittgensteinian “forms of life” approach would produce “boring, trivial and predictable” results. Those who reason



ΖΗΝΩΝ

Plato (427?–347 B.C.E.)



Aristotle (384–322 B.C.E.)



Immanuel Kant (1724–1804)

All ethics, whether religious or philosophical, must account for the ideas of the three great moral philosophers of the Western world: Plato, Aristotle, and Immanuel Kant.

along with Ackermann fear that on such terms faith will always look simply irrational or nonscientific. In respect to epistemology, the science of knowing, theology would be seen as “bankrupt”; faith would rest on nothing more than arbitrary personal and existential choice. Ackermann mourns: “What a religiously abject and defensive position [such an understanding] describes! It can’t begin to explain why some outsider should feel the strength of a religious position, and be drawn to conversion, while others remain unaffected.” Ackermann’s own proposals, shared by any number of philosophers today, all protest against a “crude conception of scientific verifiability” determining all important issues involving human concerns (Ackermann 1985:9–11, 15).

Conversations have been held between scientific and religious thinkers who see parallel issues across the borders, as it were. One conference of scientists and theologians at the Massachusetts Institute of Technology in 1979, for example, used the same mirror on both fields. Their agreed-upon statement, “Faith and Science Complement and Penetrate Each Other,” rested on connections. “Since science cannot finally prove its concepts, it is also basically a confessional [in a way, creedal] enterprise, characterized by ‘faith’ in the intelligibility of nature, in the orderliness of the universe, etc. At the same time, it is an intellectual discipline which is subservient to its object and can therefore be defined only in relationship to that object. In that sense theology can also be called a ‘science.’ In any form of understanding, therefore, there is a faith factor and a science factor, which complement one another” (Shinn and Albrecht 1980, vol. 2:16). Naturally, their arrival at such a paragraph does not mean that all participants agree or should agree with its terms. It does illustrate an emerging second opinion which carries within it the impulse to develop new research strategies.

Ethics and Philosophy

The modern first opinion separated philosophical and religious ethics.

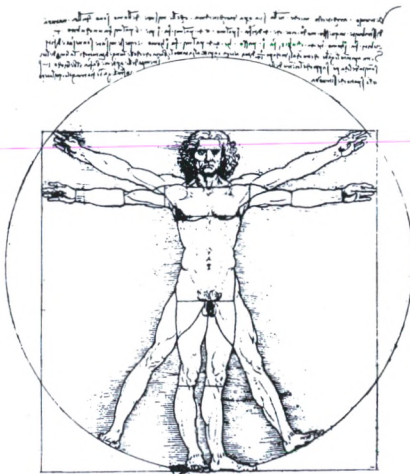
The second opinion finds openings for new relations.

The modern first opinion in academic ethics kept religious faith at a distance just as most sciences did. Theological ethicist James M. Gustafson reported

accurately: “Among the moral philosophers whose works have been taken seriously in the past decades, there are none who would base their ethics on theological principles, whether derived from ‘natural reason’ or from a historical religious tradition.” Indeed, Gustafson continued, “given the basic assumptions of the philosophical enterprise in the modern Western world, this is as it should be.” He observed that through the centuries, while they responded to the divine revelation that lay behind their faiths, most Jewish and Christian ethical thinkers had also found a need to link up with the then-current moral philosophies—Stoicism, Neoplatonism, Aristotelianism, Kantianism, and so on. Yet such linkage itself became a problem “with the more radical secularization of Western culture in recent centuries.” Why? “With the growing knowledge of cultural pluralism and various vital religious traditions, it has not been unreasonable to seek a basis for morality that transcends religious beliefs, one that can be held to by persons holding different religious beliefs and that would appeal to all ‘rational’ and ‘autonomous’ agents” (Gustafson 1981:76).

The creativity, even the urgency, of such quests is most vivid in the world of the clinic. When debates over the legality of abortion are grounded on one hand in specific revelations that most citizens do not share and, on the other hand, in “rational” philosophical systems that not all regard as universal, confusion results. That religious belief and practice can affect patterns of health is clear to anyone who studies the impressive longevity rates of devout Seventh-day Adventists and Mormons who follow certain regimes based on their faith. Yet the modern hospital could not function if at all points it had to be mindful of sectarianism as a base for clinical procedures. That is, there is no special Seventh-day Adventist renology, no particular Mormon brain surgery, no peculiarly Hindu CAT scan, no Buddhist heart transplant method. The hospital is marvelously and, one might say, secularly ecumenical. Could it function if it represented a mere collection of faith-filled tribes, each of which insisted on its own science, its own medical practice, based on its own separate and private revelation from God? When sectarian insistences do occasionally appear, they disrupt medical practices profoundly.

Bioethics is the name given to the new discipline that aspires to common, if not universal, discourse about these concerns. Encyclopedias and curricula devoted to moral discourse about *bios*, biological human life, often pay separate respect to religious interests. Many who specialize in this field



"The general direction of moral philosophy is to make man the measure of all things."

are friendly to them. Yet as a whole the discipline strives to be consistently philosophical. Gustafson summarizes this: "The general direction of moral philosophy is to make man the measure of all things" (1981:81).

The results of such measuring have been at best partial. Gustafson accurately notes that universalizing ethical thinkers have not even begun to arrive at a "moral theory that would be persuasive to all rational agents." To people in large religious camps, these efforts instead look like the forming of very small if potent sects or camps of their own, whether "secular humanist" or "neo-Aristotelian" or "consequentialist" or something else. While modest in his hopes, Gustafson recommended paying attention "to the historical traditions out of which have come a great deal of the motives and goals for action among humankind" (1981:81–82). Needless to say, most of these traditions have been, at heart, traditions of faith.

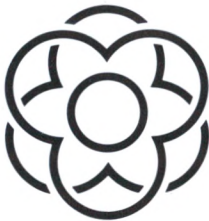
Where anti- or nonreligious ethical thought thrives, moral philosophers are careful to protect their turf. Keith Dixon represents them well when he says that to such thinkers, religion is a kind of peculiarity that can never be the basis of moral conduct. "The atheist and methodological neutralist have this in common: they believe that religion should be a datum to be explained." It cannot provide or even contribute to ethical systems in a modern, scientific, and especially pluralistic society. On the other side, Dixon notes, the person of faith "sees religion as a human experience which needs to be *understood* on its own terms" (1980:105). Such a vision can also lead to efforts at turf protection. Some advocates of faith traditions argue that these, typically the "Judeo-Christian" one in the American case, need legal protection against the ethical "secular humanism" they now think is privileged.

Sometimes those who for political or faith-full reasons make such claims get the cold shoulder from the theologians themselves. Just as Gustafson has shown that Western religious ethics has always needed philosophical partnerships, so some scholars stress that often much interest in particular motives for ethical action arises within religious traditions. Yet these traditions do not aspire to offer universally valid bases for good acts to those who do not accept their divine revelation. They have no special ethical content for people outside their tradition.

An extreme illustration of this modesty, even parsimoniousness, in the majority tradition of the West concerns the New Testament claims that stand behind Christianity. Biblical scholar Jack T. Sanders offered what he called "negative conclusions" about New Testament aims to speak universally. He found only three brief and almost accidental moments when the

writers in its canon reached toward a universally applicable ethic. One was in the familiar Good Samaritan story, where the “love commandment” was uttered. Second, in its concrete ethical directives the Epistle of James momentarily expressed a humane reaction to a developing Christian theology that appeared exclusive and inhumane. In one passage of one epistle, 1 Corinthians 13, Paul did not let thought about the end-time obscure the “qualitative transcendence of love,” which outlasts history. Those three cases were all. There was not a fourth (Sanders 1975:129–30).

To begin with that chilling dash is not to suggest that all biblical and religious thinkers in Sanders’s tradition would be quite so radical. Yet it does put others on the alert: exactly how does this majority religious tradition make its case in the academy or civil society without an appeal to some sort of reason apart from a specific divine revelation that not all fellow academics or citizens share? Such an approach helps assure that emerging research strategies will be appropriately modest and realistic. Today people who are cheered by the promise of second opinions in health and ethics can be tempted to make exaggerated claims about wholistic approaches without noticing the hard work it takes to make actual and durable advances. Francis Bacon had an appropriate word for such a situation: knowledge, he said, should be not be “supplied with wings, but hung with weights, to keep it from leaping and flying” (vol. 4:97). Even weighted down, however, it can move.



The sixfoil, symbol of The Park Ridge Center, resembles a rose with six leaflets or petals radiating from a common center. As a rose, it connotes the health and growth of a living thing (Ecclesiasticus 39:13). Yet its interwoven lines suggest the connected interests of the Center, “Health-Faith-Ethics,” and the “Dimensions-Traditions-Issues” of faith which characterize its fields of research.

II. A Picture of a New Strategy Respecting Faith

Faith Traditions: Their Potential

Any effort to devise research strategies to connect faith with health and ethics naturally begins by exploring what faiths as traditions have meant or can mean. The inquiry begins where Gustafson suggested it might, by paying attention “to the historical traditions out of which have come a great deal of the motives and goals for action among humankind.”

With confidence in such a beginning, an international company of scholars five years ago embarked on Project Ten. It has now become one of three elements in the new Park Ridge Center. Scientists, theologians, and ethicists set out to assemble knowledge of what was in the traditions. Then

they began to assess them, severally and in combinations and by comparisons. Now they seek to relate them in clinical and other circumstances.

A venture like Project Ten is obliged to consider certain basic issues. Prominent among these are concepts of *well-being* (in contrast to what John Ruskin once called “illth”), the role of *sexuality* in various faith traditions, and the way these traditions shape the *passages* of life. Most of these traditions focus on *morality*, on human *dignity*, and thus on *justice*. Mental *sickness*, or *madness*, has also been pondered in such traditions. Most with longer histories have been concerned for *healing* and *caring*, just as they have developed traditions of dealing with *suffering* and *dying*. Suffering and dying are examples of areas where faith may “know” particularly what science and ethics attend to in differing ways (Marty and Vaux 1982:187). Those responsible for Project Ten have undertaken ambitious steps to disseminate their findings; this journal is, in part, one evidence of the achievements.

What the scholars immediately learned was the need to protect the integrity of the several disciplines while also taking risks in exposing them to each other. It might be unfair to speak of the model as “interdisciplinary,” because that term often refers to policies that degenerate into superficial chatter and mere good will. University of Chicago president William Rainey Harper called for “intermigration” of groups of scholars and professionals, a concept more durable than the mere border crossings that Robert John Ackermann dismissed. They keep a responsible base in their own fields, but they actually have something to say to and hear from others. They formulate and appraise elements of traditions together.

The research strategy of Project Ten can draw terms from an admittedly eccentric essay by philosopher Eugen Rosenstock-Huessy, who migrated from Europe to America and was an “intermigrator” across disciplines. He tried to summarize the history of Western thought in three Latin phrases. First, in the rise of medieval Christendom and the university, came the voice of Anselm: “Truth is divine and has been divinely revealed—*credo ut intelligam*,” which means that I believe in order to understand. Second, in the rise of modern critical thinking and the university world it helped found, Descartes: “Truth is pure and can be scientifically stated—*cogito ergo sum*,” “I think, therefore I am.” Now a third mode was necessary, for which Rosenstock-Huessy immodestly offered his own formulation: “Truth is vital and must be socially represented—*respondeo etsi mutabor*,” “I respond although I will be changed” (Rosenstock-Huessy 1970:2, 12).

The third perspective builds on either of and perhaps both the first



These three volumes have been published by The Park Ridge Center in the Health/Medicine and the Faith Traditions series (Crossroad). Forthcoming volumes will address the Jewish, Islamic, Wesleyan, Greek Orthodox, Hindu, Secular Humanist, Anglican, Christian Science, and Mormon traditions.

and the second ones, but is in any case a necessary component in any future strategies. To employ it is not to make claims for or give promise of anything like a new synthesis across fields. It asks for something much more modest at the beginning. A physician who participates in Project Ten once ventured that the engagement of scientific medical professionals with those who made faith claims would yield an advance in human understandings and care if at first nothing more occurred than the mutual preliminary assurances that "Hey! It's all right to talk about such things around here." Not to do so would be unscientific because faith is ordinarily an element in the life of the person who seeks or would retain health and well-being.

That the traditions of faith are surviving, indeed are resurgent, should be evident to anyone who sees the words Sikh, Shi'ite, Fundamentalist, John Paul II, Jewish, Muslim, and their kin in the daily headlines. That the faith traditions have much to do with health and well-being is equally evident to anyone who deals closely with people who belong to them. Yet there are reasons to make modest claims about these as well. When the Project Ten researchers began to see how these traditions apply in the clinics, results were ambiguous. In one study of "clinical pastors" and hospital chaplains, professionals who should embody at least vestigial faith traditions, Glen Davidson (1984) found little evidence that they and their patients were overtly drawing upon these resources in their daily dealings. Similarly, in a very limited early study by Joseph H. Fichter, S.J., *Religion and Pain: The Spiritual Dimensions of Health Care* (1981), it was difficult to see exactly how people who endured intense pain relied upon their faith in order to cope in distinctive ways. Impressionistic and informal probes often suggest more vital roles for faith traditions. It will take much careful research before one can speak with confidence. In the meantime one might have to say, "What we don't know *can* hurt us." There would be pathos if people did not draw upon what their own or others' traditions could contribute to healing. There could be tragedy if they misapplied these traditions to the detriment of their well-being. We hope to "discover something over there" as the project continues.

Faith Dimensions: The Promise of Discovery

If what we don't know can hurt us, research on a second aspect of faith is even more urgent. The modern first opinion held that faith is only a matter

of particular temples and sectarian dogmas. It was part of the decor of life, not its stuff, and would disappear as reason progressed. Yet clearly the term *faith* is not restricted to its place in separate traditions. There is also a generic understanding of faith. Many anthropologists, psychologists, and theologians speak of it in such a way when they connect faith with health and ethics. They have common public usage and the dictionary on their side: faith is “belief, trust, confidence.” Not until the *Oxford English Dictionary* gets around to its third and fourth definitions does the term harden and grow specific. Then it is “belief in the truths of religion” and “that which is or should be believed.”

The alert therapy-minded believer, the wholistic healer, and many a scholar of religion explores the ways in which basic mental attitudes—many of them, at heart, religious—connect with illness or health. They do their work in a field where hyperbole, quackery, and fads often rule. At the same time, they find solid reasons to pursue faith as what Erik Erikson called “basic trust.” He considered it a human universal. Some critics thought he was reducing faith to some other property, seeing it as “nothing but” this or that psychologically grounded drive. Yet it need not be regarded that way. Erikson himself asked, “Is the religious experience and formulation a creative course, a source of renewal that is unique and providing power and insight otherwise not available?” If so, it can further both health and healing. Erikson asked another question to be reckoned with in developing research strategies: “Do religions partake of man’s ability, even as he regresses, to recover creativity? At their creative best, religions retrace our earliest inner experiences, giving tangible forms to vague evils, and reaching back to the earliest individual sources of trust. At the same time, they keep alive the common symbols of integrity distilled by the generations” in the form of faith traditions (Erikson 1958:264–65).

Erikson’s best-recognized counterpart in religious thought was the late Paul Tillich, who posited a basic faith that underlay, sometimes competed with, and generally looked more valuable to him (in respect to well-being) than the “belief that” something or other was true. This faith played a much larger role in the search for well-being that Tillich associated with “the courage to be” (Tillich 1952:171–76; 1957:4–8).

Erikson and Tillich represent but one aspect of dealing with generic “faith as trust” and of connecting it with well-being. Some scholars are wary of the diffuseness of the term and the confusion it can breed. In the face of dramatic claims that religious (or other) faith has direct effect on malignant

cells, broken limbs, organically disrupted means of hearing or seeing, there is reason to fear that those who apply faith and then fail to be cured will blame themselves for weak faith. As Dr. Barrie Cassileth (1984) said after one study reported on in the *New England Journal of Medicine*, "Certainly, there is a role for mental state and emotional factors in illness. We just don't know what it is. We know that it is not a cause-and-effect relationship."

"We just don't know. . . ." It may never be possible to acquire the means for judging the supernatural claims of the faith-healer. It is quite likely, however, that researchers can begin to work out elaborate means of measuring the role of "mental state and emotional factors," including faith as basic trust. Then those who move from laboratory to clinic, from study to situations of care and cure, may be able to promote promising connections and to discourage those that lack prospect. We call such inquiries a pursuit of the faith dimensions of life.

Faith Issues: The Challenge of Religion in Ethics

Although measures of faith dimensions to date are meager, it is dawning on the public and on scholars that in most bioethical cases, religion has to be dealt with as a controversial factor. Mormon hospital practice played a part in Barney Clark's artificial heart implants; Adventist clinical decisions were an issue in the celebrated "Baby Fae" case; the Roman Catholicism of her family, priest, and church was a page-one item in the Karen Quinlan case.

Similarly, a politician would be unwise to fare forth without knowing how large a role religion plays in debates over abortion, euthanasia, the allocation of scarce resources, justice in distribution of care, genetic experiment, *in vitro* fertilization, termination of treatment, and other situations where someone "plays God." The very colloquial term suggests that philosophical ethics must engage the question. Since this is the most developed field, we postpone for other pages and occasions further illustrations. Indeed, unless one is careful, the whole agenda of faith relating to health can easily be collapsed into ethics, so alluring is the field, so high are the stakes.

III. Conclusion: Strategies for Research and Care

Second and later opinions usually have a practical point. One is tempted to hurry toward them, to apply them to care. I have resisted the temptation to detail therapeutic promises. This article presents a view of research strategy for centers of study and the Park Ridge Center in particular; for encyclopedias, conferences, scholarships, collaborations, and lonely pursuits. In a culture with thousands of clinical and religious institutions, more attention should be paid those who seek systematic *understandings* that lie behind or that issue from both care and cure. Premature or obsessive concern for instant cure can actually deprive the culture of resources on which it must draw for longer-term care.

A voice from the scientific field helps make the point. Dr. Lewis Thomas of the Memorial Sloan-Kettering Cancer Center is a gifted and public-spirited scientist with a good reputation for care. Yet at the Whitehead Institute for Biomedical Research in Cambridge, Massachusetts, he chose to urge that “medicine needs more research, not more ‘caring.’” Perhaps the focus of that speech was more narrow than those who deal with the wholistic needs of those who are not patients—or even of those who are!—might like. Yet Dr. Thomas wonderfully cleared the air and the head when it came to specifics: “Remind the critic that the disease is the main point, not the only point but the main point, of the encounter between physician and patient.” How understand disease? Through caring? To some extent, but only to some extent.

Research: that is the need. One does research in order to pursue social values, for its potential impact on illness and suffering, for intellectual pleasures, and, legitimately, for the fun of discovery. “I’ve never known a period of such high excitement and such exuberant confidence,” Thomas said of his field. The best of what is now emerging there was not even envisionable as recently as 1972. Research is the “wildest of all human activities.” His conclusion matches hopes for the connection between the academy and the clinic in fields of faith and ethics as well: “It will make an enormous difference to the practice of medicine if we can keep the basic biomedical science going and keep it coupled as congenially as possible to clinical research” (Thomas 1985:85–87).



“Medicine needs more research, not more ‘caring.’”

—Dr. Lewis Thomas

Developers of bioethics have expressed some of this exuberance, and, when it comes to connections with health and ethics, so have theologians. By design and by serendipity alike it is possible that in new partnerships they *will* discover something new over there. The role of faith is so vast in respect to conflict and concord past and present, to ignorance and knowledge, to suppression and discovery, to despair and hope, to “illth” and health, that religious thinkers have begun to find new reasons for promoting a second opinion. The doctors among them will disagree and their casuists will doubt. They will thus express a key element in research, an element in strategies that will promote discovery. Some of what they come up with will find its way to a public through the journal which you are reading. By now it should be clear why it is called *Second Opinion*. ☉

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The illustrations accompanying this article show artists' depictions of suffering and illness. Andrea Mantegna's fifteenth-century drawing portrays Hercules strangling the Hydra, graphically representing the battle between humanity and disease.



The *Social* Meanings of Illness

H. Tristram Engelhardt, Jr.

All of us approach reality through frameworks of interpretation which help us, if not to control reality, at least to place it in human categories. Having a shared framework for understanding the forces of nature and their significance renders the world around us less alien. But more than one such framework exists. People who possess a particular, taken-for-granted world view carry with them a map of that life-world which provides a guide to experience, including the experience of illness. Because the reality of illness can be construed in quite different ways, it behooves those within the social institutions that deal with ill persons to study the values, concepts, and images through which illness is encountered.

A historically and culturally unconditioned appreciation of illness is practically, if not theoretically, impossible. As the contributions of Ludwik Fleck and Thomas Kuhn to the history and philosophy of science and medicine have shown, there are no such things as neutral, naked, or bare facts. Facts always appear already

interpreted within the embrace of theoretical explanations, whether or not these explanations are formally or informally developed as scientific accounts. In addition, they are given to us already laden with values, and they appear always in a sociohistorical context. There is no timeless theoretical or descriptive account of reality, or at least there is no such interpretation available to humans. This is particularly true of medical facts.

The history of syphilis provides a classic example. Fleck's ([1935] 1979) history of the disease from Fracastorius to Wassermann amply demonstrates that *syphilis* has no timeless meaning; that which is identified as syphilis changed radically in the nearly four centuries of his account. These changes depended not only upon shifts in theoretical perspectives but on sociocultural understandings of the disease. Thus the reality of scientific facts is as much invented or created, as discovered, and facts are always expressed in the thought-styles of the groups that pursue them.

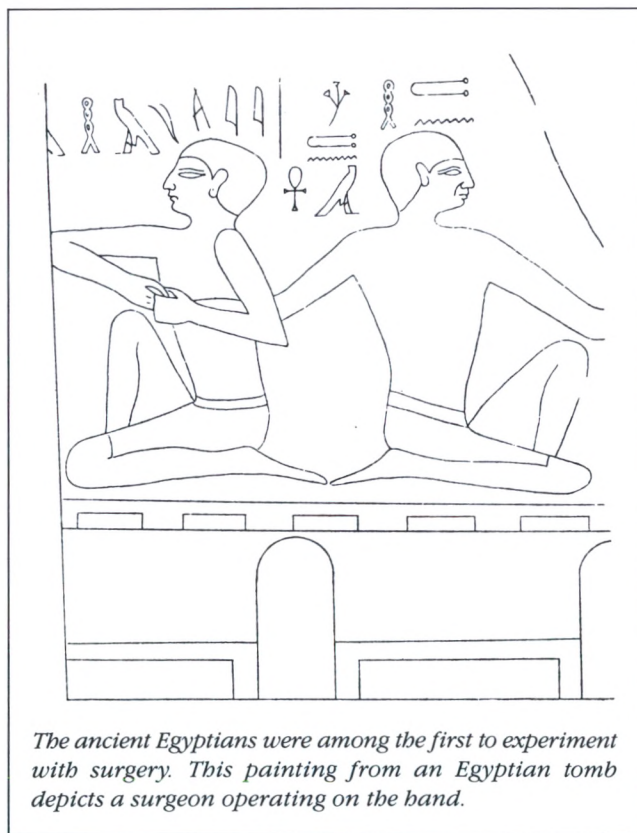
These points developed by Fleck with respect to medicine inspired Thomas Kuhn to apply them to the natural sciences. Thus, as Kuhn (1962) indicates, there is no univocal sense of oxygen. If one holds that it is Priestley (1733–1804) who discovered oxygen, one must recognize that Priestley thought he had isolated dephlogisticated air (according to an eighteenth-century view that proposed the phlogiston theory of combustion); if one credits Lavoisier (1734–1794), one must acknowledge that Lavoisier believed he had discovered the necessary condition for acids (Kuhn 1962:39–40). If their claims are understood narrowly, both investigators could be considered in error. Such qualifications will be necessary each time atomic theory develops further.

The issues are more complex in the case of medicine. Unlike the natural sciences, applied sciences such as medicine have major non-epistemic interests. Medicine approaches the world not simply to understand and explain it but to master it. From treating pain to providing cosmetic surgery, medicine intervenes not so much to know truly as to cure and care well. Physicians are therefore motivated more to classify the realities of disease and illness in ways useful to curing and caring than to knowing truly. They will accept ways of construing reality that have great instrumental value, even if they may not be natural classifications. Consider, for example, the difference between the periodic table and the various international classifications for the stages of carcinomas. The first is meant to disclose something about reality itself. The second is meant primarily to provide useful distinctions for making predictions and for instituting treatment; the boundaries between the different stages do not reflect reality as it is in itself (Lindahl and Nordenfelt 1984).

In addressing the illnesses of men and women we will need to look not only at canonical appreciations of scientific facts by leading physicians and biomedical

scientists but at the ways in which illnesses are viewed by particular groups of patients. Fashioned by a given community's understanding of medical science, the facts of illness may appear quite differently from the way they appear to well-trained physicians. Recent studies of causal explanations of disease among working-class individuals come to mind (Blaxter 1983). All groups see the world as held together by their own reigning, taken-for-granted, causal explanations.

In approaching the problem of illness, then, we



must be extraordinarily sensitive to the ways in which illness is understood within various theoretical and evaluative frameworks. We must also remember that medicine is only one of the many social institutions concerned with illness; law and religion have their own elaborate explanatory structures for illness. In the insanity defense a judgment of mental illness is available to both medicine and the courts. What counts as a mental illness for a psychiatrist is determined by reference to a set of assumptions about medical explanations and avenues of treatment. Mental illness for the law, on the other hand, is interpreted through a framework of concerns about blame and praise, criminal intent, retribution, and the right to impose treatment upon the unwilling. Consider how excess drinking can variously be seen as the sin of drunkenness, the crime of drunk and disorderly conduct,¹ and the disease of alcoholism (American Psychiatric Association 1980:169–70; see also Jellinek 1960). Depending upon the integration and cooperation of the social institutions of religion, law, and medicine, one might pray for the individual, arrest the individual, or treat the individual with Antabuse—or perhaps do all three.

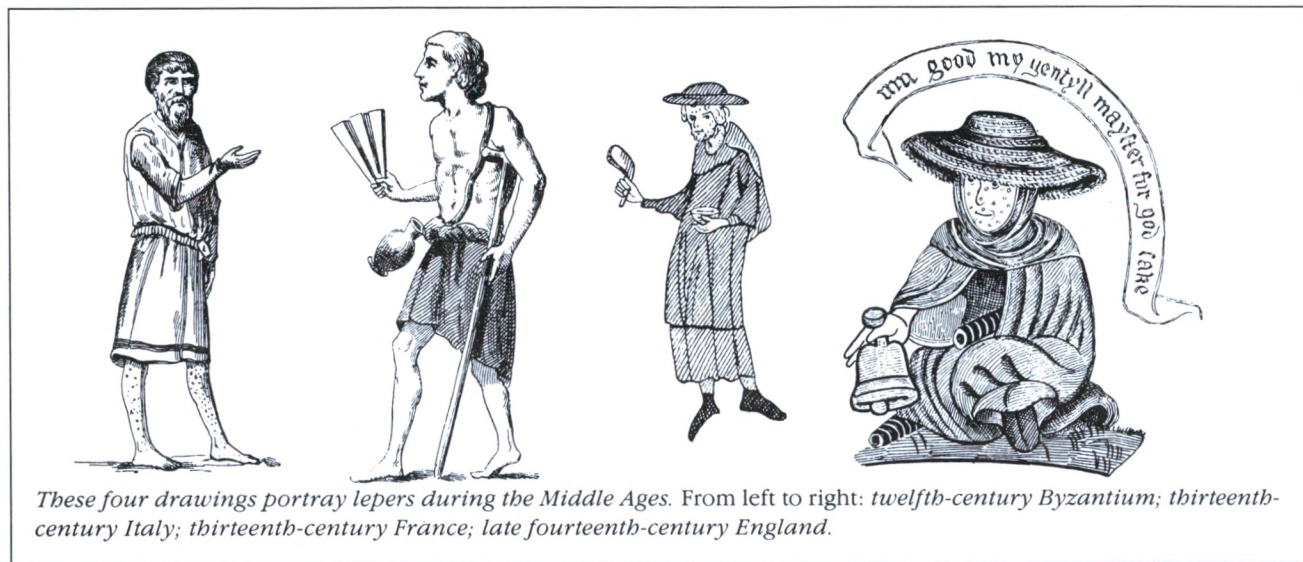
The phenomena of *illness* are less medically interpreted than the phenomena of *sickness*: there is a sense in which being ill is not yet being sick. The distinction can be appreciated if one examines primitive societies where illness combines elements of what we would associate with disease, social transgression, and divine punishment. To see illness as sickness is to medicalize it, to presume that the techniques and abilities of medicine can make it better. Of course, as Ivan Illich (1976) has shown, there are circumstances where phenomena have been improperly, uselessly, or with inordinate cost medicalized; such problems should have been solved

outside the embrace of health care institutions. The world is full of complaints, only a small number of which fall to the charge of medicine. In understanding illnesses or any particular illness, one needs to understand why that illness comes under the purview of health care. Moreover, because phenomena are complex, it is important to notice which element of an illness is medicalized and which remains in the embrace of other social institutions. Which elements, for instance, constitute the proper domain of religion or the ministry?

A few caveats are in order here. When a phenomenon is appropriated by two social institutions, such as medicine and religion, one must determine the extent to

Medicine approaches the world not simply to understand and explain it but to master it.

which the interpretations are coordinate or the extent to which one approach is subordinate to the other. In the Middle Ages, when distinguishing mental diseases from possession by the devil was seen to be important, exorcists were considered coordinate with physicians. However, when a chaplain joins the health care team, religion is often subordinated to the aims of medical treatment. Physicians and nurses may welcome the minister not necessarily because they hold that religion has a special contribution to make on its own but because they hold that the minister can in fact aid in the *medical* treatment of the patient. They may assume that the minister will, in this particular case, be more successful than others in explaining to the patient what is at stake and thus in gaining the patient's compliance with the treatment. Or they may assume that the minister will be able to calm or reassure the patient and thus have an important impact upon the level of the patient's mor-



bidity. Using a minister as part of the health care team then becomes a part of good medical treatment. It is therefore important to attend to the ways in which an illness is brought under the medical model and rendered a sickness, or brought under the religious model and rendered an instance of the elaboration of divine providence.

One must be very careful in using words such as *medical model*. *Medicine* is used here to embrace all or nearly all that is done by health care practitioners. Physicians, dentists, psychoanalysts, physical therapists, nearly all nurses, and a great proportion of occupational therapists employ the medical model, in the sense that they presume they are addressing phenomena beyond the immediate volitional control of the patient or client which can be traced to physiological or psychological causes occasioning unacceptable pain, disability, deformity, or death. By understanding their causes, medical

professionals can aid in the cure, treatment, or prevention of those phenomena. The medical model can be contrasted with the legal model, which construes phenomena in terms of responsibility and liability, and the religious model, which construes reality at least partly in terms of supernatural causes and ultimate destinies. The medical model is a special application of the scientific model. It brings with it a number of presuppositions regarding the mundane character of medical events, presuppositions as old as Hippocrates' rejection of epilepsy as a sacred disease. In holding that epilepsy was not "any more divine or sacred than any other disease, but has a natural cause, and its supposed divine origin is due to men's inexperience," Hippocrates was committing himself to a natural scientific model of explanation, though his notions of natural science differed in many respects from ours. By contrast, in the Hippocratic work "Dreams," the author admits a

religious model of explanation in acknowledging that some things are divine; he adds, though, that “prayer indeed is good, but while calling on the gods a man should himself lend a hand” (Jones 1959, vol. 4:423).

Phenomena move through various stages in being recognized and interpreted. One can have pains and problems without ascribing to them medical significance. Only later are they seen within medical

In the Middle Ages, when distinguishing mental disease from possession by the devil was seen to be important, exorcists were considered coordinate with physicians.

presuppositions as warrants for treatments (or within religious terms as reasons for prayer). To see a complaint as the kind of thing that medicine can make better is to isolate an illness as a sickness by relating it to possible medical explanations, and tying it to some out of a complex cluster of human desiderata. Headaches, broken bones, blindness, disfigurement, unwanted fertility, unwanted infertility, premature death, and athlete’s foot—all claim the attention of health care practitioners.

In interpreting such phenomena one finds an interplay between a domain of things to be explained and treated and a domain of explanations and bases for treatment. The second, a world of theory, reaches out and molds the illness into a sickness, even if this molding results only in recognizing a cluster of findings as a medical complaint, as a recognizable warrant for treatment. Phenomena congeal into syndromes, into repeatable recognized clusters of findings, signs and symptoms that shape a medical problem. As the explanatory power of medicine increases, it collects within the syndrome findings that would in the past not have been thought

related. Tuberculosis, for example, brought together under the rubric of a single disease numerous diseases ranging from phthisis to king’s evil. An explanatory account allows one to see the relatedness of things and therefore constrains one to redescribe reality.

Medicine also imparts a cluster of evaluative presuppositions. Pains are, all else being equal, to be eliminated, not suffered through in order to save one’s soul or to release the poor souls in purgatory. Pain, disability, and deformity are, as far as possible, to be prevented and avoided, and death is to be postponed. In addition, presumptions are often made by medicine regarding what is normal physiological or psychological function. Such judgments surface, for example, in discussions about the status of homosexuality as a disease (Ruse 1981). But commitments to natural norms are not intrinsic to medicine; they are remnants of an Aristotelian world view that was imported into Western consciousness—in part through the Roman Church and Scholastic philosophy—and helped to shape the ways in which a sickness or deformity is experienced.²

Besides giving the patient a new role as a sick person, illness, since medicine is interventionist, provides a warrant for casting the patient into a therapy role (Engelhardt 1976a, 1976b; see also Caplan et al. 1981). Talcott Parsons recognizes in the sick role the extent to which sick individuals are not blamed for being in the state of illness, are excused from certain social responsibilities, and are enjoined to seek treatment, with the consequent acknowledgment of a group of therapeutic experts (Parsons 1951, 1957, 1958a, 1958b). An individual acting in anticipation of having a medical problem, such as a traveler being vaccinated against cholera or a woman receiving an IUD, likewise enters into a therapy role, even though it is preventative therapy that is in-



The doctor in this medieval woodcut places a bezoar on the sores of a rabies victim. The bezoar was a stone believed to contain magical powers that combatted poison and disease.

volved. Each role establishes a pattern of rights, responsibilities, and social expectations.

There are three points to stress here. First, patients (clients) are placed in a variety of therapy and sick roles within the social institutions of health care. To understand a sickness, one must understand the therapy role or sick role it elicits. Second, sick individuals receive different social roles from health care practitioners than

they do from ministers or from officers of the law. To understand the interrelationship of religion and medicine, one will need to study these contrasts with care. One will also need to recognize the competition between the two, competition visible in the short quotations from the Hippocratic works "The Sacred Disease" and "Dreams." Finally, medical language is neither simply descriptive, explanatory, or evaluative: it creates social reality by casting people into a social context (Engelhardt et al. 1979; Engelhardt 1981). Just as the sheriff creates social reality when he deputizes an individual or arrests an individual, so also a physician or health care worker creates a social reality and a therapeutic niche in recognizing a set of phenomena as a disease or a legitimate medical complaint. Such actions of physicians and nurses can be compared with the actions of Jewish priests finding individuals to be clean or unclean, or of ecclesiastical committees determining an individual to be possessed by the devil; in both cases social reality is being fashioned.

Knowing that someone has a treatable disease raises a presumption that a reasonable and prudent person will, all else being equal, seek treatment. Compare, for example, the two statements "I've just been diagnosed as having lobar pneumonia and am going to be treated" and "I have just been diagnosed as having lobar pneumonia and am not going to be treated." The second statement requires justification, and this burden of justification is stronger the more the values at stake are shared. The more values diverge, the less clear it becomes whether a particular treatment is necessary. Disputes concerning necessary versus unnecessary surgery come to mind. How serious must complaints about back pain be to justify lumbar surgery? What number of complaints regarding dysmenorrhea justifies a hysterectomy? At times such choices can be put in monetary terms. For example, recommendations that

women only need have Pap smears every three years rather than every year appear to set the value of diagnosing a cancer at around fifty thousand dollars ("Less Frequent Paps" 1982).

Such judgments regarding costs, whether expressed in monetary terms or not, fashion the social world within which illnesses are appreciated as sicknesses warranting treatment. Going to a doctor for treatment is a social endeavor. Patients require an acknowledgment that their complaints merit the care givers' time, trouble, and energies. Medicine thus functions with a set of often implicit assumptions regarding what will count as *bona fide* versus *male fide* claims of sickness, or claims to have treatable complaints. Distinctions between necessary and unnecessary surgery, between necessary and unnecessary tests, reflect these often elaborate cost-benefit choices. Such judgments become controversial when patients and physicians disagree about the explanation of the complaint, the probability of the likely outcomes, or the comparative costs and benefits of the treatment available. Such disagreements can also exist among groups of physicians and health care givers in impeccable standing in the medical community. An illustration is the recent controversies regarding whether one-, two-, or three-vessel coronary disease justifies coronary bypass surgery (Murphy et al. 1977; Braunwald 1977; DeBakey et al. 1979; Hoffmann et al. 1980; European Coronary Surgery 1982; Rahimtoola et al. 1983).

Disputes regarding treatment condition the very characterization of the illness for the patient, and his or her view of what significance the affliction will have. Having a disease curable without surgery is very different from having a disease curable by major surgical intervention. The costs and harms that must constitute the meaning of the affliction for the patient differ. So also with disputes regarding levels of surgical intervention, as, for example, those regarding the efficacy of



In the woodcut entitled *The Syphilitic*, ca. 1496, Albrecht Dürer captured the opprobrium of this social disease.

lumpectomy versus radical mastectomy for carcinoma of the breast (Moxley et al. 1980; Urban 1980). The meaning of the affliction is changed for the patient as she must look forward to either a relatively restricted surgical procedure or a major, often quite mutilating, surgical invasion, which will alter her self-image and possibly her social roles. The kind of therapy which a diagnosis warrants thus contributes powerfully to the ways in which an illness is appreciated as a sickness.

As already suggested, social, cultural, and metaphysical assumptions about the kinds of pains and vexations that are to be tolerated or acknowledged as normal influence the degree to which constellations of

The fullest significance of illness lies in contexts other than medicine.

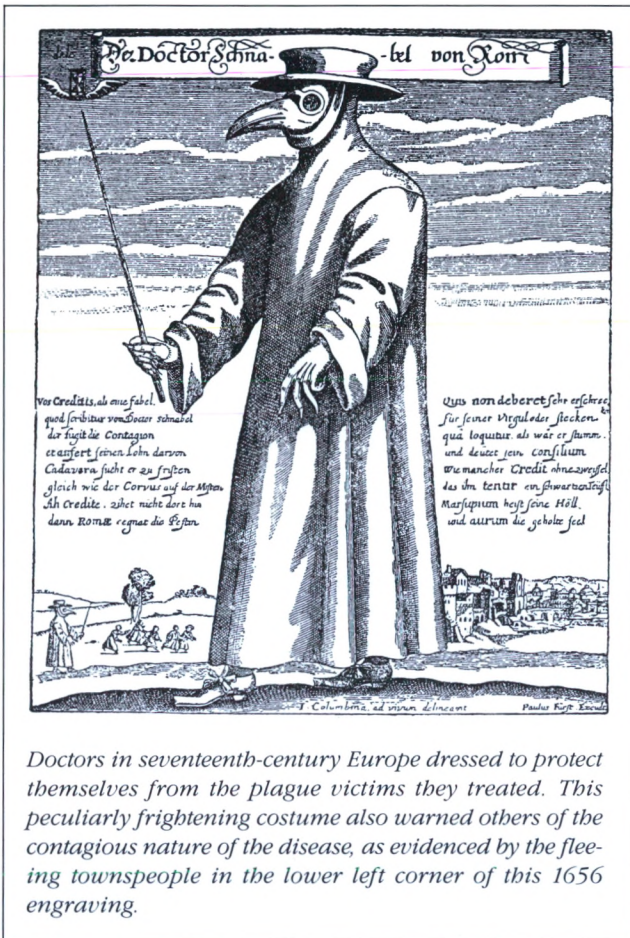
phenomena are identified as sicknesses or afflictions for medicine. Studies of appreciations of pain in Anglo-Saxon Protestants, Italians, and Jews have revealed a cultural component in responses to pain (Zborowski 1952). There are also metaphysical understandings that lead to seeing certain problems as abnormalities, deviances, or perversions. Here one need but compare responses to an individual seeking treatment for his homosexual lifestyle with responses to a heterosexual wishing to function as a homosexual so that he can better adapt to a particular socioeconomic niche.

Finally, medical explanatory models play a role as well in identifying *bona fide* versus *male fide* complaints. As Horacio Fabrega, Jr., has argued (1978), modern technological medicine characteristically accepts as genuine complaints only those that have demonstrated pathoanatomical or pathophysiological underlying abnormalities. Consequently, vague complaints for which there is as yet no clear pathoana-

tomical or pathophysiological explanation tend to be regarded as groundless. The complaints of the worried well or vaguely vexed ill fall into this category. In part, at least, these prejudices are a function of the ideology that came adventitiously to be attached to the major medical revolutions of the nineteenth century. This ideology portrayed anatomy, physiology, biochemistry, pathology, and bacteriology not simply as auxiliary sciences of medicine but as basic sciences, in the sense that they were taken to disclose truly the nature of diseases (Engelhardt 1982). Clinical syndromes were marked authentic diseases only if they were the expression of an underlying pathoanatomical or pathophysiological problem. As a result, the world of the suffering patient and the sympathetic physician was recast in terms of the world of the physician scientist and the laboratory. Pains, for example, were a large category in eighteenth-century medicine. Sauvages, in his 1768 *Nosologia Methodica*, included as a major taxon *dolores vagi qui nomen a sede fixa non habent*, "moving pains nameless in lacking a fixed site" (vol. 1:64). But in the nineteenth century pains disappeared as a major heading in the classification of diseases.

The constitution of the reality of an illness and its appreciation as a sickness is thus complex. But illnesses are not simply sicknesses to be treated by health care professionals. They are also events in the lives of individuals who often possess well-elaborated, metaphysical, and religious views of the ultimate significance and purpose of sickness, pain, suffering, and death. The fullest significance of illness lies in contexts other than medicine.

As with illness, pain also must be appreciated within the various contexts of meaning that endow it with significance (Engelhardt 1980). Pain in itself is nearly undefinable. Consider the difficulties of identifying



Doctors in seventeenth-century Europe dressed to protect themselves from the plague victims they treated. This peculiarly frightening costume also warned others of the contagious nature of the disease, as evidenced by the fleeing townspeople in the lower left corner of this 1656 engraving.

the “painness” common to the statements “it hurts so much,” “it hurts but I don’t care,” and “it hurts so good”; pain for the sufferer, the person with indifference, and the masochist is not the same. For pain to be suffering it must be appreciated in a particular context of meaning, and a major source of such meaning is

the metaphysical accounts of pain and limitation provided by religion.

Religion allows the person with an illness to see sickness as also a chance for salvation, an opportunity to witness to God’s grace, a punishment for past sins, an opportunity to expiate past sins, or a chance to release souls from purgatory. Religions place the pains and limitations of sicknesses within cosmic economies of pain and suffering. What would within the regard of medicine appear simply as surd, blind outcomes of chance or as unwelcome consequences of imprudent

Religion provides an avenue for the social mastery of illness. It both contrasts with and complements medicine’s attempt to predict and control outcomes.

judgments take on a transcending significance for oneself and others through doctrines of salvation, predestination, and karma. A religious account of illness offers a shared explanation through which a community can understand the meaning of suffering, sickness, limitation, and death. Pain, anger, guilt, and despair can be given a place and purpose in an ultimate account of human purposes and limitations.

In this fashion religion provides an avenue for the social mastery of illness. It both contrasts with, and complements, medicine’s attempt to predict and control outcomes. The modes of mastery range from reinterpretation of reality using ultimate images and stories to claims of supernatural healing and prophecies regarding outcome. A Christian who sees the crucifixion of Christ as a sacrifice necessary to placate a deity’s wrath can see his own personal suffering as a contribution to the further drama of salvation. Human, temporal suffering is



The Gout, ca. 1799, by James Gillray, is one of the most famous depictions of the pain of illness. The awesome vividness of Gillray's image has led many observers to suggest that the artist himself suffered from the disease.

exchanged for heavenly, eternal reward. The pain and limitation of disease and the degradation of death as the body loses elements of self-control are part of a cosmic scheme in which those physical weaknesses are reconstructed as contributions to eternal spiritual strength. For the believer who awaits or experiences a healing by faith, illness is an occasion for the manifestations of divine power and love.

Illnesses are thus experienced against concepts of well-being, and there are many concepts of well-being. In some areas of medicine, views of well-being compete, as the controversies regarding the *medical* propriety of abortion, transsexual surgery, and cosmetic surgery attest. Among religious interpretations the contrasts are deeper, more pronounced, and more irresolvable. Each religion offers its own understanding of ultimate human

purposes and of the true significance of suffering and pain. Though similarities exist among religions that share scriptures, religious accounts, or presumptions, such as Judaism, Christianity, and Islam, deep differences divide such monotheistic faiths from Hinduism and Buddhism. These religions offer markedly different understandings of the significance of pain, illness, and premature death, and the proper modes of deliverance from the harms they bear (Randall 1970).

To appreciate the meaning of an illness thus requires attending to how its meaning is constituted within particular provinces of meaning.³ Once one has acknowledged the multiple alternative modes of understanding an illness, a family of illness meanings may be recognized. In some cases the resemblance will be close, and in others nonexistent. One might, for example, consider here the contrast between homosexuality viewed as an ego-dystonic disorder, or a disorder that works against the aims of the ego, and homosexuality seen as a sin and a perversion of human nature. Or one might consider the greater contrast between cancer appreciated as the outcome of natural events, including the evolution of certain genetic structures, and cancer appreciated as an element of divine punishment due to the Fall. Particular modes of describing, evaluating, and explaining reality guide individuals into particular ways of reshaping and controlling that reality.

Clusters of values and conceptual presuppositions provide both patients and practitioners with projections of the contours of reality. To understand illnesses, to treat sicknesses, and to take ill persons seriously, we need to plot with care where their problems lie within a particular framework of meaning. Just as important, we need to be attentive to the assumptions behind our attempts to master those problems within our different social institutions. ☉



Edvard Munch's drypoint 'The Sick Child' represents the universal sense of tragedy associated with a child's death. The artist's grim portrayal of the tuberculosis victim alludes to the loss of his mother and sister to the same disease.

NOTES

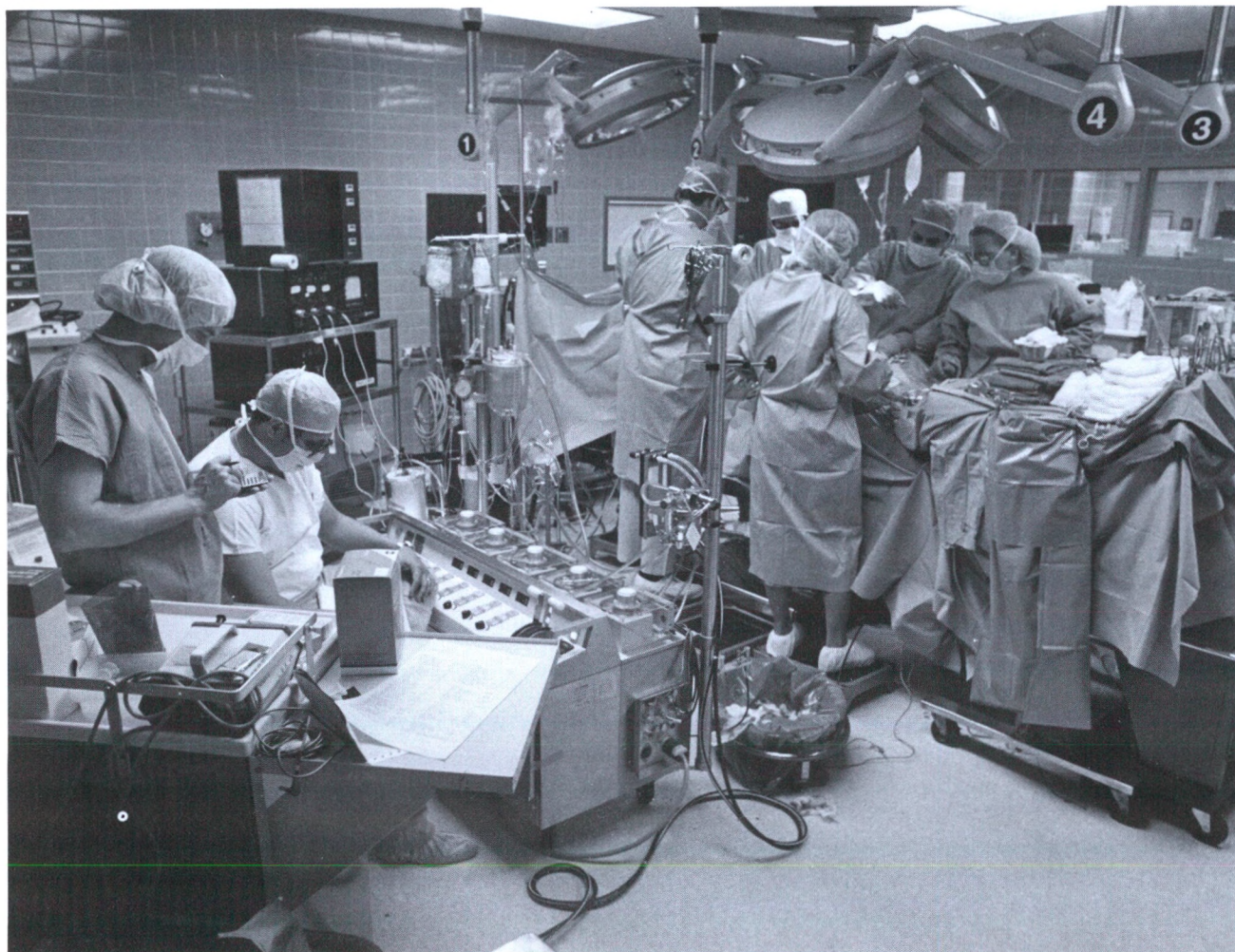
1. Public intoxication was first made a criminal offense in England by a 1606 statute. This law was carried over to the colonies and continued in all jurisdictions in the United States until 1966, when two different U.S. district courts of appeal ruled that it is unconstitutional to jail an alcoholic for drunkenness (see *Drivers v. Hinnart* and *Easter v. District of Columbia*). In 1968 the Supreme Court ruled in *Powell v. Texas* that it is not unconstitutional to jail those intoxicated in public. Although not all the states have adopted the Uniform Alcoholism and Intoxication Treatment Act, a move is underway to take alcoholism out of the criminal justice system.
2. For an example of the impact of particular views of "natural norms" on the ways in which medicine appreciates states of disease and well-being, consider the disease of masturbation; see Engelhardt 1974.
3. It should be clear that I am in particular indebted to the work of Alfred Schutz. See Schutz and Luckmann 1973.

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Organ Transplants:



Conundra without End

Jeff Lyon

In the Old Kingdom there was a pharaoh named Khufu who summoned the wizard, Djedi, to his court.

The monarch asked of Djedi, "Is it true, what they say, that you can join a severed head?"

"Yes, I can, O king, my lord," replied Djedi. And a goose was brought to him and its head cut off. And the head was placed on one side of the great hall and the goose was placed on the other. Djedi had his say of magic and the goose began waddling, and its head did also, and when one reached the other they joined and the goose stood cackling. Then a long-legged bird was brought, and the same was done to it, and then an ox, and the same was done to it. And in each case, Djedi joined their heads.

Now King Khufu ordered that a prisoner be brought from the prison, so Djedi could use his magic on him.

Cried Djedi: "But not to a human being, O king, my lord! Surely, it is not permitted to do such a thing to a man."

—From the Papyrus Westcar, "Three Tales of Wonder"

Shortly before Christmas 1984, I met two women who had returned from the dead. They were roommates at the University of Pittsburgh Health Center, where Dr. Thomas Starzl, a wizard worthy of Djedi, has elevated to an art form the replacement of worn-out body parts with new ones.

The first patient, Eva King, was a tall, vibrant blond woman who only two months before had been diagnosed as suffering from incurable liver cancer. The Mayo Clinic had sent her home to die, but thanks to a doctor friend from Salt Lake City she had learned about Pittsburgh and Starzl.

The second woman, Jo Ann Wilkerson, had been sick for ten years with a condition called primary sclerosing cholangitis, a progressive liver disease that turned her skin yellow, gave her an infernal itch, made her legs swell so badly she couldn't walk, and saturated her brain with toxic levels of ammonia, producing dementia.

Just a few days prior to my visit, Starzl had replaced both women's diseased livers with healthy ones. The result was so startling that it beggars description. King, who before surgery had been in a deathlike coma, now strode up and down the corridor in her blue silk bathrobe. Her face was full of color. Her energy level was high.

"I would have been dead in 48 hours," she told me, sitting on the coverlet of her bed, amid an array of Christmas cards from people she had served in her job as VIP reservationist for Eastern Airlines. Among them was a miniature fir tree from New York Yankees owner George Steinbrenner. "I was right on the brink, although I didn't know it because I was unconscious. When I woke up, my children and my husband were standing at my bedside. I said, 'What are you doing here?' They said, 'You've had your transplant.' I said, 'You're kidding.' I couldn't believe it. I was still alive.

"It's a wonderful feeling to get another chance at life. It's just a

miracle, that's all it is. A miracle."

Wilkerson, still bedridden but gaining strength quickly, wept as she gripped her husband's hand. "I had to do what I had to do because I was dying anyhow," she said through tears. "But I never did think I'd feel this good no more."

Nearly a year later, Jo Ann Wilkerson was back home in Powell, Tennessee, and solidly entrenched in her daily routine. She was in high spirits as she told me: "I've never been so healthy in my life. I ain't even had a cold or nothing. I could tell you I feel like a million bucks but you just can't express how wonderful it feels."

Eva King, on the other hand, had cheated the Reaper only to encounter him again in Samarra later. Her new liver began to fail a few months after surgery, and doctors at Pitt were unable to stem her downward course. She died in early summer at the age of 47.

Undeniably miraculous. Disconcertingly fickle. This is the new technology of organ transplantation, a procedure which, though still in its infancy, has already transformed medicine from a static enterprise that takes the body as it finds it into a dynamic one capable of altering the very essence of the human organism itself. As such, it indulges some of humanity's oldest fantasies about resurrection and perpetual life. And it raises a constellation of

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—Eva King,
liver recipient

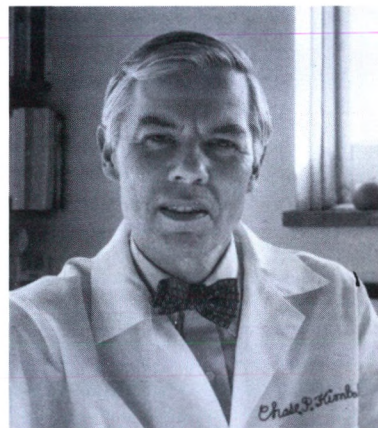
disturbing questions—questions that go to the very core of ethics, theology, social organization, and personal identity.

These troublesome issues are frequently discussed in the vacuum of the bioethical essay. But my aim in this article is to bring them to life, as much as it is possible, by speaking with the people actually involved in transplantation: the recipients, the donor families, the physicians, the nurses, the organ harvesters, and others. Sir William Osler, the Canadian physician and medical essayist, once wrote that the truest poetry is reflected in ordinary lives. My belief is that the same can be said of great ethical issues.

Almost every aspect of transplantation is fraught with controversy. The pressing need for donors has forced adoption of new definitions of death and has kindled fears that patients will be pronounced dead prematurely to satisfy the growing demand for organs. Harvesting of organs from the newly deceased collides with religious prohibitions against posthumous mutilation of the human body, and it sets up a tension between society and the next of kin with regard to disposition of a decedent's remains. The shortage of suitable donors leads to inevitable debate over how to allocate scarce organs among needy patients. What criteria does one use? Age? Nationality? Good character? Should

organs be sold to the highest bidder? And in the context of cost, does society owe it to its citizens to subsidize these extremely expensive procedures for all who need them? Finally, there are questions of a deeper philosophical nature relating to the kind of organs to be implanted and their significance for the individual and humankind in general. For example, there may be something different about receiving a heavily romanticized organ like the heart, as opposed to a more mundane servant of the body such as the kidney, and there would surely be something different about getting some or all of another person's brain. What does this mean in terms of the recipient's continuing sense of identity, and to add new levels of head-scratching, what kind of human being is created when we start adding artificial organs and even spare animal parts?

Undaunted by such questions swirling about, largely unanswered, institutions throughout the world are engaged in an unprecedented race to set up their own transplant programs. In 1982, only 3 medical centers in the United States were offering liver transplants. Today, the number has climbed to 34. No more than 5 were performing heart transplants. Today, there are 58. Currently, more than 180 centers in the U.S. are performing some kind of transplant surgery.



"You can feed a lot of poor, hungry children on what it costs society to do one heart transplant."

University of Chicago
psychiatrist Chase Kimball

The number of procedures has been rising accordingly. In 1984, U.S. surgeons transplanted 346 hearts, compared with only 62 in 1981. The number of liver transplants jumped from 26 in 1981 to 308 in 1984, and the number of kidney grafts went from 4,885 to 6,968.

One can scarcely blame so many medical centers for climbing on the bandwagon, because the survival rate for transplantation surgery has been shooting through the roof. The one-year survival rate for a heart recipient currently stands at 80 percent; for a liver recipient, it is 65 to 70 percent; and for a kidney recipient it is more than 90 percent. Long-term survival is improving as well. A full half of all the patients to whom Thomas Starzl gave a new liver in 1980 are still alive today. The three-year survival rate for hearts is 75 percent.

The reasons behind these encouraging statistics are improved surgical technique, better understanding of human immunology, and above all, the introduction in 1979 of cyclosporine.

For years the biggest stumbling block to successful organ transplantation had been the body's tendency to reject foreign tissue, particularly that of unrelated donors. Immunosuppressant drugs such as Imuran and prednisone were able to mute the rejection response, but

they also crippled the body's ability to ward off bacterial and viral invaders. More than 50 percent of organ recipients succumbed to infections. But cyclosporine has the remarkable property of suppressing that part of the immune system which is responsible for tissue rejection, while leaving intact the part that combats infection. The drug is, therefore, among the most important pharmaceutical advances of the twentieth century, and in the brief time since it has come into use, cyclosporine has given transplantation new respectability, changing it from a risky, experimental procedure to one that is entirely credible and nearly routine.

But like the parvenu who continues to inspire dark rumors, organ transplantation still carries with it a load of ethical and legal baggage. It is intriguing that, for their part, physicians often seem unconcerned about the philosophical perplexities generated by transplant. Part of this can be attributed to the tendency of some MDs to think of themselves as technicians, whose job it is to carry out medical game plans without reflecting very profoundly on what they're doing. One transplant specialist told me flatly: "I don't want to discuss philosophy. I'll talk about patient care, technique, that sort of thing, but philosophy, no. It's not my field. I leave that to the ethics boys."

"I don't want to discuss philosophy. I'll talk about patient care, technique, that sort of thing, but philosophy, no. It's not my field. I leave that to the ethics boys."

—a transplant surgeon

Even doctors who have obviously spent a good deal of time thinking at a deeper level about organ replacement are almost invariably cheerleaders for the procedure. The reason is not hard to discern. It is such an intoxicating tool, with such far-reaching potential for making sick people whole, that any clinician dedicated to the saving of lives cannot help being entranced by it.

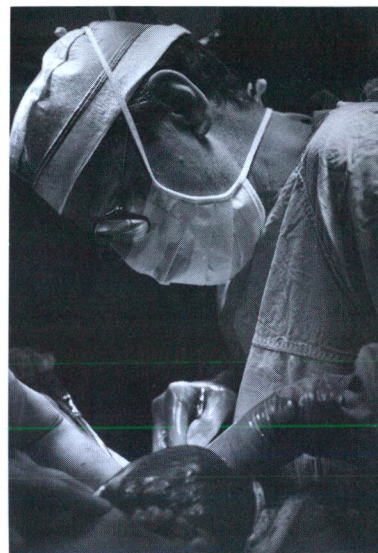
Thomas Starzl has dedicated most of his professional life to trying to make human organ transplants work. In 1958, while completing his surgical residency at Northwestern University Medical School, Starzl began looking for some area of surgery “hard enough and challenging enough to devote a lifetime to. One of the things I considered was trying to solve cancer. But all the medical journals were saying that the cure for cancer was right around the corner. I said, ‘Well, hell, if it’s that close, I’ll just skip it.’

“On the other hand, at the time, organ transplants were considered practically impossible because of the rejection factor. I decided that was the challenge I was looking for.”

In the late 1950s, extensive research was going on in organ transplantation. Drs. John Merrill, Joseph Murray, and J. Hartwell Harrison, of Boston’s Peter Bent Brigham Hospital, had performed the first successful transplant in 1954, transferring a kidney from one identical

twin to another. What everyone wanted to know was why organs from anyone but a twin seemed to provoke a severe rejection response. The hope, of course, was that a way around rejection could be found so that organs from unrelated donors—particularly those of cadavers—could be used. The experimental organ of choice was the kidney. It was readily accessible to the knife, was implantable almost anywhere in the lower abdomen, and was small and easy to handle, weighing no more than a quarter-pound. “The kidney always ran interference for other kinds of transplant,” recalls Starzl, who as a young surgeon devoted his research days to kidneys, like everybody else.

But in his spare time, Starzl began working with his real love: the liver. He spent hundreds of hours in the laboratory, with his nose buried in the chest cavities of dogs, trying to find the right blend of antirejection drugs and learning how to reassemble the complex junction box of veins, arteries, and ducts that lead in and out of the liver. In 1967, he and his colleagues at the University of Colorado performed the first successful liver transplant in a human being, extending by more than a year the life of a baby girl with liver cancer. Starzl subsequently engineered other major strides in transplantation, and he was one of two surgeons authorized to do the initial



Dr. Thomas E. Starzl chose a career in organ transplant surgery because it was “hard enough and challenging enough to devote a lifetime to.”

experiments with cyclosporine.

Not unexpectedly, Starzl is a big booster of transplants. In an interview, he waxed enthusiastic. "The movement is toward wide application of this technology. It's more than medical. It's philosophical. Think of it. These are people who are healthy except for the failure of one organ system; yet they must die. And now you can restore them to a healthy life. It's a colossal development. For example, Mozart died at 33. All he needed was a new kidney. The founder of Turkey, Ataturk, died at 45. All he needed was a liver. It's incredible, a marvelous story."

However, another physician is more restrained in his praise of transplantation. He is Chase Kimball, a psychiatrist at the University of Chicago Medical Center who helps patients and their families adjust after organ replacement. He finds the procedure to be an expensive and not particularly cost-effective use of scarce public dollars. "You can feed a lot of poor, hungry children on what it costs society to do one heart transplant," Kimball says. "I think transplants should be done on an experimental basis, but as a wholesale thing, I think we'd be better off spending the money on preventing heart or liver disease. That may make my friends in renal or cardiac medicine mad, but it's the way I feel."

But Kimball is in the minority. By

and large, most physicians involved with the transplant process echo John B. O'Connell, chief of the heart transplantation program at Loyola University Medical Center in Chicago, who says he still gets quite an emotional thrill from the surgery. "The operation has great significance for me," he admits. "To look into the chest just before removal and see the diseased heart kind of quivering, not really beating, and then to look in after the transplant and see the new heart pumping well. It's just..." He shakes his head, unable to find a word.

Nurses tend to reflect a similar point of view. Kathy Grady is nursing coordinator in Loyola's cardiac transplant program. Before coming to Loyola, she worked five years at Stanford under heart transplant pioneer Norman Shumway. She confesses to having had misgivings about her work in the past, but says the doubts have faded. "In the days before cyclosporine, I had serious reservations about transplants because the survival rate was poor," says Grady. "But since cyclosporine came on the scene, I have no more reservations at all. If I did, I wouldn't be in this business."

Notwithstanding the enthusiasm of the transplant establishment, one is left with the feeling that an important part of the picture is missing. Take Starzl's point about saving Mozart from uremia. As appealing as



"To look into the chest just before removal and see the diseased heart kind of quivering, not really beating, and then to look in after the transplant and see the new heart pumping well. It's just..."

Dr. John O'Connell,
Loyola University Medical Center,
Chicago

such a historical mercy mission might be, there would remain the difficulty of finding a kidney for Mozart and then of deciding whether Mozart is more entitled to it than, say, a peasant, a charwoman, or, for that matter, Salieri. Extolling the obvious marvels of organ recycling merely dazzles and distracts, while managing to sidestep a string of more profound questions.

Of all the issues raised by transplantation, none are so pressing and vexing as those surrounding organ retrieval. It is a disturbing fact that the supply of suitable donor organs comes nowhere near to satisfying the demand. Some 10,000 people a year are scheduled for transplants in the U.S., and recent estimates suggest that the eventual need will be for 36,000 organs annually—16,000 kidneys, 10,000 hearts, and 5,000 each of livers and pancreases. Yet of the 20,000 potential organ donors who die each year—people under the age of 55 who succumb to brain death—no more than 2,500 to 3,000 of them actually become the source of organs. This means we are retrieving only 15 percent of available organs, while burying the remaining 85 percent.

The human cost of this is apparent. At any given moment in the U.S., there are 100 people in need of a donor heart; another 300 waiting for a liver; 30 awaiting a pancreas; and 8,000 who need a kidney. A

third of them will die while on the waiting list. Many others will go through weeks and months of pain and uncertainty.

Scott Frank, 33, was on the list for a new heart for almost five months, even though he was type O—a relatively easy tissue match. “There was just a long dry spell when nothing was available,” he says. During this extended period, Frank’s cardiac myopathy (deterioration of the heart muscle) kept him on the edge of the abyss. He suffered from immobility, tremors, and severe shortness of breath, and he had to stay on massive dosages of drugs to stave off blackouts and cardiac arrest. But the anxiety was the worst part. “Toward the end, I was positive I wasn’t going to last until they found a donor,” he says. The anxiety reached its zenith when the transplant team thought they had a suitable heart for him, only to have it turn into a false alarm. “I was actually lying on the operating table, waiting for them to start,” recalls Frank. “They were inspecting a heart they had just flown in and I heard them say it wasn’t in good enough condition.” Frank’s morale struck bottom. Luckily, a satisfactory heart was located for him two days later.

Another heart recipient, Kevin Duffy, 37, discovered that being on the waiting list tends to make one mean-spirited. “You’re sitting there,



Even if Mozart could have been saved with a kidney transplant, would he have been more entitled to it than a peasant, a charwoman, or, for that matter, Salieri?

wishing for someone to die,” he says. “You’re hoping they’ll pull the plug on somebody. It made me feel kind of bad.” John O’Connell, of Loyola, encounters this ghoulish phenomenon frequently. “Patients will look out of the window and say, ‘Hmmm, it’s a rainy day outside, wonder if someone will have an auto accident.’ Then they’ll feel guilty. We tell them it’s a normal human reaction. We say, ‘The accident’s going to happen whether you will it to or not. Don’t feel guilty. You just want to live.’”



Why is there such a shortfall of needed organs? The U.S. Centers for Disease Control (CDC) conducted an experiment from 1976 to 1979 in which it attempted to augment the number of kidneys donated to transplant programs. The year before the study, kidneys were removed from only 6.5 percent of potential donors, but even after three years of intensive campaigning by the CDC, the retrieval rate increased to only 14.7 percent. The CDC found that hospitals only referred 42 percent of potential donors to transplant programs, whereupon only 47 percent of families referred gave consent.

One problem appears to be the reluctance of medical staff to make referrals, owing to a distaste for subjecting bereaved families to inquiries about donation. “We do not have a

shortage of donors,” a state legislative aide recently told the *New York Times*. “We have a shortage of askers.” Brian Broznick, a coordinator with the 24-Alert Extra Renal Organ Sharing System, a nationwide computer registry that matches recipients to donors, agrees that all too frequently, health professionals fail to alert anyone from the organ retrieval network when a patient becomes brain dead. “First of all, physicians and nurses are trained to save lives, and they don’t like to fail,” says Broznick. “When a patient of theirs dies, they want to forget about it and get on to the next case. Second, many doctors feel it’s an added burden on the family of the deceased to ask them to donate organs. Either way, they don’t bother to call the organ procurement agency and the organs go to waste.”

Broznick and his colleagues at 110 organ procurement centers around the country share a strange life. They must be ready to travel at a moment’s notice, any hour, day or night, on an errand that involves scavenging body parts from an individual who, according to some viewpoints, is still alive. The donor most likely will have died violently—in an accident of some kind, or as a result of child abuse, a gunfight, or the like. The organs are then put in a Tupperware container, dropped into an ordinary picnic

*“Patients will look out of
the window and say,
‘Hmmm, it’s a rainy day
outside, wonder if someone
will have an auto accident.’
Then they’ll feel guilty.”*

cooler filled with ice, and flown back to home base. "It's very tough on your private life," says Broznick, who is based in Pittsburgh. "Last year I spent New Year's Eve talking to a potential donor family, and then New Year's Day flying to Los Angeles for a pediatric liver."

The proceedings can lead to some bizarre moments. Joan Schultz, procurement coordinator for the liver transplant program at the University of Chicago, recalls going on a harvest to Ontario, Canada. On the way back the team had to clear customs. There was an anxious moment as the border patrol appeared ready to verify Schultz's claim that the picnic cooler on the plane contained a human liver. But then the agents, rolling their eyes, waved the team through without inspection.

It is also gruesome work. "If you didn't have it in the back of your mind that you were giving life," says one harvester, "donor surgery would be very depressing. You're dealing with young lives snuffed out—sons, daughters, young parents with children of their own. It is always a case of unexpected death. It's very sad."

Linda Szeplak, procurement coordinator at Loyola, admits it can be "ghoulish" and very stressful for a medical team to work in the operating room removing organs from a brain-dead patient. Most of the nurses will be regular scrub

nurses who have never before done organ retrieval, and they are the ones who get upset. "The patient looks alive," Szeplak says. "The body is warm and the lungs are filled with air, and even though you know in the back of your mind the patient is dead, some of the nurses still get freaked. A lot of them say 'This was really weird. I hope I don't have to do this again.'"

"The hardest thing to deal with is when they are removing bone," she says. "They actually take the long bones out and replace them with wooden rods, so the patient still has some form to his body. It is the hardest type of procurement that anyone can witness."

Szeplak has been present for dozens of organ harvests. She has gotten used to it. But when she first was starting out, several years ago, she had to work through many emotions. "For one thing, it is hard—even for the nursing staff—to deal with the concept of brain death. You wonder if that person is really dead. I used to read through every word on the chart to make sure they had done everything, every little test, to make sure the patient was dead. Cerebral blood flow tests and so on. For my own peace of mind, I'd ask the physician 'Why didn't you do this, why didn't you do that?' I still do it. You worry."

"But I'm no longer bothered by the removal part," she says. "I have



Introduced in 1979, cyclosporine dramatically increased the success of transplants. The drug is able to suppress that part of the immune system which is responsible for tissue rejection, while leaving intact the part that combats infection.

accepted the fact the patient has died; I've learned to deal with it. But I have an advantage over the scrub nurse. I get to see the recipient. I see the good purpose the organs are being used for. The scrub nurse doesn't and it makes it harder."

A recent article in the *New England Journal of Medicine* addressed the problem of depression and anxiety on the part of those present for organ removal. "The organ-retrieval process presents participating health professionals with at least three moral problems," the article said. "First of all, although medical and surgical interventions are sometimes painful, invasive, and even disfiguring, they are justified as being necessary to the achievement of the primary goal—the patient's welfare. During retrieval, the donor's welfare no longer provides the rationale for these aggressive procedures. Secondly, the organ-recovery process seems to violate a more general respect for persons, which obligates us to treat human beings as ends in themselves rather than mere means to other ends. Thirdly, organ retrieval may be viewed as being disrespectful to the dead. Our cultural and moral traditions demand that we respect not only recently dead bodies but also graves that are centuries old.

"Uncertainty about these moral questions may cause considerable

discomfort for participating health professionals. Some report sensing a 'presence' or 'spirit' in the room during the retrieval surgery. The young and inexperienced may be particularly vulnerable. . . . After surgery, nurses are often left alone with an empty shell that was once a person. They may feel resentment or envy of staff members who 'get out when they can.'"



The earliest milestone in dealing with the donor shortage was the development of a new definition of death. The traditional definition that had served for centuries—the cessation of cardiac and respiratory function—was made obsolete in the early 1960s by the development of life-support machines. It became possible to maintain heartbeat, circulation, and breathing even when the patient had no chance of recovering autonomous brain function following a massive cranial insult. To avoid the emotional cost to families—not to mention the great squandering of hospital resources—that would ensue if every patient were kept going until the body finally deteriorated, the concept of brain death was born. As enunciated in the Uniform Determination of Death Act, proposed in 1981 by the American Medical Association, the American Bar Association, and the President's Commission for the

'After surgery, nurses are often left alone with an empty shell that was once a person. They may feel resentment or envy of staff members who 'get out when they can.'''

Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, a patient was legally dead if there had been an irreversible cessation of all activity of the entire brain, including the brain stem, the part which controls the body's vital functions.

Actually, brain death was not such a radical idea. It underlay the traditional concept of "heart death," the rationale being that should the heart stop beating, the brain, deprived of oxygen, would be irretrievably damaged. Hence, heart death was merely an easily observable index of the impending demise of the brain. Moreover, it had become clear that life continues even when the heart is temporarily stopped, as when a heart-lung machine is used to maintain circulation during cardiac surgery.

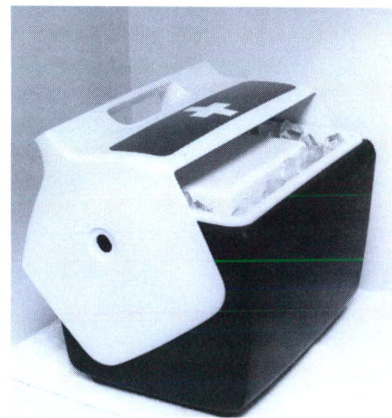
The definition of brain death dovetailed nicely with the need to find suitable organ donors. By the time circulatory function ceases, organs begin to degenerate and become unusable. But if a person could be declared legally dead before that point, then a procurement team could perform a harvest while the organs are still being perfused by the patient's blood. The life-support machines could simply be turned off at the procurement team's convenience.

Brain death has been accepted as the model in virtually all of the 50

states. But not everyone agrees with the definition. There is the fear that the still-living will be hurried into death to generate more organs, with the greedy using some human beings as a "farm" to benefit others, as in Robin Cook's novel, *Coma*. A number of years ago, Dr. Warren Warwick, of the University of Minnesota Medical School, wrote a "modest proposal," à la Jonathan Swift, in which he envisioned a society that prohibited the use of seat belts and revoked speed limit laws to promote more accidental deaths.

In his book *The Way We Die*, David Dempsey writes: "Once [the physician] is satisfied that the brain has died . . . his incentive to prolong life is diminished. Thus what began as heroic medicine, in the gallant sense of the word, threatens to become a device to regulate the death of one person for the benefit of another."

The Reverend Paul Quay, a Jesuit who teaches philosophy of science at Loyola University, argues that it is wrong to equate brain death with true death. In brain death, he says, "the person's heart keeps beating, his respiration continues, the kidneys keep putting out urine, the skin color is normal, and he sweats if the room is too warm. If the patient is a pregnant woman, the fetus will continue to grow in the womb." Quay says qualitatively different



When organs are ready to be transported to a recipient, they are packed in an ordinary picnic cooler.

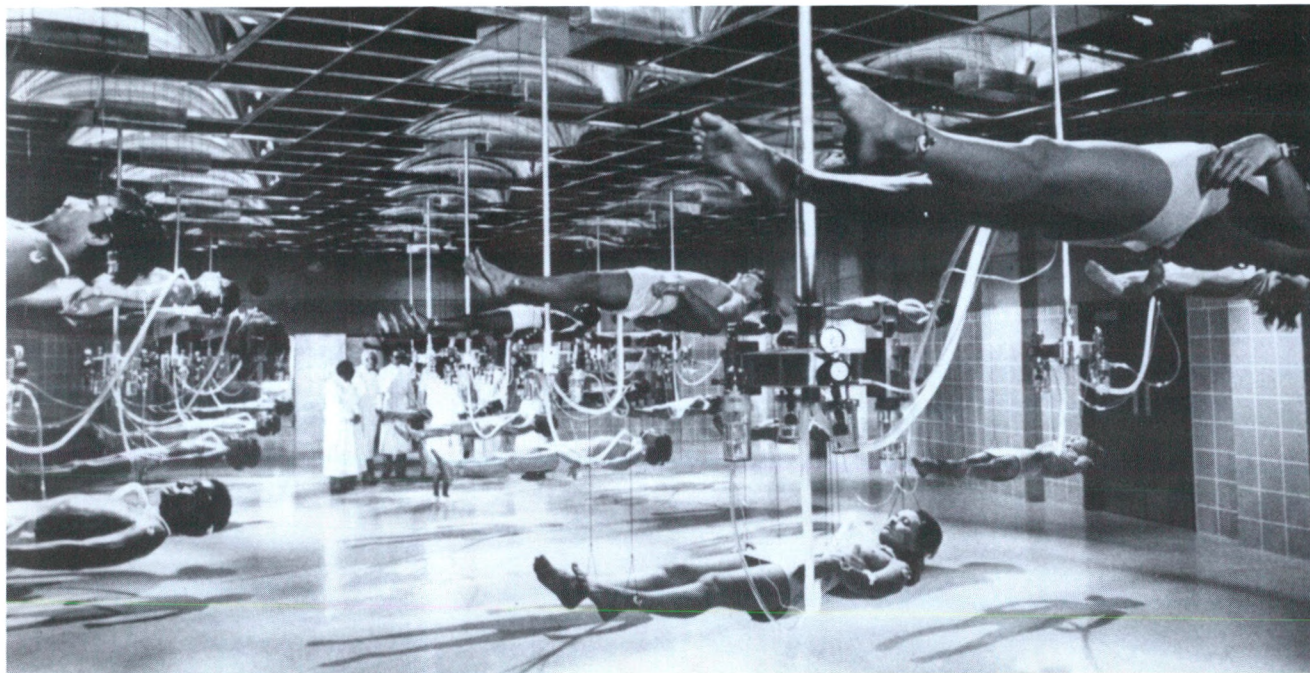
things happen during what is more traditionally thought of as death. Here, in a process which generally follows brain death by hours or days, the body ceases to function, defying any and all heroic efforts to revive it. "The heart stops; the vascular system collapses; respiration halts, the color turns bluish or gray. . . kidneys and other organs cease to function; and the fetus will die if not delivered at once by Caesarean section.

"Some people want to make both states the same," says Quay. "But the first condition is clearly not the

same as the second. I'd say the first state is the state of the person who has been mortally injured but is not yet dead. You're simply saying he will be dead. In all likelihood you're taking a vital organ from a person who needs it himself to live the rest of the time he's got."

Quay is bothered by statutory language which refers to "irreversible" cessation of brain function. "Irreversible is a question of prognosis, not diagnosis," he argues. "A thing is not permanently destroyed even though no way now exists to turn it around." He is appalled by the

The 1977 film Coma dealt with the illegal selling of harvested organs for transplant purposes. This photo from the movie depicts a "farm" where bodies were kept "alive" until organs were ready for harvesting.



British definition of death which does not even require cessation of total brain activity, but only part of it. "This means," Quay says, "that a patient may clearly have signs of brain function, even after you've declared him dead. And this can be cortical function, that part associated with thought and memory, so long as the lower part of the brain is destroyed. There is a big controversy over there, because people are still showing cortical function several days after they've been declared dead. But the dominant faction says this is irrelevant because they will be dead soon."

These arguments are strengthened by persistent reports over the years of patients who had been written off as brain dead because of flat electroencephalograms (EEGs), only to exhibit later a return of neurological activity. There is, for example, the case of the Russian physicist Lev Landau, who was crushed in his car by a truck. Four days after the accident, Landau "died": his pulse and blood pressure vanished and his EEG became flat. He had no reflexes. Yet vigorous use of adrenaline and digitalis brought him back to life, and eleven months later he was able to sit up in bed and accept his Nobel Prize. If Dr. Landau had been declared brain dead and his organs removed, it would have amounted to what author Dempsey calls "death by transplantation."

Organ transplantation is objectionable to the Reverend Quay for other reasons. He would go so far as to argue that the living never have a right to take body parts from the dead without the individual's prior permission. "The individual belongs to God and God only," Quay says. "A person, acting in charity, is able to speak in God's name with regards to disposal of his own body. He may say, 'This body of mine, when it is truly dead, can be used for organ transplantation or medical research.' But the family cannot make the donation, because the family doesn't own the body." Quay argues that if the deceased left no indication of whether he wanted his organs donated, "then all presumption is he didn't, because opportunities to do so are plentiful."

Quay does not represent mainstream Roman Catholic thought on these issues. The policy of the U.S. Catholic Conference is that cadaveric transplants are acceptable, so long as the determination of the time of the donor's death is "made in accordance with responsible and commonly accepted scientific criteria." Brain death is certainly among such criteria.

As much as there exists a Protestant body of thought on the matter, it generally agrees with the Catholic. But there are religions and cultures which have partial or total strictures on the use of a dece-

One author envisioned a society that prohibited the use of seat belts and revoked speed limit laws to promote more accidental deaths.

dent's organs. Certain fundamentalist sects adhere to the belief that bodily integrity must be maintained for ascension to heaven. Some Haitians—perhaps because of beliefs based on voodoo superstitions—will not entertain the idea of organ donation. And an organ procurement specialist who formerly worked at the University of Chicago, which serves a large inner-city population, reported difficulty in getting many families to donate their loved one's organs. "They always said no. They believed in miracles, and they did not seem to understand or care what brain death was. They felt that the person would all of a sudden wake up and be better again. It's hard, because they see the chest rising and falling, and urine going into the bag on the side of the bed, and a heart rate on the machine, and IV fluids going in. It's all artificial, but many people just don't understand it."

Orthodox Jewish law contains conflicting views on the subject. Ordinarily, it does not permit mutilation of the body, and autopsies are expressly forbidden, in keeping with the Talmudic directive that a corpse be buried on the day of death. However, the rabbinate has approved of organ removal and transplants in principle, based on the higher good of saving a living patient's life.

"But there's a problem," says

Judaic legal scholar J. David Blich, of Yeshiva University in New York City. "Organs cannot be removed unless and until the donor has actually died. And neurological criteria of death aren't satisfactory. Jewish law uses the classic common law definition of death, which is cessation of cardiac and circulatory function. So that effectively eliminates removal of such organs as the heart, since tissue degeneration sets in rapidly following classic death."

This obligation to provide care until heart death is based on the deeply held Jewish conviction that where there is breath there is life. "Do not resuscitate" orders, for example, are prohibited by many Jewish authorities. Says Immanuel Jakobovits, president of the Institute of Judaism and Medicine, Jerusalem: "If seventy years of life are of infinite worth, so is one year, one week, one day, or one hour of life. All are equally valuable and inviolable. A human 'vegetable' is unknown in the moral or legal vocabulary of Judaism. Where there is life, there may not always be hope, but there is always the spark of a uniquely precious soul."



If religious values occasionally complicate the search for usable organs, more often than not the problem has little to do with religion but reflects simple, often arbitrary re-

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—Immanuel Jakobovits,
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Jerusalem

sistance on the part of potential donors and family members. Many people have a private aversion to the idea of their body being tampered with after death. Meanwhile, our culture believes that, even though the spirit or life-force may have left the body, and the husk or shell remaining is not really Uncle Joe, there is an obligation to the memory of the deceased to provide a decent burial. Conceivably, we might just dump human remains in the trash, but this is considered disrespectful and therefore wrong. The primary responsibility for burial, we have decided, rests with the next of kin. The body is not deemed to belong to the State, as it is in Communist societies, which may take organs from the dead at their pleasure, nor to the Church, as was the case in medieval times. This familial duty to arrange for burial has evolved into a legal right to decide what is done to the body between death and burial. Relatives may refuse autopsies, except in a public health emergency or criminal investigation, and they may deny permission for organ donation.

Legally, the Uniform Anatomical Gift Act, proposed in 1968 and since approved by all 50 states, provides that where an individual has willed his organs prior to death, his relatives may not revoke the gift. But as a practical matter, organ procurement teams seldom if ever go against

a family's wishes, even if a donor card indicates the desire of the deceased to donate his organs.

"We still ask next of kin for permission, even if there is a card," says Linda Szepelak, of Loyola. "If they said no, we wouldn't take the organs. They probably couldn't sue you on the procurement part, but the emotional anguish might be grounds."

Why so many relatives reject requests for organ donation, in contradiction of a Gallup Poll which shows that 70 percent of U.S. adults approve of the donation of organs after death, is something that isn't fully clear. "There are some misconceptions that probably play a role," says Szepelak. "Some people think they can't have a funeral if you remove the organs, or that the body

UNIFORM DONOR CARD

Or _____
Print or type name of donor

In the hope that I may help others, I hereby make this anatomical gift, if medically acceptable, to take effect upon my death. The words and marks below indicate my desires.

I give: (a) _____ any needed organs or parts
(b) _____ only the following organs or parts _____

Specify the organ(s) or part(s) _____
or _____
for the purposes of transplantation, therapy, medical research or education:

(c) _____ my body for anatomical study if needed.

Limitations, or
special wishes, if any: _____

Virtually all states issue organ donor cards with drivers' licenses.

becomes disfigured, neither of which is true. We try to supply them with facts, but a lot of time the uneducated population just say no, immediately, and they don't want to talk about it further. Once they start getting a little stressed out, you have to back off. You don't want to intensify their grief."

Says the University of Chicago's Joan Schultz, "I think there's a little bit of anger. They miss their loved one dearly and they feel, 'Why should someone else benefit when I just lost my little boy or my husband or whomever.' It's very hard to be generous when you've just lost one of the most important people in your life."

The Reverend James Reed, a Methodist minister from suburban Chicago, lost his 21-year-old son, Mark, in an auto accident a little over a year ago. He and his wife were called in the middle of the night to come to the hospital, where they were told that Mark's brain stem had been severed and that he would not recover. Soon afterward they were approached, "in a very low-key way," by a nurse who asked whether they would consider being donors. "We made our decision to say yes almost immediately," Reed says. "It was more instinct than anything else, it just seemed right, that if some good could come out of this tragedy then it should be done." He says they had no prior knowledge

of Mark's attitude about organ donation. "We found out a month later from our daughter that at a memorial service for my wife's mother, they had had a conversation about donating organs and he was in favor of it at the time. But our decision was not based on anything we knew about his thoughts, only that we felt it was in the spirit of what he might have chosen."

Reed says he approved the donation, even though he had misconceptions about the success of transplants. "I was not aware how far they had come with human heart transplantation," he says. "If you had sat me down and asked me what I thought this would really achieve in someone else's life, I would have said it would give them only a short time at best. I didn't know until later how well and healthy people can get with a heart transplant."

A major factor in their affirmative decision was their having recently gone through a parishioner's struggle to find a kidney donor. "We had been intimately involved and knew how desperately he wanted a new kidney and how he had been deteriorating. Once, he had gone all the way to Madison when they thought they had a donor and it had been in vain. So that experience set the stage for our decision in Mark's case. We asked ourselves how we could be in favor of something for

"It's very hard to be generous when you've just lost one of the most important people in your life."

—organ procurement coordinator Joan Schultz



someone else and not do it when we had the chance.”

For all their desire to help, the Reverend Reed says, he and his wife still had fears that they were prematurely consigning Mark to the grave. “His heart was beating and he looked great lying there. It was hard for us to believe he couldn’t recover. I think at a subconscious level we were suspicious of how badly the hospital wanted his organs, and we asked ourselves how we’d feel if six months later we heard a story about people with damaged brain stems who recover. So we decided to get a second EEG reading 24 hours later. I called an internist I trusted and asked him about it, and he assured me there was no chance of recovery.” Even with such assurances, Reed’s wife carried nagging doubts around with her for some months. “She was haunted later by dreams that perhaps we had acted too

soon,” Reed says.

Many family members who donate a loved one’s organs have a sense that their relative is gaining a kind of immortality by “living on” inside another person’s body. In a sense, it is a new outlet for activism; social consciousness may be carried beyond the grave. But Reed says he does not feel that a specific piece of Mark lives on inside the four people who received his heart, liver, and kidneys. “I feel he lives on much more in the people he affected as a living person. But still I had a feeling with theological overtones when I saw the helicopters at the hospital, ready to lift off with his organs. There were two of them, one to take the heart, the other to take the other organs. Watching the helicopters take off, I had a sense of symbolism, of helicopters rising and life continuing.”

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“Watching the helicopters take off, I had a sense of symbolism, of helicopters rising and life continuing.”

—Reverend James Reed,
father of an organ donor

A number of proposals have been made for easing the shortage of donor organs. Three states—California, Oregon, and New York—have passed laws requiring hospital staff to ask families for organ donations whenever a patient dies. The laws are seen as a way to cut through the reluctance of the staff to broach the sensitive subject to the newly bereaved. However, if hospital personnel have prior knowledge of a family's religious objections to organ donations, they may forgo the request.

Even more drastic suggestions have been made. Thomas Starzl has proposed relaxing still further the definition of brain death. And he would replace the current laws governing organ donation with "presumed consent" laws, which would allow organs to be removed from patients as a matter of course unless the family entered an objection. Such a law is already on the books in France, but it has not worked successfully because of moral reservations on the part of hospital staff, who have largely ignored it.

Joseph Fletcher, the well-known situational ethicist, favors doing away with present funeral practices of burial and cremation, which he calls a "shameful waste of human tissue." "My central thesis," Fletcher says, "is that it is immoral to deliberately rot or incinerate human tissue which could be transplanted

to save other human lives. I maintain that Christian burial is in itself an immoral act. It would be far more ethical for Christians to give up having funerals and allow usable tissue of the deceased to be removed."

Less dramatic is the tack taken by the American Council on Transplantation, which believes that public education is the answer. "I think it's mainly a question of making people aware of need," says the advocacy organization's executive director, William Berry. Berry believes such a nonlegislative, voluntary approach can in time generate the ten thousand annual donors needed to fill the growing demand for organs.



The organ shortage has led to a crisis in the allocation of organs. The best-publicized manifestation of this occurred at the University of Pittsburgh, which came under fire recently for bypassing waiting American citizens to implant organs into foreign nationals, many of them wealthy. Some 28 percent of Pitt's transplants in 1984 were performed on nonresident aliens, including several members of the Saudi royal family. The practice is also carried on at other transplant centers. Critics argue that Americans should get first crack at organs donated by other Americans. Others respond

"I maintain that Christian burial is in itself an immoral act. It would be far more ethical for Christians to give up having funerals and allow usable tissue of the deceased to be removed."

—Joseph Fletcher

that such reasoning is jingoistic and that medical need alone should govern triage. But the debate is part of a much larger question of how to distribute a resource that means life or death to those dependent on it.

Most hospitals that perform transplant surgery limit the operation to people under the age of 55. Until recently, when state agencies and insurance companies began to underwrite the exceedingly costly procedures, transplants were also limited to those who could afford the \$100,000 to \$200,000 price tag. "The first question," asks David Thomasma, ethicist and director of Loyola University's medical humanities program, "is whether it is ethical to choose to prolong one person's life and not another's." Thomasma wonders whether it is "ageist" to deny new organs to those over 55, and whether ageism is a kind of discrimination as deplorable as racism or sexism. He concludes it is not. "Age happens to all of us, no matter what our race and sex," he says. "Thus, to choose some, rather than others, on the basis of age, is not the same injustice as choosing based on race, sex, or other criteria. Consequently, it can be appropriate to use age as a measure of medical indications to determine a cutoff point beyond which a transplant would be a form of useless therapy."

But what about where two potential recipients are both under 55 and

fit the same medical indications criteria? The tendency, Thomasma says, is to employ social criteria. The most "worthy" individual, in terms of intelligence, income, family size, character, is likely to be selected—a policy discredited in the 1960s when a Seattle committee was found to be selecting people for kidney dialysis based on perceived social worth.

Thomasma's solution? First-come, first-served. But this is clearly arbitrary, too. And what happens if the person first in line is a unanimously unpopular individual? The first artificial heart in Sweden was implanted into a business executive with reputed underworld ties, sparking heavy criticism. Does adherence to first-come, first-served require that a mobster's life be prolonged at the expense of a college president's?



The most intriguing of all the philosophical issues surrounding transplantation are those which deal with the effect of the procedure on the recipient. One matter always leaps to mind. Do those who have received new organs feel guilt that another person had to die so that they might live? The answer: not very often. When they do, it is a sensation that quickly passes. "I would say I feel more thankful than guilty, that he [the donor] or his family

"The first question is whether it is ethical to choose to prolong one person's life and not another's."

—David Thomasma,
Loyola University

would have thought so much of other people that they would allow removal of his organs," says liver recipient Jo Ann Wilkerson. "The way I look at it, if he didn't need it anymore, why not let someone else use it?"

Jillian Rainford, of Perth, Australia, is the mother of Kelley, a four-year-old girl who received a new liver in Pittsburgh a year ago. "I sometimes get sad," says Mrs. Rainford, "when I think of the other mother, the mother of the donor child. But I am grateful to those parents that we have a second chance to have Kelley alive and healthy. We don't know who they are and we don't care to know. What could you say to them, even if you could contact them? As far as we are concerned, the organ came from God."

Anticipating such reactions on the part of recipients and their families, most, if not all, transplant centers try to see that the recipient of an organ does not learn the identity of the donor, and vice versa. The only information passed along is the other's age and city of residence. It is a bit of medical paternalism based on some unpleasant past experiences.

"Anonymity makes it easier," says Dr. O'Connell, of Loyola. "One patient got a Christmas card from a donor's family in Rochester, New York. They somehow found out who he was. They were very proud that their son, in his untimely death,

could have helped someone else. They wanted to stay in touch. The recipient didn't want to. He didn't want to feel that he profited from someone else's misery. It made him feel uncomfortable. At my suggestion, he wrote and thanked them, and said, 'Look, I'm pleased, and I'll take very good care of this heart, but I don't see any reason for us to correspond further.' I thought he handled it very well."

Heart recipient Scott Frank says, "I really wouldn't want to know whose heart I have. I don't think I'd feel guilty. But it would just become too personal. It would be one more thing to think about. There are certain aspects of getting a transplant that you simply don't want to dwell upon too much because they are too overwhelming. For example, the whole process is beyond understanding. It's beyond visualization how you can take someone who is terminally ill and literally without any chance of survival, and in one operation, and with a reasonably short recovery time, get them to where they can lead normal, high-quality lives. It's too much for the human mind to grasp.

"And let's face it. There are also problems that crop up that you don't want to think about. Rejection. And infection because you're immunosuppressed. And one of the side effects of cyclosporine is an increased risk of cancer. Not that I let



Heart transplant patients feel a unique kinship with one another. This grateful recipient shows his appreciation at Loyola Medical Center's First Annual Heart Transplant Picnic.

it bother me. What's the alternative? I'd have been dead eight months ago if I hadn't had the operation. I'd rather be here than be dead."

O'Connell agrees that the post-transplant patient has enough to think about without having to become chummy with a donor family. "These people have other things they must adjust to," he says. "They had adjusted to dying, and to being the object of kid-glove treatment by everyone around them. Now, all of a sudden, they have to adjust to living. Though they feel normal, and can resume all normal activities, they still have to see the doctor all the time and have a heart muscle test. They could start to die at any time. Also, during their illness, the wife may have become the dominant figure in the family, the bill payer and breadwinner. Now the male wants to be dominant again. It creates conflict. Then there is the problem of finding work. The second heart patient we did here had been unemployed four years because of his heart. After his surgery he tried to get a job, but whenever he told them he'd had a heart transplant, they said sorry. He now works here for us."



Much more baffling are the questions organ transplantation raises with regard to human identity. In principle, it would seem to

be a difficult thing to cope with the idea that one has become a chimera, a hybrid; that the ultimate intimacy of one's body has been violated by the presence of alien tissue. In point of fact, however, patients seem to have little or no difficulty in maintaining a continuing sense of identity while harboring somebody else's organs.

Louis Bonesio, 52, of Gilroy, California, is the only person in the world to have received transplanted organs from two separate donors. In 1974 he developed cardiomyopathy and was given a new heart by Dr. Norman Shumway's team at Stanford University Medical Center. Then in July of 1985 he was stricken with hemolytic uremia syndrome, a form of renal failure, and he was given a new kidney at the University of California, San Francisco. There was no connection between the two diseases, "just bad luck, the story of my life," says Bonesio. Bonesio likes to joke that "the only thing I've got left that's original is my Social Security number." But for all that, he feels no loss of identity. "I don't feel strange," he says. "People ask me if I feel different. No, I don't. I just feel that my organs were no good and I updated them with available parts. I'm very privileged that I had that availability. I am literally three people, but it doesn't really enter my consciousness."

Patients seem to have little or no difficulty in maintaining a continuing sense of identity while harboring somebody else's organs.

If two organs aren't enough to alter one's self-concept, would three be enough, or five or six? At the University of Pittsburgh Health Center, Thomas Starzl has announced that he is ready to attempt the world's first total gastrointestinal transplant in a man who has six inches of intestine left, the result of chronic ulcerative colitis. The operation, if approved by the hospital's institutional review board, would involve the simultaneous transplant of small intestine, liver, pancreas, spleen,

stomach, duodenum, colon, and rectum. The organs would all be from one donor and would be lifted out and installed in modular fashion, like a circuit board. The possibility of someone walking around with eight organs other than ones he was born with—organs making up a large part of his viscera—raises the question of identity even more dramatically. Is there some point at which an individual has so many foreign organs in his body, is a patchwork of so many different peo-



Dr. Starzl hopes to perform the first gastrointestinal transplant, lifting out eight organs from one patient and installing them in a modular fashion, like a circuit board, in another.

ple, that he ceases to be entirely himself?

In a literal, objective sense, it is certainly true that the person is not the same individual that he was. Parts of him will have different genes, slightly altered protein, and various other biochemical signatures. If he received a testicle transplant, he would father children who looked like the original owner of the testicle, not himself.

But in a subjective sense, the only sense that matters to the recipient, he hasn't really changed. Not even when the transplanted organ is the heart, the fabled seat of human emotions. The person feels the same for the plain and simple reason that his brain, the seat of self-perception, is still intact.

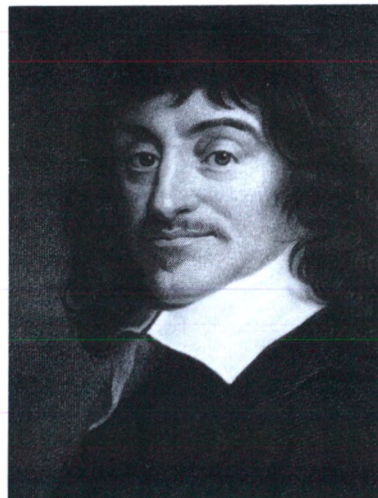
"I don't put much stock in issues of body image and body perception," says Kenneth Vaux, professor of humanistic studies at the University of Illinois College of Medicine. "In the early heart transplant age, I asked people who had gotten new hearts if they felt like a different person. But those aren't real issues until we start to do things with the mind and brain. Other organs are really just tissues which don't affect consciousness in any way."

But David Thomasma disagrees. "Once you buy Descartes's idea," he says, "that the person is a soul inside a body, you can say the soul is there even if the brain is transplanted. But

my own view is based on personal experience: I had an accident with a table saw in which I chopped off fingers. I find years later that we do think and feel with our hands. The things I can't do anymore frustrate me. You see, your relationship to the environment is determined by how your body relates to the world.

"Maurice Merleau-Ponty, the French existential phenomenologist, argued, in contrast to Descartes, that a person is a body in the world. So it is a question one can go around on. Emotional attachment to the heart is strong. It's what you hear go boom boom boom when you fall in love. And it goes blump bloomp when you are 49 and going up stairs. Suddenly it's going to be taken out of you and somebody else's put there. When I talk to patients about their feelings, nothing clear comes out. I'm positive, though, that there is emotional content with the heart. It's got to be there somewhere."

It is tempting to arrange a test of how truly indifferent recipients are to identity questions surrounding their new organ. Ask a 250-pound male construction worker how he feels knowing his new heart was that of an 18-year-old female. Ask a black man how he feels knowing he has a white man's heart in his chest, and vice versa. Sexist and racist feelings aside, the recipient would almost certainly discover an intensified awareness of the presence of that



"If you buy Descartes's idea that the person is a soul inside a body, you can say the soul is there even if the brain is transplanted."

organ. It would very likely become almost palpable, and possibly begin to seem, however mildly, like an intruder. I suggest it would alter most people's sense of identity, whether they would admit to it or not.

The philosophical question becomes more meaningful, and grows virtually insoluble, the closer we get to the transplant of brain tissue. As Joseph Fletcher points out, if an entire brain were transplanted it would not be a brain transplant at all, it would be a body transplant. "The brain is where the person is," he says. "The person being saved would be the donor, not the recipient. You'd be giving someone the gift of someone else's body."

Be that as it may, the issue is largely academic, for whole brain transplant is probably going to elude us forever. The technical problems are just too great. The brain has such a short life following loss of its blood supply that it would die before the surgeon could get it unhooked from the donor's skull. Moreover, it is hard to imagine surgical proficiency of a degree sufficient to rewire all the tiny connections that feed into a brain.

That said, however, it seems at least possible that we will soon be able to transplant some kinds of brain tissue. It has been talked of, for example, as a treatment in Parkinson's disease. No one can say for sure that certain processes associ-

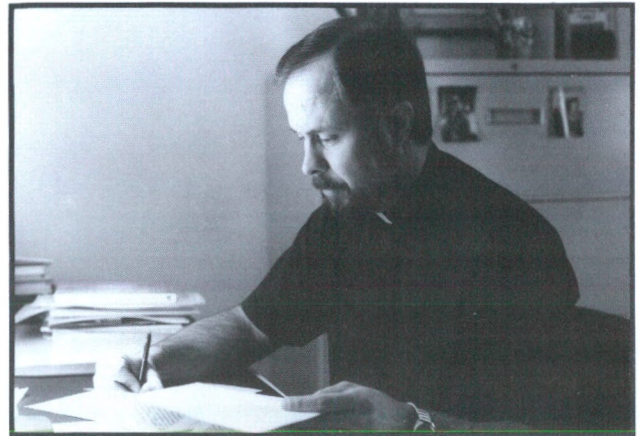
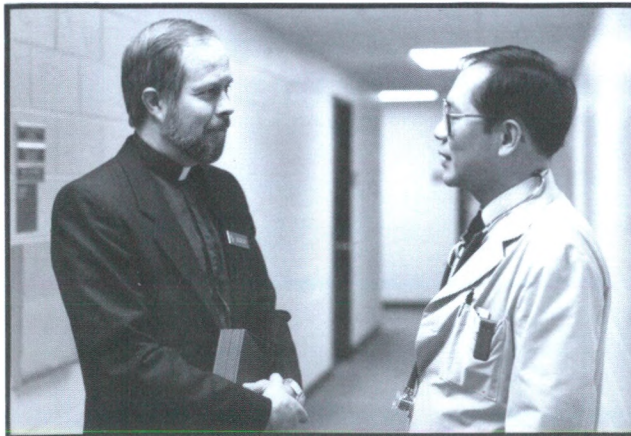
ated with thought and memory aren't localized to some extent in motor tissue, hence there is the chance that in curing someone of Parkinson's one would be altering the mental state, intellectual capacity, or stored memory of the recipient. If two personalities were melded, however subtly, in such a way, who would the resultant person be?

Questions of a similarly troubling nature are raised by artificial organ transplants and xenografts, transplants of animal organs. Kenneth Vaux is disturbed by "this discontent we have with our mortality and the ambition we have to infinitely interchange parts and pieces. I think it's probably a misguided search for physical immortality. And the ultimate immortal substance, these days, is plastic: plastic parts and plastic pieces. It raises a fundamental anthropological question, What kind of human being are we searching for?"

Clearly, as we pursue the logical course dictated by progress in transplant technology, we risk ever more disturbing questions, conundra without end. One is reminded of the old wizard, Djedi, hoisted by his own magic, crying plaintively to a pharaoh intoxicated with the game of tampering with nature: "But not to a human being, O king, my lord! Surely, it is not permitted to do such a thing to a man." ☸



Hospital Chaplaincy



as Public Ministry

Don S. Browning

In the 1960s, two books issued the call for the church to go beyond its own walls and develop new ministries to the outside world—Gibson Winter's *Suburban Captivity of the Church* and Harvey Cox's *Secular City*. Ministries within the contexts of community organizations fighting urban blight, industry and labor unions addressing economic injustice, and social service organizations dealing with problems of health or poverty gained the most attention. In these areas lay the deepest needs, it was thought, for public ministry.

What was often overlooked during this period was the supreme example of public ministry to be found in the well-established tradition of the hospital chaplain. It was also not recognized during the 1960s that within a few years the hospital would become the setting for some of the most challenging and dramatic social and ethical issues facing the modern world. In those days of the church's heroic social action in the areas of racial relations, peace, housing, and employment, few of us could have anticipated the special opportunities for witness, care, and action available to the chaplain within the religiously and ethically challenging context of the modern hospital.

Although I am not currently a chaplain, I have

served in the past as a chaplain in two hospitals, and my career as a writer and researcher in the area of religion and mental health has given me further opportunities to observe this remarkable ministry. Ministers and lay persons, as concerned individuals, volunteers, and members of hospital boards, are all part of the church's full ministry to the modern hospital, yet the hospital chaplain's contribution remains a crucial and distinctive public ministry.

The Meaning of Public Ministry

What is a public ministry? And how does it differ from the work of ministers and lay persons who visit the ill in their local congregations? Aside from the obvious facts that the chaplain is always available, is open to all patients of the hospital and not just those of a particular congregation or faith, and is especially trained to be sensitive and understanding, why should this ministry be called a public ministry and be distinguished from the work of the parish minister? A public ministry is one that uses the resources of the Christian or Jewish faiths to address an issue in the public world which will in some way help various individuals or groups but may not necessarily lead them to become Christians or Jews. A public ministry is rooted in the belief that there are strong theological reasons to use the message and

The author would like to express appreciation to Chaplain John Serkland, Coordinator of Pastoral Services and Research, Northwestern Memorial Hospital, for discussing the ideas of this article.

symbols of these faith traditions to work for the increase of any one of a number of goods—food, housing, employment, health—which will benefit the larger civic community even though it may not make the individuals of that community any more likely to be faithful members of these religions. A public ministry serves a value, or set of values, that both the public and the Christian or Jewish faiths hold dear. A public ministry recognizes the pluralism of modern societies and works to enhance the good of the community by cooperating with and respecting all of its traditions. But it does this on the basis of the beliefs of a particular religious tradition.

The hospital chaplaincy is a ministry of this kind. Working from the conviction that both Judaism and Christianity are vitally interested in health, the chaplain uses the theological resources of these faiths to enhance the value of health for hospital patients. The Christian faith—the tradition I represent in this article—clearly is interested in more than health; it has vital interests, for instance, in salvation, justification, and sanctification. But it is also interested in bodily and mental health.

The Judeo-Christian tradition makes a few simple but profound affirmations about the importance of health. First, health is a gift of God and part of the goodness of creation; all humans were created to have and enjoy basic mental and physical health. Second, faith and trust in the goodness of creation enhance health. This is a very basic kind of faith—what we rightly can call a pre-Christian level of faith that is grounded in God's general revelation to all of creation. The Christian hospital chaplain hopes that all people and all patients have this fundamental level of faith and trust whether or not they acknowledge that the God Jews and Christians worship is the source and object of this trust. Finally, for the Christian,

the particular faith that Jesus reveals God's love in a special way is an additional source of health; it helps overcome the tension and anxiety that the human proclivity toward sin and idolatry injects into our lives.

The affirmations of God's general concern with creation, its fulfillment, and its health constitute the theological grounds of the Christian chaplain's public ministry to a pluralistic patient population. Of course, at times the chaplain performs care directly out of the central Christian affirmations about the nature of God's work in the person of Jesus. But almost always the chaplain uses these resources to promote health or help someone deal with the loss of health. This is the primary goal.

The chaplain's ministry in the modern hospital has several dimensions. (1) The hospital chaplain performs public ministry primarily in the service of health. (2) The chaplain addresses issues of health and loss of health in light of the Christian faith and represents its larger meaning about life within the specialized context of health care. (3) In doing this, the chaplain functions as a value-committed cultural anthropologist: he seeks to become attuned to the world views of the patient, his family, and the staff as these shape their respective understandings of health and the larger purposes of life. (4) Frequently, the chaplain helps to negotiate the conflicts that emerge when the faith of the patient differs from that of the staff or the family. (5) When this happens, the chaplain sometimes facilitates, and even stimulates, a religio-ethical dialogue about the goals of treatment for the patient. (6) Although health is the primary value that chaplains serve in their public ministry, they often help deepen the faith and enrich the spiritual growth of the patient as well. The case of Margaret provides a rich and moving illustration of a chaplain's work with a patient.

Margaret and the Will of God

Margaret, a patient with a severe kidney problem, entered a hospital in a southeastern state during the early 1970s. At this time the practice of kidney transplantation was just commencing, and resources for renal dialysis were still scarce. Margaret had three children, was divorced, and appeared to have a low I.Q. The hospital committee that made decisions about who would receive dialysis and transplantation was at first inclined to deny her these treatments. They defended their decision on the grounds of Margaret's limited education and cultural background and apparent low intelligence. Margaret appeared generally unable to take care of herself, and the committee thought that she simply would not be able to follow the routines and procedures necessary to make her treatment effective.

The chaplain, Reverend Carr, objected to this line of thinking. He argued before the committee that Margaret was not as mentally deficient as they thought and that the cultural differences between her and the members of the committee should not be interpreted to mean that she was undeserving or unable to use these resources.

Soon after the chaplain took his stand, he had a most interesting set of conversations with Margaret and her family. Margaret's family adhered to a rigid version of Reformed Christianity, a form of Scottish Presbyterianism in which all of life's fortunes, good or bad, were regarded as the direct will of God. Margaret herself subscribed to this "stout Calvinism," as Chaplain Carr referred to it. She once said, "God wills that I be sick, and once God has made up his mind, there is no changing it. You doctors can't really help me. No bunch of doctors can save me if God has decided that it is time for me to go." These words were not just

idle chatter. Margaret did not comply well with even the simple routines of her everyday care. There was little hope, the doctors thought, that she could comply with the more complicated procedures of dialysis or a kidney transplant.

In conversation with Margaret's father, Chaplain Carr made it clear that he did not believe it was God's will that she be sick. He acknowledged the Presbyterian belief in God's providential governance over the events in this world, but said he did not believe that it covered such details as Margaret's illness. The chaplain was skilled enough to give a scriptural argument for the view that God's providential rule does not mean that God wills particular sicknesses. For instance, if God willed particular diseases, why did Isaiah pray to God "restore me to health and make me live" (Isaiah 38:16)? If God wills our specific illnesses, such a prayer would be pointless. Furthermore, he argued that if God wills each sickness, there would have been no point to Jesus' own ministry of healing. God indeed wills sickness as a part of the general plan of life, but not particular sicknesses, "not my sickness or your sickness or Margaret's sickness." In fact, God's providence, the chaplain explained, is something we can latch onto and cooperate with in the struggle to return Margaret to health. "God's providence," he pointed out, "primarily works for our health."

Later, Margaret told Chaplain Carr that she had heard from her father about the conversation. The father thought that the chaplain had made some good points and "really knows his Bible." Then Margaret asked, "Pastor, do you really think I can get well?" The chaplain answered that he thought there was a genuine possibility that she might.

After a few days had passed, nurses on the ward asked Chaplain Carr, "Have you seen Margaret recently? You will be amazed. She is now cooperating beautifully with her treatments."

The Chaplain as Servant of Health

This case illustrates clearly the first point about the nature of hospital chaplaincy: the chaplain is involved in a public ministry aimed primarily at enhancing the value of health. Chaplain Carr does not attempt to convert Margaret or make her a better Christian. He does not speak to her about the meaning of salvation or attempt to induce a religious experience. He might have done these things had Margaret in some way invited him to take these steps; this would have involved special understandings or covenants of permission between them.

Although the chaplain did discuss with Margaret and her family their understanding of God's will, the purpose was not to change Margaret's beliefs to fit more closely his own. The purpose was to detect elements in Margaret's beliefs that were working against the possibility of her becoming well. The value of improved health was the aim of the conversation; conversion, salvation, justification, or sanctification as such were not Chaplain Carr's immediate concerns. He might wish that she would eventually move toward these deeper religious experiences, but they were not uppermost in his ministry as a chaplain in the health care context.

This case also illustrates the second point, that the chaplain enhances health by representing a fund of symbolic resources within the Christian faith which enable people to see life as a whole. Notice that when the chaplain discusses with the family their understanding of Calvinism, he is only indirectly discussing health. The central issues are the nature of God's providence and the role of human agency. Is God's providence such that there is no place whatsoever for human responsibility for oneself? This question had implications for Margaret's health, but it was not

directly about that. If the answer is that there is no place for human agency and that God's will is the basic cause behind every single event (even Margaret's kidney problems), then there is nothing for Margaret and her family to do and Margaret's health can no longer be influenced either by her or by her doctors. The point is that questions of health are often part of much wider systems of meaning. The chaplain's training prepares him or her to deal with these larger questions about the meaning of life, the role of God's action in life, the place of human responsibility, the nature of human fallibility and sin. In addition, the chaplain should be an expert on the relation of religion and health in the Western religious traditions. Questions of medicine and health rarely stand isolated; they are integrally related to other systems of meaning which the theologically trained minister ought to be adept in understanding and uncovering.

The Chaplain as Cultural Anthropologist

This case strikingly illustrates the third point—that the chaplain should function as a value-committed cultural anthropologist. Chaplain Carr resembles a cultural anthropologist because much of his work with this case involves uncovering the beliefs about health, agency, and the will of God which Margaret and her family hold. But he is a value-committed cultural anthropologist in the sense that he has a particular value stance and normative framework for the interpretation of life—the Judeo-Christian tradition.

It is interesting, however, to notice how prominent in these conversations is the value framework of Margaret and her family and how secondary is that of Chaplain Carr. Chaplain Carr spent most of his time

A public ministry uses messages and symbols of faith traditions to benefit the larger civic community—even though it may not make members of that community any more likely to join these religions.

getting inside Margaret's world: he listened to what she and her family had to say about how they saw life, God, human freedom, and health. In the process he gleaned information which indicated that Margaret's problem was not so much that she was mentally deficient or lazy but that she saw the world differently than her doctors and nurses. This was all the more a problem because these doctors and nurses were making decisions which would affect whether she lived or died. Their decisions were based to some extent on a misperception of her situation.

Chaplain Carr's theological training proved to be a valuable tool in dealing with Margaret's case, making him a better cultural anthropologist than were the other professionals who attended her. It was precisely Margaret's religious views that were so crucial to her attitudes about responsibility for her own health. In taking time to speak with the family, in hearing what they said, and in taking it seriously, Chaplain Carr entered deeply into their world view and learned something about Margaret that was absolutely pivotal for the possibility of her regaining some degree of health.

Although Chaplain Carr was successful, even adroit, in his ability to comprehend aspects of the world view of Margaret and her parents, he did not just stop with this. His commitments to the Christian faith came back into the picture, albeit in a special way. Chaplain Carr's own religious views doubtless led him to believe that there were more adequate ways to speak of God's providence, even within Calvinism, than Margaret and her family had received. But rather

than giving Margaret and her family a lecture about his views of the Christian faith, the chaplain helped them grasp a more classic expression of their own Calvinist faith. He helped them to reinterpret God's providence as the most active and most determinative source of good behind all events but not the direct cause of our specific diseases and misfortunes. All of this was done with the primary aim of promoting health.

The Chaplain as Negotiator of World Views

But the chaplain did not just describe Margaret's religious beliefs and attempt to lead her to a deeper understanding more conducive to her health; he tried to explain her motivations to the committee that was deciding whether she should receive dialysis or a kidney transplantation or neither. The professionals making up this committee themselves had been socialized into a particular religio-ethical world view: they believed health to be a primary value, if not *the* primary value of life. Furthermore, they believed that hospitals should be prepared to use heroic methods to save lives. But they also were acutely aware of the shortage of resources for both dialysis and kidney transplantation. And they had come to the conclusion that the individuals worthy of these heroic methods were those who valued health as dearly as they did

and who demonstrated the competence required to follow the regimes that these heroic interventions entailed. Margaret appeared to be disqualified on both counts.

Chaplain Carr, aware of this conflict, tried to mediate between the two sets of values. He tried to point out that Margaret's lack of competence might not really be evidence of mental deficiency but instead of an attitude toward life based on certain inadequate and distorted religious and cultural ideas—ideas which were not consistent with the classic expressions of her own tradition. Furthermore, in contrast to a condition of mental incompetence, these religious ideas could change. In fact, on the basis of his conversations with Margaret and her family, he had reason to believe that these attitudes were indeed changing.

How often do chaplains perform this act of mediation as part of their work? And is this kind of mediation a legitimate part of their ministry? I believe that chaplains do a significant amount of such mediation, more than they themselves may sometimes recognize, and that in doing it they are indeed performing both a legitimate and a crucial part of their total ministry. I do not mean to imply that patients and hospital staffs frequently experience cultural conflicts. Generally this does not happen. Yet it may happen more than we think, more than we know about. It was only by a combination of luck and sensitivity on Chaplain Carr's part that the conflict was unearthed in this case. But it stands to reason that such conflicts are often there in submerged and inarticulate form. Catholics, Jews, Hindus, Buddhists, the great variety of Protestants, as well as the large number of people who believe that they have no faith but in fact do—all these groups use the modern hospital, and their respective faith traditions all hold beliefs and symbols which have implications for health. The case of Margaret and her family provides one concrete ex-

ample. The chaplain should be trained to understand not only the religious views of those who are broadly of his or her own faith but also as much as possible of the religious views of patients from other traditions.

The Chaplain as Stimulator of Ethical Deliberation

It would be misleading to suggest that the chaplain is solely or even largely responsible for ethical deliberation in the hospital. But chaplains do have a contribution to make to the substance of that deliberation. More than that, they have a responsibility to use the ethical sensibilities of the individual traditions they represent to raise important ethical questions. Of course, their ethical judgments may not always be correct. The ethical issues facing the modern hospital are very difficult and quite new. It takes deep study of both the ethical traditions of the Jewish and Christian religions and the ethical issues facing modern medicine in order to make these traditions actually relevant to the complex particularities of modern medicine. No single chaplain may be fortunate enough to have mastered all that is required. Indeed, no single person today would be willing to boast a mastery of all that is needed to bring the ethical resources of these traditions adequately to bear on contemporary medicine's ethical challenges.

But the chaplain can and should, along with others, be a stimulator of ethical deliberation. In attempting to negotiate between the respective world views of Margaret and the committee, Chaplain Carr fulfilled this function. His belief that Margaret was not mentally deficient but simply came from a cultural background which made it difficult for her to take responsibility for her health was not presented as an indi-

cation that she was any more deserving of these treatments. He argued that Margaret was a human being and for that reason alone was deserving of treatment. She was self-reflective and self-transcendent. She was aware of herself as a distinct person. She controlled her life in its various areas. Her mental limitations, whatever they may have been, were in some ways beside the point. One either is or is not a human; there is no way to be half a human. In addition, he pointed out that Margaret was more competent than the committee believed, and that her changing religious and cultural attitudes toward agency and health might make her even more competent to handle these treatments.

From the perspective of formal ethical theory, Chaplain Carr's view of ethical obligation can be contrasted with the committee's more teleological and perhaps utilitarian position. What do these terms mean and what kind of ethical thinking do they represent? For the teleologist, to act morally is to act in such a way as to produce more good than evil, while the utilitarian, a kind of teleologist, holds that the moral thing to do is to produce the greatest good for the largest number of people. The committee doubtless thought that, in a situation of finite resources, the moral action was to use these resources to produce the greatest good for the largest number of people: since we do not have the resources to give everyone dialysis or transplantation, we have to choose those who will be able to use it well and live fruitful lives, which will in turn do more good for more people. On this score, Margaret seems to lose out. In addition to appearing mentally deficient, she also appeared so culturally limited that it seemed unlikely she would make significant contributions beyond her own life, except perhaps to raise her children. (It must be admitted that this latter contribution, if she were actually to accomplish it, would

be no small contribution to the good, even on strictly utilitarian grounds.) The utilitarian position is old and respected and probably the dominant operative ethic in most medical situations. Many ethical positions are far less defensible, but there exist still other significant points of view, some of which are thought to be more compatible with the basic commitments of the Judeo-Christian tradition.

Chaplain Carr takes a more deontological position: he defines moral action not in terms of other goods—the nonmoral goods such as food, health, or education—it will promote, but in terms of certain intrinsic features which can be recognized in and of themselves to be moral, for example, truth telling or promise keeping or treating other people as ends and never as means only. Some argue that this is the way to interpret such commands, found in both Judaism and Christianity, as *love thy neighbor*. To love one's neighbor as oneself is to treat the neighbor as an end and never a means only—as one would want to be treated oneself.

I am not prepared to argue that Chaplain Carr's position on the ethical question at stake in this case is superior to the committee's. Nor am I willing to say that his views are clearly more Christian than those of the committee. We must recall that this is a case from the early 1970s and that the ethical guidelines for programs in kidney dialysis and transplantation have been greatly refined. Neither the chaplain's nor the committee's response might be quite typical in the situations that exist today. Although this should be acknowledged, analogous issues exist today in various fields of medicine. Taking this into consideration, I do believe that Chaplain Carr has a good case and that his position should be taken seriously. Furthermore, a variety of weighty authorities could be cited to support both his interpretation of the Christian tradition and his application of it to this case. But regardless of

In terms of access to the entire family, as well as to the patient, the chaplain may have the edge on the other professionals of the health care team.

the merits of each side's position, Chaplain Carr provided a valuable ministry in raising these questions and stimulating this conversation.

The Chaplain as Stimulator of Spiritual Growth

The primary goal of the chaplain's ministry is the increase of health. Related to this is the goal of helping people to handle, with a fund of adequate meanings, the loss of health. But spiritual growth can still be an important consequence of such a public ministry.

Once again, we see this point in the case of Margaret. Margaret did grow in the process of her conversations with Chaplain Carr. In addition, he was able to say things to the family which in turn were communicated to Margaret. The chaplain's access to the entire family, as well as to the patient, is part of the potency of the chaplain's ministry. In this, he or she may have the edge on the other professionals of the health team. Through this indirect route, the chaplain was able to shift Margaret's view of God, life, and health sufficiently to give her a new sense of responsibility for herself. Insofar as this applies to other realms of life besides health, it can honestly be said that Margaret was helped to grow spiritually, although perhaps haltingly and in a fragmentary manner. Margaret was now possibly more able to entertain the idea that she and her God were in a covenant

partnership, and that although God was the principal actor in the covenant, Margaret still had responsibilities. In this view, life is a matter of growing in one's ability to assume these responsibilities. It would be premature to say that Margaret was entertaining this view of life in a very profound way, but she may have been taking steps in that direction. Many other examples could be given of how a ministry aimed primarily toward the value of health can have important secondary consequences for the larger spiritual enrichment of the patient.

Opportunities for ministries of spiritual growth can occur when the chaplain develops special covenants with patients. There is little that is mystical or complicated about this process. In asking, "May I offer a prayer?" or "May I return tomorrow and discuss further your views about the church?" the chaplain is inviting the patient to extend an invitation, and if one is forthcoming an implicit covenant is established. The chaplain, even within the context of public ministry, can then go as far in encouraging the spiritual growth of the patient as the patient is willing. This may be a spiritual growth in the face of the extremes of life, in the face of inevitable death, or in the face of enduring pain and suffering. The idea of chaplaincy as a public ministry does not preclude such special covenants. It only means that the chaplain cannot *force* spiritual growth on a patient or require it of the patient; he or she must establish covenants of mutual understanding which permit it to occur.

It would not be fair to use this case without telling

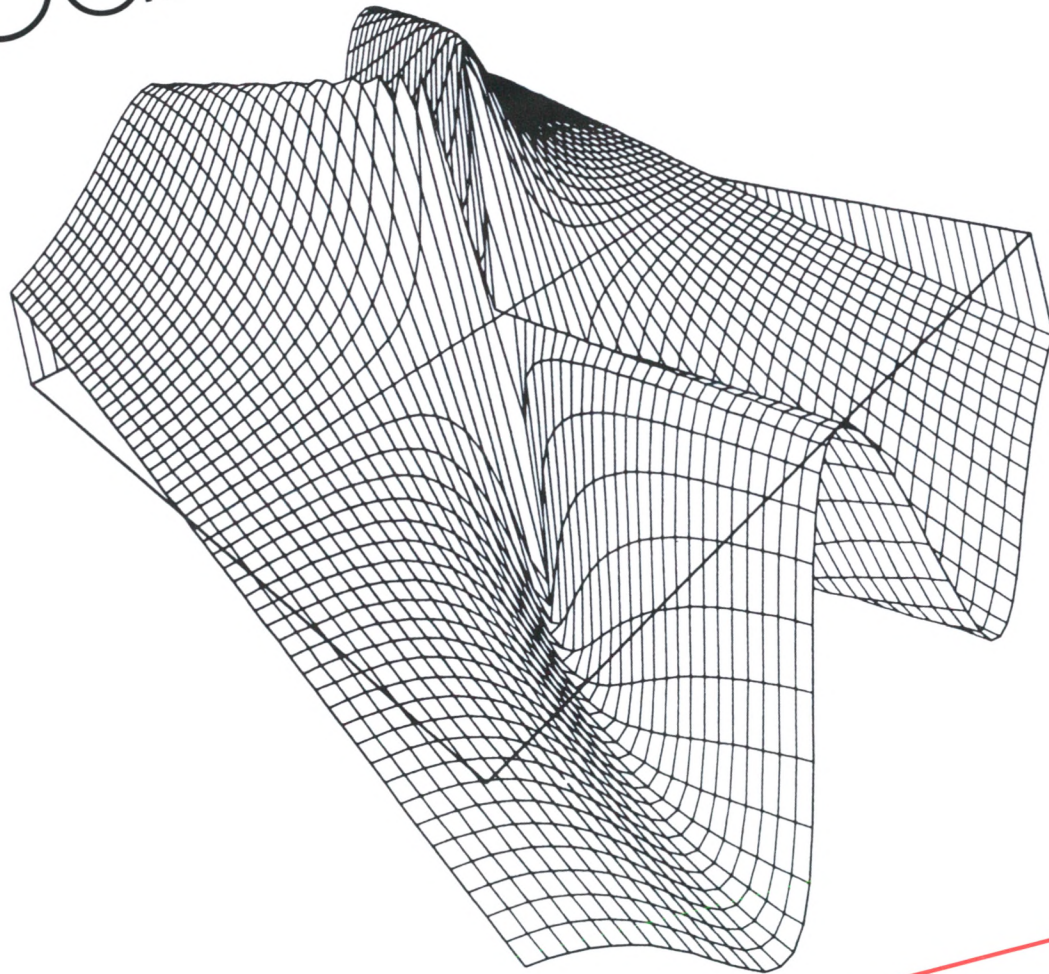
the end of the story. After several days of excellent progress on Margaret's part and excellent reviews by her nurses and doctors, a series of unfortunate events began to unfold. First, Chaplain Carr had to be away from the hospital for an extended time. In addition, several other staff members who were close to her and who supported her were, for one reason or another, away from the hospital. Only a person who has worked in a hospital or spent time there as a patient can fully understand how important these close relations are for a person as precariously balanced as was Margaret. Without these supports, Margaret began to lose heart and regress. She took less interest in her health and her routines. She became less cooperative and more fatalistic. The committee therefore concluded that it should stand by its original decision that she was a candidate for neither dialysis nor transplantation. Margaret was finally discharged and is thought to have died shortly after

she returned to her home.

This conclusion, I believe, undercuts none of the validity or importance of the observations elaborated above. It only underlines just how important the work of the chaplain is and what may happen if it is lost. The chaplain's ministry *can* make a difference in the health of patients. Had Chaplain Carr not been absent for an extended period or had there been others able to sustain his ministry, Margaret's progress might have continued and the committee might eventually have taken a different view of her case.

The presence of the professional chaplain in the modern hospital signifies a profound recognition on the part of modern health care that health hangs on many threads, and that two of these are religion and ethics. As the representative of religious and ethical traditions, the chaplain has a special contribution to make to the health care team, one which merits further study. ☺

Four Pathways



Second Opinion

of Medical Ethics

Kenneth Vaux and Sara Vaux

Medicine today is much in the public eye; practically a media star, it has become the subject of talk shows, news hours, *Time* magazine covers, and a great deal of in-depth coverage. Our growing concern with the health care enterprise has been substantially affected by the powerful forces of expanding technology, unpredictable economics, and new scientific knowledge. Mechanical ventilators, prospective reimbursement schemes, and the discovery of the AIDS virus have entered the realm of our public discussion, and we are newly curious about this field of medicine, which appears both glamorous and mysterious. Yet beneath explanations of *how* and *how much* lie questions of *why* and *for whom*, questions about the moral landscaping of modern medicine. The adventure of medicine seems at times to have become the vehicle of that age-old quest for life's meaning, its moral charter.

The landscape of medical ethics is crossed by four pathways: the instinctive, the professional, the political, and the transcendent. These paths sometimes intersect, sometimes vanish, but all are part of a cultural terrain we label the ethos, or moral atmosphere, of modern medicine. Each pathway merits attention.

I. Instinctive Ethics

Case A: The teenage girl lives in a Chicago housing project. No father is present; the cycle of poverty leaves meager resources for eating and living adequately, let alone expanding the young woman's world. Not really aware of what is available at the health clinic of her high school, she follows peer custom and becomes pregnant. She does not utilize the technological option of terminating the pregnancy; rather, she sees the baby as something to give her life security, love, and meaning. In a very simple way, she feels she is giving something back to the world, another chance for the human race.

Case B: Grandma asks her children to sell her frame house and place her in a nursing home. Her husband died some years ago; all her friends are gone. She has emphysema and congestive heart failure. She wishes not to burden anyone, to go away and die peacefully with as little pain as possible, to herself and all others.

Each case represents a primal/communal response to the health care technology available to that person. Both the teenager and the old woman believe they are choosing life. Each has made an ethical decision within a communal context, a resolve formed by instinct and intuition, yet shaped too by in-

grained familial and tribal (or social) mores. The language is heavy with inherited values and taboos: "I want my little bitty thing to love," "I don't want to be a burden to my children." The teen refuses available technology. The grandmother chooses to enter the system rather than linger at home: she has lived longer than she "ought."

The instinctive force in ethics is constituted from basic human responses tempered by the values of the community (family, society) of which that person is a part. How individuals care for their own health and that of family members—and how far they see their responsibility to lie in caring for persons outside their own tribal configuration—is not dictated in isolated reaction to the situation but has been shaped by communal expectations and fears: What has worked in the past? Which patterns of diet or exercise or mating, which responses to suffering, which family groupings have brought about a feeling of well-being, of unity within the natural world, of rightness? Collective tradition gathers up and embodies the styles, responses, and group attitudes belonging to the history of a people.

How has this instinctual force operated in its individual and collective meanings? Primitive people form their sexual behaviors and morals, for example, out of a sense of the allowances and sanctions,

the testing and taboos of their intimate communities. According to early field anthropology, not only overt actions but the underlying dispositions of such patterns of promiscuity or fidelity are formed by this mechanism. Similarly, the Hebrew strictures regarding cleanliness, diet, and sexual practices arose to protect the whole and save the people from unconstrained impulses. Behaviors which endangered human life (such as eating certain foods) or threatened the procreativity of the group (such as “letting the seed spill upon the ground”) were proscribed.

In the American colonies a kind of primal moral empiricism prevailed. A person entering Ben Franklin’s Philadelphia Hospital engaged in a contractual arrangement to take care of other patients.¹ Hundreds of sects of healers abounded in the colonies; a healer was one whose success in curing or helping the sick had been observed and thus empirically verified—“confirmed by the populace.” The lay test for accepting someone as a healer or midwife was “Does this person aid life?” The response of the community to disease in these instances was neighborly sympathy and care, akin to the mutual aid given in land clearing and barn raising. Solidarity and sanctity—the sense of one’s own life being bound up in the life of the tribe or community and of being communally precious—have been strong instinctual moral responses

throughout human history.

Today’s revolution in childbirth practices expresses a lay yearning for the return of intimacy, the restoration of familial and communal involvement, and a renewed sense of delightful mystery in place of technical mastery. Many parents practice the Lamaze method of birthing or have home birth, midwife-attended delivery, or some other more “natural” way of birth. At the same time that technological capacities (artificial insemination, amniotic screening, fetal monitoring, Caesarean section delivery) are increasing, more and more people are seeking to retain some of the primitive and natural elements of childbirth.

Although this rediscovery of earlier childbirth practices stems partly from revulsion toward the dangers of high technology obstetrics (anesthesia, labor-inducing drugs, and endemic hospital infections), it is more a restitution of certain goods that humans have always known intuitively to be the meaning of procreation and childbearing. The moral action visible here is in part maternal and paternal instinct, in part reassertion of tradition learned through generations, in part a rational decision based on the wisdom of simplicity. It is a primal/communal ethic based on common sense—instinctual ethics. Health care decisions today still trace portions of this primary moral pathway.

When a civilized society is thrown into crisis, existing social stratifications and ethical abstractions are muted, and the community regresses to this primitive manner of moral response. In *The Plague*, Albert Camus created precisely this type of altered situation: a city shut off from the rest of the world by a plague raging within its boundaries. "No longer were there individual destinies; only a collective destiny, made of plague and the emotions shared by all" (p. 150).

Is America entering such an era with the emergence of AIDS (acquired immune deficiency syndrome) as an inscrutable killer impregnable to our concentrated technological assaults? As AIDS and ARC (AIDS related complex) continue to double the number of their yearly victims and as the number of virus-exposed individuals mounts—there are now two million in the U.S.—will America's priorities in citizen protection and delivery of health care be challenged? Were AIDS to spread widely into the heterosexual population (and therefore to shed the label some have given it as a "judgment of God"), would the populace at large respond compassionately? Or would quarantine—or a witch-hunt—begin, as many homosexuals fear?

New York City, along with Chicago and Houston, has responded thus far by isolating the gay community, seeking to protect the whole

of its people from the threat of contamination. This prophylactic response is noble, but so also is that of San Francisco, where current public policy seems committed to staying with the sick. Camus's Dr. Rieux tirelessly fought the plague: "there was not one of [his patients'] anxieties in which he did not share, no predicament of theirs that was not his" (p. 272). These, too, are instinctual reactions to suffering.

The appearance of AIDS, the modern plague, has the potential to disrupt the instinctual ethical traditions: easy assumptions about right and wrong are being questioned. Such crises reveal just below the surface of all personal and public moral responses the spontaneous "gut" reactions which influence and shape all of the more reasoned and deliberate decision making.

AIDS, the modern plague, disrupts easy assumptions about right and wrong.

II. Professional Ethics

The instinctive moral response gives rise to the professional approach, as the community comes to feel the need for a chosen cadre of healers. The original recognition of herbalists, bone setters, medicine men, and soul healers was grounded on their experience-based technique and their exhibited wisdom. Authority or charisma was projected by this professional elite who possessed therapeutic knowledge,

and it was reciprocated by the implicit recognition and trust of the community. Hippocrates, the great Greek physician of the fourth and fifth centuries B.C.E., wrote that “some patients, though conscious that their condition is perilous, will recover their health simply through their contentment with the goodness of the physician” (Reiser et al. 1978:8). The professional pledge of the Hippocratic Oath (“to do no harm”) acknowledges this instinctual trust. A physician friend once observed that “parents and children harm, even kill each other. When persons put their lives in the hands of a physician, they do so trusting that he will neither harm nor kill. They can go to sleep [go under anesthesia] in this confidence.”

Historically, the clerical or professional class emerged from lay popular culture only after a considerable period of social development. This new social structure with its new ways of making moral determinations in life and death came only after subsistence and then manor and city life had replaced hunter-gatherer history. Beginning in the first millennium B.C.E., new groups of specialists emerged. Older traditions of self-healing and family sufficiency were challenged, and medical deliverance became the exclusive domain of the specialist. Codes of ethical conduct were formulated, but they upheld professional accountability within

the guild in place of a covenant between physician and patient. The older immediacy between healer and patient, between healer and transcending power, was replaced by a collegial authority. In the modern age, the processes of apprenticing, training, licensing, reward, and censure became functions of the in-group and not of divine or popular mandate.

The controlling ethics of the modern period were articulated in the seminal work of the English physician Dr. Thomas Percival (1801) and the American Medical Association codes (1847), which drew upon his ideas. These nineteenth-century codes dealt with obligations between physician and patient and between physician and the profession. Obsessed of necessity with such issues as fee-splitting, referral, gratuitous treatment for colleagues and their families, and bedside manner, the codes were found by the medical historian Chauncey Leake to be hopelessly irrelevant to the great bioethical issues of the twentieth century.

After the nineteenth century, American medical ethics became professionalized. Unorthodox practitioners—the healers of early America—were repudiated and put out of business. The Flexner Report (1910) called attention to the deficiencies of dozens of proprietary medical schools, assuring their doom and insuring the survival of

*Professionalism
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only the scientific university medical centers.

But the whole professionalism movement can also be seen as an evasion of fundamental ethical responsibility and accountability to patients. The professional ethic, like the instinctual one, has its dark side. Concerns with monopoly, reputation, prosperity, cordiality, and etiquette seem almost an escape response to the crises of life and death and to the imperatives of justice. The fact that medical ethics today is much more directed by public and political forces than by professional mandate is surely a symptom of this professional failure.

Despite these besetting weaknesses, certain positive features of the professional ethic of medicine exert enduring salutary effect. What are the virtues of the medical tradition as a moral pathway? We mention three out of many: the tradition of the profession as a calling or vocation, the emphasis on integrity, and the commitment to community welfare.

The older idea of profession in Western Catholic and then Protestant civilization was *vocatio*, calling and ministry. In some parts of the world—in Canada, for example—we still see remnants of this legacy when we speak of the “ministry of health.” The *iatros*, the therapist, is seen to be a representative or ambassador of God, a concept which provides for the profession a

transcendent reference and a higher accountability. In Hebrew medicine, for example, the standard is Yāhweh, the physician (Exodus 15:26). In Hippocratic medicine Apollo and Asclepius, Hygieia and Panacea give guiding inspiration. Early Christian medicine looked to the example of Jesus of Nazareth, the Great Physician. In Hindu, Islamic, and modern Jewish medicine the medical oath is a solemn pledge before the divine source of life and health. Even today, when a medical college graduates a new class of physicians, some version of one of the classic professional oaths is recited. It may be the Oath of Hippocrates, the “Hippocratic Oath as a Christian May Subscribe to It,” the Oath of Maimonides, or some version of the Helsinki, Nuremberg, or AMA codes. In most of these recitations, the neophyte physician acknowledges that he or she now stands in a position of awesome responsibility before the moral powers of the universe, in the train of dedicated practitioners who have gone before and who now labor in the community of the sick and troubled. The notion that the doctor is singled out for special service, whether it be anchored in divine call, subjective awareness of one’s gifts, or the authorization that comes from public need, has always had a morally liberating and chastening effect.

While the sense of having a calling in ministry or medicine creates the

risk of arrogance and disdain, it also provides the foundation for a wholesome sense of pride, freedom from untoward influence, and integrity. The inherent and integral power found within the medical profession is bolstered by privileged knowledge and techniques transmitted to the apprentice. Admittedly, certain modern developments, among them the emergence of specialist teams of respiratory or dialysis therapists and visualization techniques that can replace the human touch of palpation, are now lessening the aura of technical magic which has always surrounded the physician. These developments severely challenge both the uninterrupted intimacy of the doctor/patient relationship and the self-sufficiency that once marked the profession. Now other health care workers and machines of various sorts do things better than the doctor can. The doctor of pharmacy better knows specific indications and counterindications of cancer drugs. The nurse is better equipped to overview the psychosocial dynamics. The computer can climb the decision analysis tree more surely and swiftly. Yet that strength remains.

This integral strength, a certain moral power, is reflected in added dimension in a third virtue, the physician's acceptance of the role of servant to the community. The root meaning of *doulos*, of servanthood,

is religious. It is a religious refinement of servitude, that ancient and perennial social disorder of holding some persons—women, blacks, or the poor—as slaves. In the Christian tradition it is Jesus who provides the model: Jesus the God emptied himself of divine power and became servant (Philippians 2:5). Service professionals may conceive themselves to be likewise expendable, open to serve whatever human need exists in the community. The plague in Camus's story can be seen as an isolated disease, as disease itself, or, as one old man comments at the end of the novel, "life." Dr. Rieux observes that "the only means of fighting a plague is—common decency." When asked to explain further, he replies, "in my case it consists in doing my job" (p. 150). Perhaps the finest expressions of the professional ethic of service are found in charity and volunteer medical ministries in inner cities, rural areas, and foreign missions. Walter Reed and the noble trail of pioneers fighting infection at great personal cost, often involving auto-experimentation, risk, and even death, have exemplified this spirit of self-sacrifice. The San Francisco physician who stands near in service to his patient with AIDS comes to mind today.

The 1985 Nobel Peace Prize was awarded to an organization, International Physicians for the Prevention of Nuclear War. American Bernard

Lown and Russian Yevgeny Chezov, cofounders of this organization, accepted the prize in Stockholm. Though unpopular in this day of resurgent ethnocentrism and nationalism, this movement expresses the finest spirit of professional ethics in its concern for insuring public safety and well-being.

III. Political Ethics

The image of the physician as public servant opens yet another dimension of medical ethics. By virtue of their special knowledge medical professionals serve as monitors and sentinels of health dangers. The political responsibility to forewarn both patients and communities of risk and impending danger is part of all ethical codes. The Centers for Disease Control provides an example of this public health function.

The political dimension of medicine has ancient roots. In classical Greece and Rome, for example, parental prerogatives were operative in the first days of a child's life, so that their private decision prevailed regarding disposition of a handicapped newborn. But after ten days it became a political matter. The child was presented to the polis, to the state officials, to receive a name and formal citizenship. Then new laws, protections, rights, and obligations were conferred.

The great political revolutions of Western civilization (England's in 1640, America's in 1776, France's in 1789, Germany's in 1848) displaced monarchic and oligarchic power with democratic systems of human rights and civic duties. Health and happiness, once thought to be dispensations of divine grace or the benefits of status in the feudal hierarchy, came to be seen as natural rights, in some sense secured and provided by state policy and programs. Bismarck's health and welfare systems and other Western entitlement programs made health care not a privilege but a presumed right and therefore a public responsibility.

Today one hears of the rights to privacy, to sexual freedom, to health care, to life, and of the right to die. Citizens expect these rights to be secured and safeguarded by political mechanisms. Conflicts have precipitated the need for new legislation, public policy, or case litigation. For this reason many of the moral determinations about health concerns from birth to death now seek resolution in the political forum. One need only recall the names of Karen Quinlan, Baby Doe, or Barney Clark to be aware of the impact of law and politics in this area of human decision making.

The sense of entitlement not only to rational freedoms but also to goods, desires, and needs, has inevitably been accompanied by colliding claims on those common and

Health and happiness, once thought to be dispensations of divine grace or the benefits of status, came to be seen as natural rights.

The responsibility to forewarn of risk and impending danger is part of all ethical codes.

limited resources. Do aged and terminally ill patients have access by right to life-sustaining technologies such as dialysis, transplantation, chronic mechanical ventilators, artificial hearts and other organs? Does the right to die with dignity or the right to privacy entitle one to elect to forgo antibiotics, food and water, respiratory resuscitation, or mechanical ventilation when under care in a hospital? Where and when must the private liberties of sexual behavior, life-style indulgence, and resource exploitation be set aside for public goods and interests? The limitations conveyed by these questions betray the inadequacy of political ethics as the solitary vector. The political ethic is viable only when undergirded by instinctual and professional ethics and when overridden by transcendent ethics. The political pathway, when joined to the others, provides more secure passage through the moral wilderness.

In the 1980s, the political is the dominant mode of medical ethics, as the volume of malpractice cases, judicial decisions, and legislative actions clearly indicates. But such dominance is dangerous, and fluctuations in the political mood can lead to inconsistent moral positions on profound issues. In the 1930s the Nazi state enforced a demonic political ideology in the areas of eugenics, sterilization, abortion, and euthanasia. Today prevailing political moods have influenced decisions

about whether to save handicapped newborns and whether to cease treatment of the terminally ill. Baby Doe and Karen Quinlan have become slogans for political causes and groups.

Political decisions also shape the patterns of disease in a given society at a given moment in history. Illness and mortality rates from causes as diverse as premature birth and hypertension are very much affected by political and economic policies. Will funds to treat the poor in American hospitals be cut further? A policy change here will affect the unborn as well as the ill in this economic group.

The political arena will always be the court of last resort, at least in temporal terms. Only if courts deny jurisdiction can issues finally be resolved elsewhere. The judges in Karen Quinlan's case, in response to her parents' claim that God was calling Karen home and that treatment decisions should be made in that light, said that the court could only decide the temporal issue. Similarly, a New York judge recently wrote that he found the temporal courts particularly unsuited to rule in matters concerning the human spirit, in this case whether to allow death in the presence of terminal illness.

IV. Transcendent Ethics

Case A: Baby John is born with a severely shortened and damaged intestine. With most of the bowel already dead, he must be fed by a direct line into his neck. He will never be able to eat on his own, but could well live for some years with artificial feeding. The ongoing need for repeated injections provides occasions to let the child die. The doctor asks the hospital ethics committee to advise.

Case B: The young woman is afflicted with aplastic anemia. Treatments fail to check the disease so that the bone marrow can again generate the blood components. The doctor has difficulty broaching the subject of resuscitation orders and facing with the patient decisions about discontinuing treatment.

The toughest moral decisions faced by physicians involve actions taken in the face of impending death. Though instinctive, professional, and political perspectives are present, such crises of decision by their very nature demand that more fundamental, transcendent values come into play.

How can ethical claims from the age of belief be made in this secular age? Broadly, the transcendental perspective encompasses elements of both private and communal ex-

perience: the “still, small voice,” the consciousness of mystery felt at a birth or a death, the comfort of hearing the congregation recite the Torah at a young friend’s bar mitzvah. Personal decisions to deny the objective reality of the Divine or to remain unattached to a religious community are somewhat separate from any discussion of the influence of transcendent ethics on the practice of contemporary American medicine. Faith traditions based on revelation and humanisms not grounded in theology intimately intertwine with the ways in which medicine is practiced and received, and both need to be understood.

More often today than perhaps a century ago, the physician is present at moments of passage such as birth and death, filling roles earlier played by the pastor, priest, or rabbi, or by family members. When faced with crisis and shorn of securities, human life is cast up against mystery. Reason fails, politics does not suffice. Times of love, joy, hope, and ecstasy, periods of dread and despair—these are moments of transcending significance, when closed categories are broken open and unasked questions beg for answer. At these moments, as Teilhard de Chardin wrote, we “lose our footing completely in ourself so as to deliver us over to the powers of heaven and earth” ([1917] 1974:23).

Transcendent ethics, then, are theological ethics; their reference is

How can ethical claims from the age of belief be made in this secular age?

to that which is ultimate. A woman watching in silence at the deathbed of her mother may feel that no element of her daily life has prepared her for this moment of letting go. On instinct she may react to the challenge according to a sense of rightness or of community values; her physician may counsel her by his professional lights; the laws of the State of Illinois may sanction or forbid certain behaviors at this edge of life. Yet the woman who is still daughter feels the need for (and possibly the absence of) a higher ethical norm than those provided by the human constructs of self, profession, or law.

Likewise, periods of national or community stress, such as the regression of the Nazi era (which Camus represents as the plague in the extended parable of Dr. Rieux and his city of Oran) may stimulate among many people an awareness that the self, one's occupation, and the political milieu cannot alone serve as sources of guidance for the moral life. The consciousness of the "Other," what Rudolph Otto referred to as "the Holy," may emerge even within a secular world view. Dr. Rieux, though he looks for transcendence and sees only the abyss, behaves as though some activities (healing, loving one's friends and one's wife) are value-laden, as though some ways of being with other persons are of more worth than others. Why is he faithful? Does

he feel these values to be eternal and not simply expedient? Whence arises that awareness of some ultimate value such as charity, mercy, or human love? Traditions of belief attempt to answer that question. Individuality and immediacy do not suffice. Collectivity, memory, and hope are required.

Faith traditions are embodied in human communities which discover, develop, inculcate, and nurture the beliefs and values that touch on the profound moments of existence. Transcendent ethics within these traditions refer to faith-derived thoughts and actions which guide members of a religious community through tough and sublime moments alike.

The complex influence of various faith traditions (whether overtly religious or not) on medical decision making becomes apparent at many points in the history of medicine. In the first great Egyptian religious-medical text, the Ebers papyrus of the second millennium B.C.E., for example, the healer was portrayed as a priestly figure, a mediator of the divine therapy. In the Hammurabi Code of 1800 B.C.E, in which the earliest rules of justice were advanced, the physician was ultimately subject to the judgment of the divine king. In this code, too, is found the idea of the sanctity of the human person, an ethic later intensified in Jewish and Christian thought.

In the Hippocratic writings, furthermore, Pythagorean mysticism colors this view of the connection between healing and the divine. In this tradition the physician was held accountable before the Divine Word, the “Mystery.” “Things . . . that are holy are revealed only to men who are holy. The profane may not learn them until they have been initiated into the mysteries of science” (Reiser et al. 1978:8). The Divine, Hippocrates believed, was the source of the physician’s therapeutic power.

The Jewish medical texts of A.D. 200–1200 continued to express this consciousness of the divine element present in the human arts of healing. The Oath of Asaph, for instance, enjoined adherents not to “harden your hearts against the poor and needy, but heal them . . . Ye shall not make use of any manner of idol-worship to heal thereby [but] put your trust in the Lord your God, the God of truth, the living God, for He doth kill and make alive, smite and heal. He causeth healing plants to grow and doth implant in the hearts of sages the skill to heal by His manifold mercies” (*Encyclopedia of Bioethics*, p. 1733). “The Daily Prayer of a Physician” (or “Prayer of Moses Maimonides”), though not written by that thinker, nonetheless reflects the beliefs of the celebrated physician and mingles religious concerns with professional ones.

Almighty God . . . thou hast endowed man with the wisdom to relieve the sufferings of his brother, to recognize his disorders, to extract the healing substances . . . Thou hast chosen me to watch over the life and health of thy creatures . . . Support me in this great task so that it may benefit mankind, for without thy help not even the least thing will succeed. (*Encyclopedia of Bioethics*, p. 1734).

Centuries later Thomas Percival echoed the theme of transcendence when he commented in his 1801 code that “the moral and religious influence of sickness is so favorable to the best interests of men and of society, that it is justly regarded as an important object in the establishment of every hospital” (Reiser et al. 1978:18).

Early ethical codes openly declared “the Divine” as the source of healing power. Today, although a transcendent reference is reflected in many major medical activities, its presence is largely unacknowledged. Discussions of the implantation of the Utah artificial heart into Dr. Barney Clark have suggested that this medical activity was profoundly influenced by a prevailing Mormon world view and the “values of Mormonism,” despite the chief surgeon’s disavowal of priestly (and sectarian) identification. Renée Fox comments that

The transcendent reference reflected in many major medical activities is largely unacknowledged.

the artificial heart implant dramatically exemplified . . . fundamental principles of Mormonism: its pioneering, innovating history and perspective; its sense of manifest destiny; the at-once secular and spiritual importance it attaches to health . . . the practical and this-worldly, but transcendental significance it accords to personal and collective improvement, accomplishment, mastery, and progress, through vigorous human effort. (1985:84–85).

When transcendent perspectives are unacknowledged, they can become dangerous because their influence is never self-consciously ex-

amined. Somehow physicians and other health care providers must learn to bring reason, criticism, judgment, and empathy to an examination of all dimensions of medical decision making. That effort will require an openness to consideration of transcendent dimensions and claims which may be quite foreign to individual decision makers. Such openness may be a subtle but important first step to moving beyond the dominance of inadequate political responses to the problems that beset us in the modern medical realm. It may also make us more responsive to all the needs brought to a health care situation by patient and professional alike. ☉

The "Four Pathways" computer graphic on the opening page of this article was designed by Melvin E. Prueitt of the Los Alamos Scientific Laboratory, University of California. It has a function of $F = XY^2/X^2 + Y^2$ with a relatively large range for X and Y, and was based on a function suggested by Dr. Norton Starr, University of Waterloo. Source: Computer Graphics, Dover Publications, 1975.

NOTES

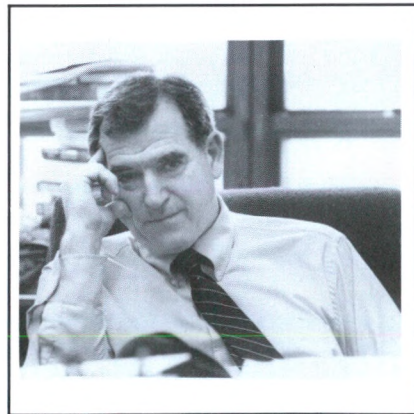
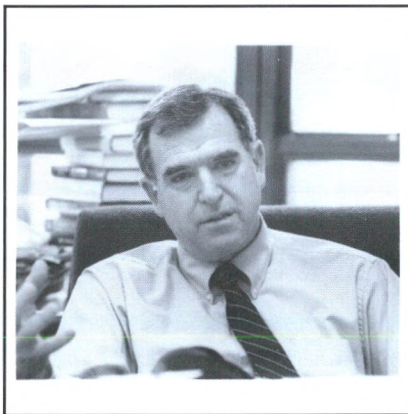
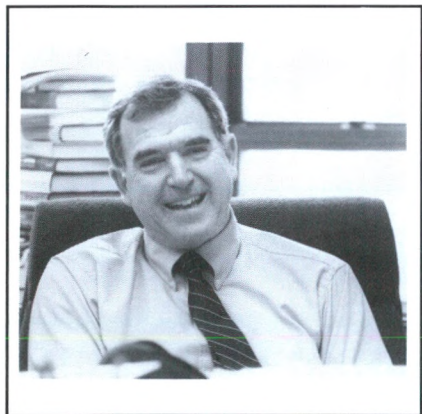
1. Philadelphia Dispensary, Minutebook 18, 25 June 1816. Archives of the Pennsylvania Hospital, Philadelphia. See also "Brief History of the Southern Dispensary," Southern Dispensary, 81st Annual Report (Philadelphia, 1898), 6–10.

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Raising Questions about Modern Medicine:

Chances are that when a medical story makes national headlines, whether in *Time*, *Newsweek*, the *New York Times*, or network TV news, the original source was the *New England Journal of Medicine*. Each week medical reporters around the world (and more than 200,000 other paid subscribers) rely on the Journal for the latest in medical research and technology, certain that the Journal will not knowingly publish findings that have appeared in any other publication. Testimony to the Journal's success lies not only in its size and reputation, however; founded in 1812, it is the oldest existing medical periodical in continuous publication.



An Interview with

New England Journal of Medicine

Editor Arnold S. Relman

With this in mind, *Second Opinion* traveled to Boston to interview Arnold S. Relman, M.D., editor of the Journal since 1977. Before assuming his editorial responsibilities for the Journal, Dr. Relman held academic and administrative appointments at the Yale University School of Medicine, Boston University School of Medicine, and the University of Pennsylvania School of Medicine. In addition to his duties at the Journal, Dr. Relman currently serves as professor of medicine at Harvard Medical School and physician at Peter Bent Brigham Hospital and Women's Hospital. On 6 November 1985 Dr. Relman provided readers of *Second Opinion* with this wide-ranging discussion of the current medical scene.

Second Opinion: We are interviewing you because we think you sit in a spot that allows you to address and monitor a very significant part of the medical profession. How would you introduce yourself to *Second Opinion's* readers? What led you first into medicine and then into medical journalism?

Dr. Relman: As a high school and college student I was interested in journalism and editing. I like to

read and have always paid attention to writing and literature. At Cornell University I majored in philosophy—I started out with the idea that I might actually become a professional philosopher.

Second Opinion: What changed your mind? How did you end up in medical school instead?

Dr. Relman: Well, my interest in philosophy was always accompanied by a fascination with

science. Indeed, my interest in philosophy focused on philosophy of science and logic, although I also studied the history of philosophy and philosophy of religion. In high school, after reading books like Sinclair Lewis's *Arrowsmith* and Paul De Kruif's *Microbe Hunters* and *Men Against Death*, I was gradually drawn to the idea of a medical career and medical research. Although in college I was a philosophy major, I also accumulated enough credit

hours in chemistry, biology, physics, and math to be a strong premedical major as well. I finally decided that I was more interested in medicine as a career because I saw myself essentially as an individual interested in practical works and in being useful. I have never lost the feeling that philosophy is terribly important; I thought it was something I could enjoy personally but concluded that I would be more effective and useful as a physician. So I went to medical school at Columbia University.

Second Opinion: What other decisions shaped your vocational path?

Dr. Relman: When I finished my training and found an area of research that I was interested in, I decided that I wanted to be a full-time academic doctor. I chose not to be primarily in practice, and I was fortunate to get an academic appointment at a teaching hospital where I taught, did research, and practiced medicine in consultation. I did not have a private office practice, but as a teacher with students making rounds and as a consultant I still saw a lot of patients.

Second Opinion: What about your interest in journalism?

Dr. Relman: As my career developed, I was drawn back to my interest in writing and editing and began serving first as a

reviewer and then on the editorial board of a number of scientific journals. One of the journals I became especially involved with was the *Journal of Clinical Investigation*, probably the leading general medical research journal. The *JCI* is not specialized in any one field like immunology or genetics or cardiovascular physiology; it covers all areas of medical research, some fairly basic. Eventually I was asked to edit that journal in my spare time, which I did from 1962 to 1967 here in Boston.

Second Opinion: What brought you to the *New England Journal of Medicine*?

Dr. Relman: During that same time, I was asked to serve on the committee on publications of the Massachusetts Medical Society, which is in effect the board of directors of the *NEJM*. The *NEJM* has been owned by the Massachusetts Medical Society since 1923, but it has always remained editorially independent. I had previously published articles in the *Journal* and had reviewed for it. By serving on the committee on publications, while I edited the *JCI*, I got to know the *NEJM* well.

In 1967, Joseph Garland, a distinguished and much beloved editor of the *Journal* for many years, retired, and the committee on publications was asked to

“Young people are being encouraged to think of medicine as simply a respected and rather interesting way to earn a good living.”



nominate a successor. I was on the committee that had the inspired good luck to appoint Franz Ingelfinger. At the time Ingelfinger became editor, he resigned from his positions as professor at Boston University Medical School and chief of the Boston University Medical Services of the Boston City Hospital. I, too, was a professor at Boston University at the time, and I was asked to succeed Franz as chief at the Boston City Hospital, which I did. A year later I went to the University of Pennsylvania at Philadelphia as chairman of the department of medicine and chief of the medical services of the hospital at the University of Pennsylvania. I left Boston in 1968, never thinking that I would have any direct association with the *NEJM* again. I resigned from the committee on publications and took up a new career as head of a very big department of medicine, which fully occupied me for the next nine years.

Second Opinion: What brought you back to the Journal?

Dr. Relman: In 1976 I found myself on sabbatical leave in England at Oxford University trying to think through my career plans. It was a turning point. I was 53 years old at the time and had been in full-time academic medicine for about 27 years. It was, you might say, a late midlife crisis

for me. Then out of the blue, I learned that my friend Franz Ingelfinger had suddenly become ill and had announced that he would have to resign as editor.

Second Opinion: And you were chosen as his successor.

Dr. Relman: The committee called me at Oxford and asked whether I wished to be considered for the position. After I thought about it, I realized that yes, I really was interested in the editorship. It wasn't that I was unhappy doing what I had been doing. But I saw the editorship as an opportunity to use everything that I had learned in a different and perhaps a more powerful and effective way. The *New England Journal of Medicine* is a very influential educational institution. It is a university without walls, and it has had a great impact on the education of medical students, young physicians, and physicians in practice. And with so many changes occurring in medicine, so many new problems to deal with, I thought that the Journal would in the years ahead play an even more important role in the education of physicians and quite possibly in the education of the public. Faced with such an opportunity I accepted the appointment and came here in 1977.

Second Opinion: What happened to your early interest in philosophy as you made this migration?

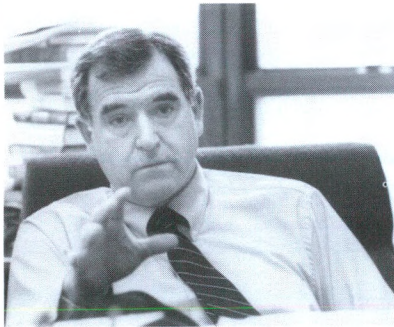
Do your responsibilities as editor provide occasion for you to return to some of those concerns?

Dr. Relman: Yes, they do, although I have not continued as a serious student of philosophy. I don't have time for it, and I can't say that my reading has kept up with all the currents in academic philosophy. But I continue to read philosophical works from time to time, and I have remained interested in philosophical questions. I think that having that interest is very relevant to my job as editor, because there are all kinds of philosophical issues that you have to deal with.

Second Opinion: Many observers characterize this period in the history of medicine as a time of the emergence of bioethics and all the issues associated with that new discipline. Which ethical concerns do you think need the most attention?

Dr. Relman: Even as the technical and scientific base of medicine broadens and deepens, we're seeing the need for more and more consideration of ethical and philosophical questions. Questions not only about the relationship between doctor and patient or the relationship between the patient and those around him, but about how *society* is going to deal with health care. I think that the rise of bioethics as a

"Doctors have a right to expect that they will be paid a decent living, but economic interests should be secondary."



discipline in the last ten or fifteen years is clear evidence that the more we learn about the biology of man and the more our technology expands, the more we have to stop and think very carefully about what we are doing and why we are doing it.

Second Opinion: How do you think your profession is doing on that agenda?

Dr. Relman: Well, I don't want to be too hard on my profession. It's easy to be critical and I have been. I have not hesitated to raise uncomfortable issues and to criticize my profession for its deficiencies on occasion, but we all need to remember that doctors, after all, are human. We are no wiser nor more moral than other people, and we are doing the best we can. Having said that, I would have to add that I don't think our record is an outstanding one. A large amount of unfinished and unattended business remains on the agenda.

Second Opinion: Is medical education on this agenda? It seems to be high on yours.

Dr. Relman: It's quite fashionable today to flail away at medical education or premedical education. We've recently had a new commission considering the general education of physicians, including premedical, medical, and post-

graduate. There is a lot of ferment in the air these days, people talking about the need to educate better-rounded physicians who are more concerned about ethical, social, economic, and political issues. I agree that we've been turning out young people who have been excessively concerned with technical competence and not sufficiently aware of the broader social and ethical issues. I agree, but I'm not sure that a quick fix is possible. I am not sure that another premedical requirement or an additional course in philosophy or ethics is going to provide a cure. I think what we are seeing is a reflection of contemporary culture and contemporary values. What we need is something broader and deeper than simply juggling the curriculum.

Second Opinion: If a quick curricular fix is not the solution, what steps should medical education take to address these needs?

Dr. Relman: Well, certain things can be done at the level of the educational system, and other things can take place only in a much broader context.

At the premedical level there should be more emphasis on liberal arts and more encouragement for students to pursue these subjects. During medical school, there should be some changes in the curriculum. Medical educators

naturally bridle when outsiders come along and tell them to add certain things to their curriculum. But the curriculum is not so crowded. There is a good deal of wasted time. I say that as an erstwhile medical educator and former chairman of curriculum committees. I believe there are ways to make the medical curriculum more sensitive to values other than those of hard science.

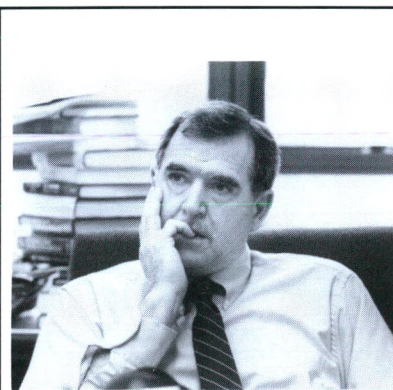
But there is something else medical educators can do. They can be more interested in the human values, the aspirations, and the interests of their applicants. I think that they ought to be more sympathetic to the student who maybe does not get straight A's in science, but brings a strong personal commitment to the serving aspects of medicine. There's no room in medicine for the inept science student who does not really understand the machinery of the body and cannot think logically about biological problems. Competence in biology is a prerequisite. But there's a lot of room for people who may be only average in science, but who have in abundance the human qualities that are so important. They will make excellent physicians, sometimes much better than their classmates who get higher grades in the sciences. Medical schools ought to realize that without that eagerness to serve and without that moral commitment, medical

students don't offer very much, regardless of how bright they may be. They are simply not going to be very good doctors. Medicine, after all, is an amalgam of science and human service. It is basically a serving profession. Without that moral element, it becomes mere technology and potentially dangerous. We do not want to encourage a whole generation of indifferent technicians whose only ethical commitment is to technical competence. The moral component is essential.

Second Opinion: Are you concerned that our society is about to lose physicians with this sense of moral commitment?

Dr. Relman: We are living in a time when there is a great inclination to view all reality as a marketplace. People forget that we live in a society and not an economy, that economics is not all that is important or all that motivates people or should motivate them. But when the federal government is running an annual deficit of \$200 billion, when people are not willing to tax themselves to provide social services, and when the prevailing philosophy seems to be everyone for himself, it is easy, I think, to see why young people are more concerned about their own livelihood and advancement and less concerned about service.

It seems to be old-fashioned



“We cannot have a civil, prosperous, and tranquil society unless we provide decent health care for all, regardless of ability to pay.”

to be concerned about service, ethical commitment, and professional calling. Doctors are encouraged by society, government, and the law to think of themselves as businessmen. I'm not saying that business is necessarily immoral—it isn't—it's just that the market does not concern itself with the kinds of values that physicians have to be thinking about.

Second Opinion: Why has the marketplace mind-set become such a serious problem for medicine?

Dr. Relman: For various historical and political reasons, we live in a very materialistic, self-centered era. We live in an age when young people are encouraged to think of themselves first, where there is less communal concern than there used to be, where wealth and material things are terribly important, where

young people are encouraged to think of education strictly in terms of the dollars it will earn. That mind-set transfers to medicine. Young people are being encouraged to think of medicine as simply a respected and rather interesting way to earn a good living, to earn economic security at an early age. Not enough attention is being paid to what is really important in life, what really counts.

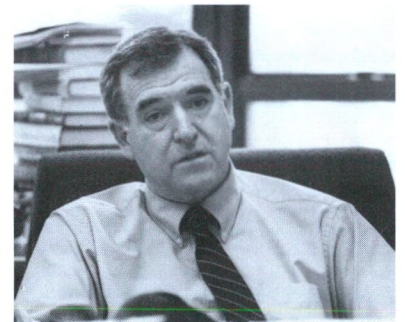
Second Opinion: Is medicine in any way responsible for this situation?

Dr. Relman: I don't see it as a failure of medicine so much as a reflection of today's values, and I believe that that will change. It will change when it becomes apparent to everybody that we cannot live successfully that way on a shrinking planet where we all have to share responsibility for survival,

where each citizen's life and welfare is related to everybody else's. When we realize that inequity and unfairness breed civil discontent, which in turn breeds destruction of the social fabric, then the lesson will be learned that we really are our brother's keeper—that we really do have responsibilities that go beyond ourselves. In the long run there can be no tranquility and prosperity unless everybody shares in the tranquility and prosperity.

With respect to health, I don't think our country is quite ready to accept the idea that we cannot have a civil, prosperous, and tranquil society unless we provide decent health care for all, regardless of ability to pay. The responsibility for such health care is something that we all have to share. To accomplish this we must have professionals who are committed to providing health care

“Doctors have an obligation to advise their patient, society, that there is no medical help for nuclear war.”



because it's needed, because it's the right thing to do, because they have a high calling—*not* because it's a good way to make a living and an attractive lifestyle.

Second Opinion: You are obviously inviting vigorous debate. Where do you see sources for the renewal, for new values to emerge or old ones to be reconsidered? Is there a place for religion in this search for fundamental values?

Dr. Relman: Yes, there is. But we live in a pluralistic society, and in the 21st century we will not depend for our values purely on religious convictions. I believe there is an important role for religious values in modern society, but those values must be the kind that allow us to accept people with all shades of belief and skepticism. To those who say that without religious conviction you cannot build a moral society, I would reply that if that's true, we're in trouble. I don't think it is true. I think that religious conviction can lead the way, can be a model, can light a lamp, but in addition we need a widespread popular acceptance of the idea that there is a pragmatic basis for morality.

If we are going to have a civilized world to live in, we have got to be able to rally people of all varieties of belief and disbelief. To do that we need a pragmatic

or empirical standard which finds a basic survival or biological value that can be affirmed by a variety of systems. I believe in that. I believe that there is biological and empirical justification for the values that people of religious conviction hold and for those held by people who do not espouse formal religious convictions. If that were not the case, I do not believe we could survive.

Second Opinion: You propose a biological solution to the problem of modern pluralism; it all comes down to the issue of the life of the whole human family?

Dr. Relman: Yes, if we survive, I think it will be because of a growing realization that survival requires us to act in a civil and humane way. I believe that all of the great world religions have biological roots, that religion has such great power because it meets a very deep-seated biological need. *If* we are going to survive—and I make that conditional because for the first time in the history of this planet, we have the power to destroy ourselves—it is not going to be because of a treaty or because of any arms control arrangements, although those things are terribly important. If we survive it will be because we, humanity as a whole, have finally learned that we have to help one another. We cannot follow the law of the jungle and

last much longer—not in the atomic age.

To link this to my earlier comments about the market in American society, it's clear that although ours is a relatively civilized jungle, and although there are rules by which the game is played, the basic idea is everyone for him- or herself. The market has no mechanism for equity, no concern for the poor. We need to add to the market something else which we apparently are not willing to do right now. We can't have two classes, an upper one that lives by the market and a lower one where people subsist as best they can. We can't live that way. It won't work. It has not worked in the past for any length of time. Such inequities are always unstable; now the potential for instability is even greater and even more dangerous because the explosions, when they come, can be cataclysmic.

Ultimately we are faced with a biological question. It is a question of whether we are going to be smart enough to learn the lesson before it is too late, that ours is one world and that we have to treat other people pretty much as we would like to be treated ourselves.

Second Opinion: Are you optimistic that this kind of fundamental examination of basic beliefs and stances will take place and that a consensus can emerge?

Dr. Relman: I have to be optimistic. There is no choice but to be optimistic.

I do not believe in inevitable disaster. But we are in a race. It is a race between humanity's selfish instincts (its irrational side), and its better nature. The race is not over yet, but I am optimistic because humanity has always shown itself to be perfectable. Humans can learn quickly, and we have great opportunities for learning today. Technically, we can feed the world, so there is no reason for people to starve. We have to realize that we can overpopulate this planet, but we have the resources and the technical means to provide a decent life for most people on earth if we control population. Science has given us incredibly powerful tools to solve all kinds of medical and environmental problems. The question is whether we will be smart enough to apply what we know and what we will learn quickly enough to prevent disaster.

Second Opinion: You have a moral image of the physician. What is that image? What is the proper role of the physician in the society you describe?

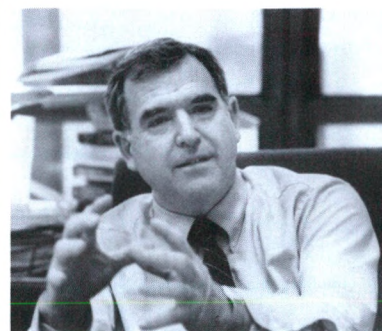
Dr. Relman: The physician first of all has to be a healer, a person devoted to helping, caring for, and restoring health to his patients. Furthermore, the moral contract

that society has made with the medical profession shapes that fundamental commitment. It is a de facto contract which has never been spelled out, but if you look at the history of the American medical profession, it is very clear that the contract is there. By virtue of this unwritten contract society gives doctors a licensed monopoly to practice their medical profession with a remarkable amount of autonomy and authority. Until now, society has virtually guaranteed doctors a very good living by granting them this licensed monopoly.

At the personal level, doctors have the great privilege of the trust and the confidence of their patients. Patients tell doctors things they will not share with anybody else; they expose their bodies and their innermost feelings. They put their very lives in the hands of doctors. Doctors are given all of that, and in addition they get a substantial subsidy as far as their education is concerned. They do not pay the full costs of their education by a long shot, even if they go to a private institution. When they begin to practice medicine, their overhead is largely paid for, too. When a surgeon operates on a patient in a hospital, all the equipment, facilities, and help needed to take care of his patient are provided free.

Second Opinion: What is the other side of the contract?

"I believe that all of the great world religions have biological roots, that religion has such great power because it meets a very deep-seated biological need."



Dr. Relman: Doctors are given all of that in exchange for something very important that society expects from the doctor: that the doctor will serve the patient's interests first. Doctors have a right to expect that they will be paid a decent living—but economic interests should be secondary. Regardless of compensation, doctors are expected to serve. They are expected to do what is necessary in any given situation, and they are expected to make their decisions primarily in the patient's interest, not in their own. That is the contract between doctors and patients.

Second Opinion: What about the relationship between physicians and society as a whole?

Dr. Relman: If you enlarge this understanding and your patient now becomes society, it follows that doctors are expected to give the best advice they can in society's interest, to support society's health. Doctors may not be authorities on economics or politics, but they are authorities on health. That is why society and governments have to rely on doctors collectively and individually to give the best advice to protect the public's health, and that is where the doctors' interest in nuclear war comes in. Doctors have an obligation to advise their patient, society, that there is no medical help for nuclear war. They have to make it

clear that if there is a nuclear war, people are going to die horribly by the millions, where they fall, unattended. Medicine will have nothing to offer. Doctors owe society the kind of education that explains matters to people who really cannot quite conceive what a hydrogen bomb can do, who never really thought about nuclear devastation in practical terms, who always assumed that the wounded would be attended to and taken to a hospital. Doctors have to explain that that is not the way it would be. They have to make it clear that if there is a nuclear war the initial survivors will envy those who die quickly. It would be a hell beyond belief. Doctors have some understanding of what would happen, and that is what they must say.

Second Opinion: But why should physicians in particular address this subject?

Dr. Relman: Doctors don't have any special expertise about how to prevent a nuclear war. I don't think that doctors are smarter than anybody else when it comes to dealing with the Soviet Union and ensuring that nuclear weapons are never used. But they *do* know more than anybody else about what will happen if these weapons are used, and that is the story they must tell. That is why the International Physicians for the Prevention of Nuclear War were awarded

the Nobel Prize, because they have spread that message. All of this nonsense that the International Physicians for the Prevention of Nuclear War has been a dupe of the Soviets, that they have forgotten about Andrei Sakharov and human rights, and so on, is irrelevant in the context of a nuclear confrontation. Human rights will mean nothing if we have a nuclear war. We have to do what we can to see that a nuclear war never happens. Human rights are terribly important, but politics comes after we assure our survival.

Second Opinion: When you look out across your desk as an editor who reviews all the latest developments in the science and practice of medicine, what are the discoveries and breakthroughs that make you most excited and hopeful?

Dr. Relman: To paraphrase Dickens, this is the best and the worst of all times. In a sense, we are entering into a new golden age of medicine. Our understanding of basic biological processes is growing at such a rapid rate that we soon can expect truly revolutionary developments in the diagnosis and treatment and prevention of disease. We will shortly be entering an era, if we're not already on the threshold, when we will be able to alter our genetic makeup and attack the

terrible burden of inherited diseases. It's also clear that if we want to we have the technical means to eliminate almost all of the epidemic diseases of the Third World. We will probably have an effective vaccine for malaria very soon, and all the terrible parasitic and epidemic diseases that have decimated the Third World can probably be conquered in the foreseeable future.

Second Opinion: What else is on the horizon?

Dr. Relman: Consider mental disease, one of the great plagues of contemporary life. We are just beginning now to understand the chemistry and physics of the brain. I can't get into a philosophical dissertation on mind-body relations here, but it is clear that what happens in the physical substance of the brain determines mental ill-

ness. Now, that doesn't say anything about whether or not there are emotional and psychological causes. Whatever the case may be, mental phenomena arise in the brain, and there are physical events that correspond to what we call mental illness. Those physical events are being progressively identified, understood, and manipulated. We so far have only an imperfect understanding of exactly what is going on, but we already have drugs that change the chemistry in certain parts of the brain with astounding effects on human behavior. We have been able to use drugs to deal with schizophrenia, and that is just the beginning. We are going to see fantastic developments in our understanding of neurobiology and therefore in our ability to treat or prevent mental illness.

The two most common killers in our society are cardiovascular

disease and cancer. I have no doubt that in the not-so-distant future, we are going to understand and prevent arteriosclerosis, which is the most common form of cardiovascular disease. The Nobel Prize was just given this year to two young American physicians who have made a very important start in understanding the transport of low-density lipoproteins, and what we have learned from their work is going to be amplified many times over and applied to the prevention of arteriosclerosis. Or take hypertension. Already the number of deaths due to strokes has dropped off very sharply in the U.S. because of better control of hypertension through drugs. And that statistic will continue to improve. Cancer is a very subtle and complicated problem because it is not one disease, but many. We have already made major inroads in understanding cancer, and I

"We are geniuses when it comes to the scientific questions. . ."



have no doubt that in the decades ahead, we are going to be able to treat or prevent many, if not most, types of cancer.

Second Opinion: And what about “the worst of times,” the dark side of the future?

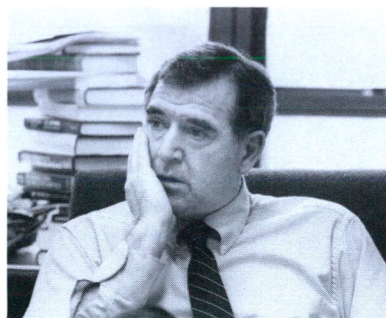
Dr. Relman: We seem to be generating economic, social, political, and ethical problems which we are not able to deal with. Our physical and biological science is outrunning our ability to cope with human, philosophical, ethical, and political problems. We are geniuses when it comes to the scientific questions. We are children, we are primitives, we are *savages* when it comes to dealing with many of the social, political, and economic issues. This is the great problem facing humanity today: can we bring our social, political, and economic behavior

up to the level of rationality and civilization that our scientific progress requires?

Second Opinion: When you stand at the bedside of a patient, what does all that you have just said really mean?

Dr. Relman: The challenge to medicine is to be as sophisticated and as effective in dealing with the human aspects of illness as we are with the physical, with the technical. Our challenge is to learn how to use the instruments and the techniques that we have in the most civilized and beneficial way, so that everybody shares in the benefits and so that the least possible amount of harm is done. Clearly, we haven’t solved that problem yet. We have the techniques but we are not using them effectively from either the economic or the ethical points of view. We are tor-

turing ourselves with questions about the right to die and the decisions that must be made in the newborn nursery. We struggle with the problems of equity and the distribution of expensive medical resources. It is clear that we are asymmetrical. We are moving ahead technically, but we have not caught up in terms of the human questions. That is the challenge to medicine. ☹



“...but we are primitives when it comes to dealing with many of the social, political, and economic issues.”



The transitions which have occurred in nursing from preprofessional times to the present are made vivid when contemporary photographs are placed alongside artwork from earlier periods. These two images contrast the specialized technological care of the nurse in the newborn intensive care unit with the care portrayed by W. L. Taylor in his late-nineteenth-century painting of a nurse administering medicine to an ailing girl.



Professionalism and Ethics in Nursing

Mary-Carroll Sullivan

Case 1. Aware that her patient's physician has acceded to family wishes to withhold diagnostic information, the nurse is unsure how to respond when Mrs. H., an alert, intelligent 67-year-old woman, asks the name of and the reasons for a new intravenous medication which causes severe and distressing symptoms. The nurse knows that it is an extremely toxic chemotherapeutic agent used in treating cerebral metastatic disease.

Case 2. In charting a progress note at the end of his shift, the nurse recalls finding an incorrect dosage of medication which was set up by the night nurse. It was infusing as he made his pre-shift rounds. Since the patient suffered no apparent ill effects, he is in a dilemma about whether to report his colleague.

Case 3. The special care nursery staff meets to discuss whether and how to broach the parents of one of their patients about seeking the opinion and advice of another physician regarding recommended surgery. The parents have wondered aloud whether their child is being properly cared for, a concern shared by the nursing staff. The nurses ponder the primacy of the nurse-patient relationship when it may conflict with the physician-patient relationship.

These cases typify the myriad problems that assail contemporary nursing practitioners in a terrain being newly surveyed by nurses. None

deals solely with clinical or legal matters. Rather, they reflect the pressing need for nurses to shift their questions from “what *can* I do?” to “what *should* I do?”

The social history of nursing provides a framework for understanding the growing importance of ethics within the profession in recent years. Elsie Bandman, a nurse-historian, has divided that history into four distinct periods: the pre-Nightingale period, during which nursing was a service provided by religious personnel and institutions; the Nightingale era, in which nursing was separated from religion and became an arm of secular humanism but retained an almost vocational sense of service and duty; the period from the 1930s to the 1970s, when the academic discipline began to develop a corpus of nursing ethics literature; and the current period, from the mid-1970s through today, when the profession is experiencing a “Renaissance of nursing ethics” (Bandman 1981).



In the Middle Ages, nursing was integrated with religious traditions of caring and healing and for several centuries was not regarded as a secular profession. This recent painting by Robert Thom depicts a religious nurse in a medieval hospital.

I

The status of the nurse has changed decidedly in the latter half of the twentieth century: nursing has now achieved four criteria usually associated with independently functioning professions. First, the practice of nursing requires a specialized knowledge or expertise; specific educational requirements must be met, tested, and certified. Nurses are now expected to have a broader fundamental education as evidenced by the ever-growing state licensing bias toward baccalaureate graduates.¹ They are further encouraged to select and train beyond the undergraduate level in a clinical specialty. Witness the expansion of nurse practitioner programs, clinical nurse internships, increasing memberships in groups like the Association of Critical Care Nurses, the Association of Operating Room Nurses, the Society of Peripheral Vascular Nurses. With these changes in academic preparation and specialization has come an increase in the number of options for nurses in exercising their learned skills.

Second, the services offered by nursing are of acknowledged value to society. They have been recognized as making a unique contribution to patient care and as being a worthwhile investment for the health care consumer. Because the delivery of health care, at least in the United States, has become, according to many observers, industrialized or corporatized (Starr 1982), the nature of the relationship between patients and their health care providers has altered significantly. In an age of vast specialization in medical and surgical practice, health maintenance organizations (HMOs), day surgery, home obstetric deliveries, and large group practices, the rapport that was previously considered the province of the family doctor has been in many cases assigned to the nurse. "Nurses, who usually spend more time with patients than physicians, often know considerably more about their patients' strengths, weaknesses, desires and needs than do some physicians who may only see patients during short visits" (Benjamin and Curtis 1981:81). Certainly, advocacy for the patient is a primary function of the nursing role as perceived by nurses. That this perception is shared by patients and their families has been well-documented in the literature and is empirically obvious to nursing practitioners even in their student days.² In addition, nurses perform such clinically oriented functions as history taking, physical examination and nursing diagnosis, and administration of medication and other treatments. The nursing role also includes educating

patients, educating peers and colleagues from medicine and other allied health fields, and fostering community awareness of health needs and the ways in which practitioners of nursing meet those needs.

Third, the graduates of nursing programs function autonomously in a variety of settings. They are responsible for their own actions and accountable to patients/clients and their families, sometimes to their employing institutions, and, in a collective sense, to their peers to uphold the standards of their professional community.

Fourth, the nursing community is a self-regulating one. The educational and licensing standards of the profession and the requirements for continuing education demand that the individual practitioner meet certain competency measurements (though these are sometimes not rigorous enough). Nurses have given input and guidance in the passage of Nurse Practice Acts by most state legislatures, another indication that nursing monitors itself (see Sullivan 1984).

The emergence of nursing as an independent profession has meant an increase in society's expectations of nurses (Greenlaw 1980:4–5). The general public's increased consumer-awareness has been applied to the health care industry and its services, including nursing. The visibly different roles played by today's nurses compared to those of their earlier counterparts have brought about well-articulated contemporary statutory definitions of nursing and nursing practice, as expressed in the legislated Nurse Practice Acts of most states. Finally, with the move away from the doctrine of *respondeat superior*, which deemed physician or hospital responsible for the actions of the nurse, legal liability has in the last two decades been bestowed upon nursing. This in turn has deepened a sense of moral maturity—and of moral accountability—within the profession (Sullivan 1984).

II

Some have argued that the professionalization of nursing has made necessary the establishment of nursing ethics as a separate and specific category within medical ethics. Certainly the profession, increasingly secure in its self-image, has begun collectively to articulate a sense of urgency that a corpus of literature be available to those within and without nursing which demonstrates and investigates the areas of ethical concern that are nurse-specific. The literature itself gives witness to an escalating concern with

ethical issues in nursing: a computer search under the heading of *nursing ethics* found an exponential increase in the number of entries over the last two decades.³ Further evidences of the profession's concern are a Hastings Center conference on the state of nursing ethics, held in 1981; the growing number of nursing ethics seminars; and the inclusion in state nurses' associations of ethics committees that deal not with the investigation of malpractice and censure of wrongful behavior but with educating its members in ethical theory and concepts of moral development.

The new consciousness of legal repercussions in no way obviates concern with the moral issues at stake in nursing dilemmas. Indeed, Kathleen Fenner (1980) argues that a discussion of health care law necessarily encompasses a study of the fundamental moral principles involved and that a truly comprehensive examination of legal trends in health care must acknowledge their concomitant ethical values. She asserts that when one reports for duty one takes on a new responsibility and accountability: the private citizen, whose values-motivated decision making is quietly done and the implications of which are interiorized or quietly accommodated, becomes the public professional, whose decisions and the reasons behind them are publicly scrutinized. This shift becomes difficult and at times impossible when the individual lacks sure knowledge of his or her own personal values and how they are applied consistently in the private and public arenas of life. Hence, the need to be able to recognize those values and the role they play in decision making and to be able to articulate the process by which those decisions are made.

As the term *medical ethics* comes more and more frequently into public discourse, the question still remains: should a distinction be made between *nursing ethics* and *physician ethics*? Is there a substantive difference between the stuff of physician ethics and nursing ethics? As an agenda specific to nursing ethics is formulated, it will perhaps become clear that similar issues are peculiar to physician practice patterns and problems. A question for future consideration may well be, What would constitute an agenda of generalized health care ethics if physicians and nurses attend to their own practice-specific roster of concerns?

Medicine is the core of knowledge defined by *Webster's* as the "science and art of preventing, alleviating, and curing disease." While some may seek to elaborate on or embellish one or another dimension of this definition, it is one to which most people would subscribe. Comprised within it would be all of the medical and surgical specialties and most other

clinical services. By extension, then, any issue or problem deriving from that generic body of knowledge and any application of it, whether by physician, nurse, physical therapist, pharmacist, belongs to the general category of medical concern.

Some issues relating to the performance of specific tasks or roles, however, are not shared across the boundaries of clinical practice (see Veatch 1981:17-19). An example would be the potential problems that come of a nurse's questioning the written order of a physician regarding the care of a patient that they are both attending. Because of the legal restrictions placed on nursing practice—the need both to follow physicians' orders and to refrain from a fairly large range of diagnostic, therapeutic, and prognostic interventions in the absence of written physician orders—the issue of answerability provides a solid justification for the existence of a separate ethical agenda for nursing. In addition, as indicated in the cases introducing this article, nurses are confronted daily with situations involving such issues as truth telling and withholding of information; whistle blowing; recognizing and then ranking their moral duty and obligation to patients, to families, to colleagues, and to their own consciences.



This fifteenth-century woodcut from Heidelberg, Germany, represents a type of nursing care, midwifery, paradigmatic throughout all but the most recent phases of human history. Facing page: The photograph of the nurse administering a heart catheterization illustrates the impact of new procedures and responsibilities on the caring relationship.

III

Although still evolving, the agenda which nurses are composing can be categorically bisected. In the first column, nurses are enumerating moral and philosophical problems which arise from the larger health care milieu and the place that nursing would like to claim in it. The other half of the nursing ethics agenda demonstrates a preoccupation with nursing education and nursing practice patterns. There is a conscious attempt on the part of the discipline to make sure that the seemingly always existing discrepancies between theory and praxis do not create moral inconsistencies and that the rhetorical goals are achievable.

With regard to the first category of concerns, those that deal overtly with questions of morality in health care delivery, as with the larger body of health care ethics of which it might be considered a subset, nursing ethical theory relies heavily on the vocabularies and methodologies of moral philosophy and moral theology for purposes of analytical discourse. However, unlike the other health care disciplines, nursing has placed a heavy emphasis on the incorporation of the moral development theories of



scholars like Lawrence Kohlberg and Carol Gilligan. These theories deal with the formulation of one's moral sensitivity and expound the thought that unless one knows how to recognize moral dilemmas and understands how that perception is developed, ethical analysis and moral problem solving cannot be accomplished.⁴ The significance attached to these theories has implications both in the decision-making role nurses assume and in the education of nurses about their responsibilities in the decision-making process.

One of the health care issues in nursing ethics is the conflict between the nurse's role as patient advocate and the functional role of the nurse on the health care team. Despite the acknowledged and amply demonstrated relationship between nurse and patient, an implicit understanding still exists among members of a health care team that the physician-patient relationship is primary. These two relationships can be a source of conflict for the nurse, particularly with regard to confidentiality, truth telling, and questionable doctor's orders.

Consider the last subject. Nurses are educated to review carefully all written orders before transcribing them into the nursing care plan and carrying them out. In that way, any inadvertent error of medication dosage, improper patient identification, or inappropriate fluid prescription can be called to the physician's attention and corrected before a mistake is made. In the usual course of events, the problems that nurses have with physician orders fall into one of these areas, and the built-in system of checks and balances allows any problems or potential problems to be resolved before injury occurs. The nurse is obligated to refrain from carrying out any incorrect order, and, indeed, is legally liable for doing so.

In the face of increasing technological advances, clinicians are confronted daily with a growing number of decisions from which one of several possible options must be selected. The category of question that they face has shifted. Rather than asking themselves "what can I do?" the amplitude of choices forces them to ask "of all possibilities, what should I do?" In seeking to answer this question, clinicians are forced to step outside the confines of science. They turn to the tools of value ranking and analysis offered by philosophical and religious ethics. When seeking to resolve the dilemmas clothed in the language of duty and rights, the "shoulds" and the "ought tos" of clinical decision making, one must necessarily move from the perceived sure ground of science, where the data are objective, verifiable, and reproducible, and become concerned with things that are in-

tangible: sometimes well-articulated religious beliefs, sometimes sentimental or emotional considerations, sometimes etiquette or protocol.

When such decisions are made, those making the decisions must shift from a quantitative methodology, fairly rigidly prescribed and thus fairly easy to follow, to a qualitative judgment. But when the qualitative judgment is articulated by anyone other than the individual most affected by it, the correctness of the judgment is almost always open to skepticism, review, modification, and occasionally outright rejection by those secondarily affected by it. Thus, the nurse who is asked to carry out the orders that are written as a result of a judgment call frequently is faced with testing it against the standards of personal conscience, a professional code of ethics, or legal liability potential rather than a pharmaceutical formulary or clinical reference text.

Does the nurse have any recourse when a written order opposes moral, ethical, religious, philosophical, or medical beliefs? The American Nurses' Association Code for Nurses, as reaffirmed and amended in 1976, states clearly:

If personally opposed to the delivery of care in a particular case because of the nature of the health problem or the procedures to be used, the nurse is justified in refusing to participate. Such refusal should be made known in advance and in time for other appropriate arrangements to be made for the client's nursing care. If the nurse must knowingly enter such a case under emergency circumstances or enters unknowingly, the obligation to provide the best possible care is observed. The nurse withdraws from this type of situation only when assured that alternative sources of nursing care are available to the client.

In many cases, the alternative to absent oneself from participation in a case is not a satisfactory solution. For nurses who feel the fiduciary or trust relationship with their patients quite as strongly as do physicians, to allow the implementation of what is felt to be a morally incorrect order is as much a problem as to participate in it. Conflicts between physician orders and nursing action arise frequently when such subjective, qualitative judgment calls are involved. Case stories abound.

The delivering doctor didn't think the baby would make it, so he didn't want him resuscitated. He'd simply told [the delivery room nurse] to get him into the nursery quickly—probably to spare the parents pain. That settled the matter for the doctor—now busy with a more pressing emergency in the delivery suite. But we were holding a live baby, with respirations and a

heartbeat. We couldn't just dismiss him. The doctor wasn't pleased when he learned we'd gone against his order and resuscitated the baby after all. (Tibbels 1984:49).

There is a growing assertiveness among nurses, at least at the grassroots level, to argue for parity in the resolution of matters requiring extraclinical deliberation.

While the reality of the health care situation provides for the legal acceptance of physician orders only, many contemporary writers take a more liberal view, maintaining that change will come only when the need for it has been demonstrated in actual cases. Decidedly a controversial position, it is nevertheless being espoused by growing numbers of nurses. They point to the already noted changes in nursing responsibility as an indication that change must be initiated by members of the profession, from whom the rest of society will take its cue. Neonatology specialist Ruth Weise (1981:52-53) reminds her colleagues that "decisionmaking involves not only expertise in



reasoning but also willingness to take risks.” She cites the guidelines offered in the system of humanitarian ethics developed by Jacques Thiroux, in which the value-of-life principle propounds reverence for life and an acceptance of death. Thiroux’s system also upholds the principles of goodness or rightness (to promote goodness over badness, to cause no harm or badness, and to prevent badness or harm); of justice or fairness in distributing goodness and badness; and of truth telling or honesty. Encompassing the ways and means of being moral within the framework of these four principles is the principle of individual freedom.⁵ Although the quality of scholarship involved in the reasoning or articulation of those principles is certainly open to debate, the spirit behind them is felt in a variety of settings, from textbooks to on-unit staffings, from staff lounges to major conference halls.

As a direct result of the willingness of nurses to address patient care issues and the urgency with which they do it, certain topics have become very closely identified with the nursing profession. Paramount among these



Facing page: *The century-old engraving depicts a lecture on the use of bandages at the Blockley Training School for Nurses, Philadelphia. Above: In marked contrast to the basic skills portrayed in the scene from 1886 is this picture of the modern surgical nurse with her specialized roles and duties.*

is the whole panoply of issues that surround questions of withholding or withdrawing treatment.

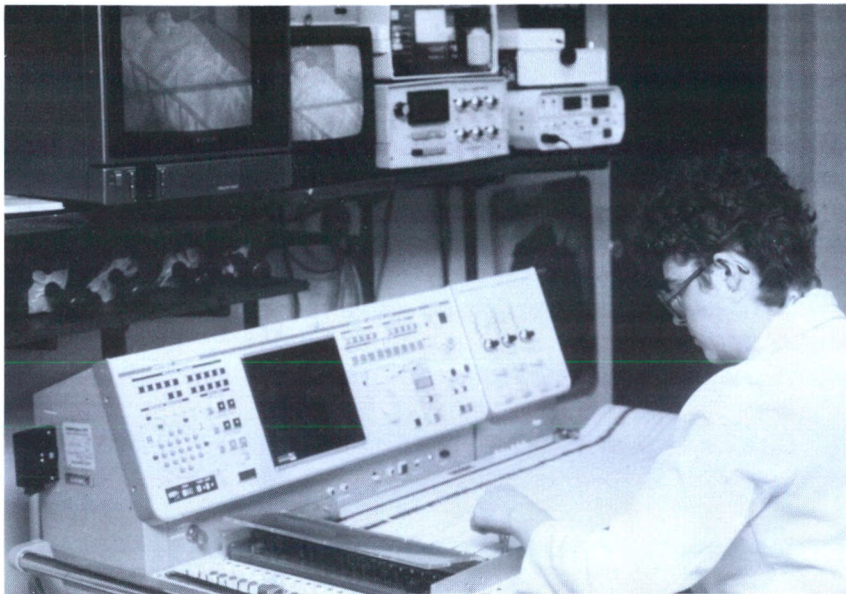
Because nurses spend a great deal of time with their patients, it is easy to understand the ambivalence of many nurses as they see the seemingly irreversible, downward course of those under their care. On one hand, the rapport that is developed over time with patients and their families provides a tremendous impetus for wanting to take advantage of whatever means are available to maintain that tenuous connection. More frequently, however, it is the nurse who sees the evolving debilitation, the increasing lack of responsiveness (socially, neurologically, emotionally), the cost of the struggle to keep on that is paid by patient and family. And so, more often than not, it is the nurse who raises the question that is the hardest to ask and the hardest to answer. Not surprisingly, because they are frequently the first to raise the question of discontinuing therapy, nurses are often charged with



wanting to give up too early. The distinction between raising a subject for discussion and casting a vote one way or another is sometimes lost in the emotional overlay of the conversation that ensues.

That this problem haunts nursing practitioners everywhere can be empirically demonstrated by perusing the contents pages of the major monthly professional journals. “Dilemmas in Practice,” in the *American Journal of Nursing*, “Controversial Issues,” in *Nursing*, and “Personal Choices,” a feature in *Nursing Life*—each title heads a regular column which invariably focuses on a case study and analysis of the role thrust upon an individual practitioner as a participant in or observer of decision making at the end of life. The problems are faced among nurses serving the range of perinatal patients to geriatric patients; no service is exempt.

Of growing concern to students of nursing ethics are the problems that stem from theoretical speculation upon nursing practice. One can ask



The contrast between the tools employed by nurses at the turn of the century and those used today is readily apparent in these photographs. Left: Nurses receive instruction in the bacteriological laboratory of Bellevue Hospital, New York, ca. 1900. Above: A nurse monitors the progress of a patient in a sleep disorder clinic.

whether this is perhaps a realm of consideration not entered into by any other health professional than nurses. It has to do with the way in which the academic discipline that is nursing is growing and evolving, and the ways in which those changes affect its membership. Many changes have been wrought in the nursing curriculum. The inclusion of broad fundamental principles and concepts from the liberal arts and humanities as well as more concentrated attention to the history and philosophy of nursing as a discipline is now a given in contemporary education. What is remarkable is the push to incorporate the material drawn from these sources and to assimilate it into integrated, wholistic nursing concepts. For example, it is not at all exceptional to find integrated curricula that combine not just courses in systematic microbiology and biochemistry with the associated ones in systemic physiology and anatomy,⁶ but which also present transdisciplinary syntheses of pertinent concepts. This technique not only is used in classroom teaching but is seen in the literature of the clinics and is the focus of graduate study in nursing (Cowles 1984). For example, a recent journal article which ponders the criteria for discontinuing treatment



in a man suffering profound and irreversible neurologic injury also speculates upon the notion of personhood, that concept which holds so many implications for therapeutic intervention, legal protection, and social standing.

Thus, just as historians' tools or social scientific methodologies have become part of every health care deliverer's mental baggage, so have the aids of philosophical speculation and analysis. As one continues to investigate the nursing profession's very self-consciously directed moral concerns, one sees that the literature reports time and again the practical repercussions of an intense period of growth and development that affect those attempting to keep up with the changes. In keeping with the self-monitoring that is an ongoing project of any profession, the nursing literature contains cautions that steps be taken to guard against some of the abuses that are the inevitable outcome of dramatic rethinking and reshaping. These abuses are most likely to affect the collective moral consciousness of the profession. The competitive spirit that will undoubtedly arise (if it hasn't already) may provide a positive impetus to action and push for productivity and creative



Caring remains one of the essential qualities of nursing, despite changes in technology and roles. Facing page: An illustration from Harper's Monthly, 1878. Above: A recent photograph of a pediatric nurse.

new approaches to already recognized problems, but it can also bring about the pressure that results in destructive and corruptive behavior.

A recent journal editorial addressed two well-known examples of such detrimental actions, plagiarism and exaggerated claims on *résumés*. The feeling within the nursing community that it lags behind other professional-academic disciplines in research has created a fiercely competitive drive to draw up research proposals, obtain administrative approval and public or private funding, implement the protocols, and report on the correlated data. One editor, in the awkward position of having to select between two reports submitted for publication, both dealing with the same research project but coming from two unrelated sources, embarked on a series of editorials that examined the issue of plagiarism.⁷ Another editorial attacks the emergence of “the Pinocchio Principle,” the tendency to hyperbole that surfaces when nurses attempt to market skills, training, and experience (Kelly 1984). The writer exhorts the nursing community, despite its newfound enchantment with academic pedigree, to work together to maintain the moral integrity it has traditionally possessed. The temptation to enhance, sometimes to the point of distortion, the entries on nursing *résumés* is a new one. Although no one disputes that edification and growth are the goal of requirements for higher and continuing education or that these newly acquired skills and principles can be applied usefully in advanced clinical and managerial positions, unless the profession works to create a nurturing as opposed to an intimidating environment within which to carry out these changes, the effect of the improvements will be greatly weakened. In this case, then, moral duty and self-interest dictate the same course. Dispelling an atmosphere of intimidation and undue pressure well serves the best interests of nursing professionals.

Conclusion

In a dawning recognition of its own professional status, nursing seeks to establish its moral identity; it attempts to set out the parameters of its concerns in a clear and concise way. And like all who newly arrive at an understanding or awareness, it could be accused of trying to do too much too fast. Ethical theory, theories of moral development, ethical implications of dilemmas in the clinical setting, moral compromise that potentially results from the competitive environment of accelerated growth and development

within the profession—all these topics are of vital concern to nurses individually and collectively.

It is well to remember, though, that despite its ever-increasing familiarity with theory and fascination with esoterica, nursing is first and foremost an applied science. Hence, nursing ethics, despite its reliance on and reference to philosophical and theological ethical theory, enjoys its most specific and well-formulated articulation when viewed as an applied ethics system. ☉

NOTES

1. Although most of the involved jurisdictions include grandfather clauses which exempt presently practicing nurses, an estimated 23 states are considering or have already passed legislation requiring baccalaureate preparation for registered professional nurses.
2. In *Nursing Clinics of North America*, vol. 14, no. 1, March 1979, the duty of the nurse as advocate is examined from the perspectives of the clinical specialties, administration, and education.
3. Computer searches on the Medline database conducted by the author in the periods 1964–68, 1972–76, and 1981–85 under the general heading *nursing ethics* yielded 15, 64, and 192 results respectively. Granted improved indexing procedures, the trend is nonetheless undeniable.
4. See Kohlberg 1983 and Gilligan 1983. The writings of Catherine Murphy, Patricia Crisham, Shaké Ketefian, Kathleen Mahon, and Marcia Fowler underscore the importance of understanding moral development theory in order adequately and accurately to assess behavior for its moral motivation and its moral implications.
5. For a more comprehensive discussion of this system, see Thiroux 1977.
6. This educational paradigm was introduced into curricula at the University of Connecticut Health Sciences Center, Farmington, Connecticut.
7. Penny A. McCarthy, “On Piracy,” *Nursing Outlook* (Jan. 1982): 21, and “Still on the High Seas,” *Nursing Outlook* (March 1982): 167; letter, “Speaking Out on Piracy,” *Nursing Outlook* (May 1982): 278–79.

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Hospitals and the Emergence of Bioethics

Perspective

Five realities facing hospitals today are radically reshaping the delivery of health care.

First, hospitals are receiving decreased funding from patient services. Consumers demand new and expensive technology, yet they have at the same time a mounting desire for “high touch” and human compassion. Hospitals are perceived to be too expensive, and people think they do not provide humane care. Many applaud cost containment—big government, big labor, big industry, and the American consumer (you and me). With the resulting political pressure, hospitals will have less money available to them in the future from traditional sources to meet the cost of doing essentially the same work that is being done now. This, of course, poses severe financial problems for American hospitals.

Next, the pace, the intensity, and the nature of change are so profound that hospitals and health systems are almost in panic. Consider this short list of recent changes: new methods of health care delivery, such as birthing centers; new methods of payment, as represented by the diagnosis-related group (DRG) reimbursement mechanisms; the doctor glut (or shortage) depending on location (there are too many physicians in suburbia and not enough in rural America and the inner city); the emergence of Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Independent Practice Associations (IPAs), group practices, and multihospital systems; and price competition. The list indicates only some of the rising pressures that demand response and significant changes from hospitals today.

Third, the hospital industry is the most over-regulated enterprise in the nation today. Every element of every level of government regulates hospitals. In addition, they are regulated by financial institutions. Beyond these external constraints are those created by the industry, such as professional and institutional accrediting bodies. All of this regulation is

increasing faster than hospital personnel can read it, let alone comply with it.

Fourth, limited reimbursement, price competition, and increasingly sophisticated technology are creating a nation of body shops concerned only with organisms that work well. Brick and stone palaces of technical excellence have been erected in which the whole human being is lost in a maze of body parts to be repaired.

Finally, many American hospitals may not have the capacity to cope with the first four issues. Hence, we see the growth of investor-owned chains and of hospital systems, affiliates, and alliances. We see some hospital closings. Questions of survival are being addressed in the boardrooms of many of our nation's institutions.

How did we get to this critical situation? Before World War II and for a few years thereafter, hospitals, without the availability of the new technology, were organized by and closely connected with either religious denominations or community groups who possessed a strong sense of social service or religious commitment. The absence of technology in the forms we encounter today required hospitals to concentrate on being *healing places* addressing themselves to the needs of whole human beings who were temporarily sick or broken. Commitments to the whole human being were demonstrated in these institutions in profound ways.

As technology grew, including the development of new drugs, new surgical techniques, electronic monitoring, and manufactured body parts, the hospital climate changed. Hospitals became doctors' workshops where these new technologies were applied, and emphasis shifted from healing the whole human being to fixing the part of the body that was broken. This transition in identity from *healing places* to *fixing places* affected the manner in which hospitals regarded their mission.

Recently hospitals have been faced with yet another challenge as they have become players in the large "business" of medicine. In response to the environmental changes already mentioned, many hospitals have corporately restructured, diversified, merged, consolidated, developed into comprehensive systems of care, and sought new ways to raise capital. In short, they have become *business places*.

Hospitals today are clearly not the healing places of the past. They are likely to be the providers of technological fixing in the future. And

they will need to continue behaving in businesslike ways. All the available evidence suggests that the technological and economic changes will only accelerate. Unfortunately, our human capacities to cope with these changes cannot keep the pace.

What will be the essential character of hospitals in the next era? It seems likely that the next major step in their evolution will be toward becoming *places of moral questioning*. The important human and ethical issues illustrated by the Baby Jane Doe and Karen Quinlan cases are only the tip of the iceberg that institutions will be dealing with in the 1990s and beyond.

Now that we are technically capable of creating and sustaining life in such forms as *in vitro* fertilization, the matters currently being discussed in the realm of bioethics are becoming more important and more visible. If resources are withdrawn from the health system, the waters will recede from the iceberg, the serious ethical issues will become more apparent, and bioethics will become more crucial.

Consider the young couple who have recently become parents of a premature, malformed infant and the difficult moral decisions that face them. The physician (with assessments of the prognosis) is of limited help. The ethicist typically counsels with the couple on matters of philosophy and law; but the question whether to terminate intravenous feeding remains in the hands of this couple. Alone with their new dilemma, they confront deep questions about life's meaning and purpose. In all likelihood they will look to their faith and ask to see their pastor, priest, or rabbi. People in this situation provide frequent and telling evidence of an important point my pastor often makes: "when all else is gone, faith remains." Even if they are not practicing a faith, they frequently ask for the nearest clergy person.

In these days when instances of life and death come more and more to be decided by human beings, the discipline of bioethics (as it is now developing) is not prepared to meet the deepest needs of most human beings. Issues of spirituality and faith need to play a more important role in this new and important academic discipline.

Bringing faith to the center stage of this developing discipline will not be done by the nation's medical schools and is not being done by our leading universities. For this reason the Lutheran Institute of Human Ecology has established an interdisciplinary research center to study the

complex relationships among health, faith, and ethics. It is my belief that the questions to be pursued at The Park Ridge Center will be the dominant ones for the coming generation. Whether the Center succeeds or fails depends in large measure upon its ability to provide resources to people of many faiths—and no faith—as they struggle with their deepest questions and concerns.

This long-term goal of providing significant help to people in real-life circumstances will require the contributions of the finest scholars of the country and the world. But through their efforts a door can be opened which will permit the entry of a wisdom that responds to all the needs brought by patients and providers to the hospitals of our land. ☸

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