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BULLETIN

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"Clergy ethics" is focus of initial project

Center launches first inquiry into professional ethics

The Park Ridge Center began the first in a proposed series of long-term studies of professional ethics with the undertaking of a project on clergy ethics earlier this spring.

The purpose of the project is to consider the ethical bases drawn upon by people within ministerial professions, the norms that shape their practice, what happens when they fail to act ethically, and how one measures their actions.

Initial papers were presented by Martin E. Marty and Langdon Gilkey, both theology professors. They reflected on the societal and religious context of clergy ethics, considered how historical images of the good minister or good rabbi relate to modern standards of clergy conduct, and examined specific ethical problems that confront ministers of all faiths. Highlights of both papers are excerpted below, and the project findings will eventually be published in book form.

In the opening presentation, Park Ridge Center president (and University of Chicago church historian) Martin E. Marty gave a historical account of the evolution of clergy ethics in America, asserting that the "American context for clergy ethics has moved from a theologically-ecclesiastically sanctioned (and thus determined)

situation to a privately contracted, more independent 'entrepreneurial' approach. What clergy picture as 'good' or 'evil' or 'ambiguous' personal or social presuppositions, judgments, or activities—in short, their 'ethics'—

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increasingly reflects the entrepreneurial element. This, at least, is the public perception of the ministerial role, no matter what various clergy picture their sanctions and thus their contexts for ethics to be. Attempts to provide standards for or to reform clergy ethics which do not take this perception and context into consideration will not address the actual condition of people in the ministerial profession or the profession itself.”

Marty listed five elements that encouraged the centuries-long shift from the theologically-ecclesiastically sanctioned norm ("in which most clergy believe") to the contractual-entrepreneurial one ("with which most of them live or are perceived to foster"):

1. American clergy norms developed in a "secular" epoch.

By "secular" I mean here what British sociologist Bryan Wilson means: no single symbol system dominates or gives shape to a whole society. In medieval Christendom, for example, no matter how many paganisms were smuggled in in plain brown wrappers by ordinary people, elites promoted a single Catholic symbol system. There were varieties and schools of thought and there was local color, and moral lapses in the clergy were documentably frequent if not constant. But all were at least nominally responsive to a single hierarchy, informed by a sacramental system, given norms by a natural-law-based ethic connected with biblical revelation, Catholic tradition, and magisterial teaching.

Many religious migrations to various American colonies were intentional efforts to "repeal" the secular trend in

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U.S. issues first animal patent

On April 13, the United States Patent Office issued to Harvard University researchers the world's first patent for a higher form of life—a genetically altered mouse. The mice carry multiple copies of a single cancer-causing gene, and half of the females in the breed develop breast cancer within 10 months of birth. The doomed rodents were developed to study the relationship between genes and cancer and to provide scientists with more reliable subjects for testing possible cancer causes and cures.

When it issued the patent (number 4,736,866) the Patent Office said that 21 applications for patents on other genetically altered animals were pending. Critics in Congress, supported by religious groups and animal welfare organizations, called for a moratorium

on the issuance of such patents until numerous economic and moral questions can be addressed, such as whether it is fair to allow one party to own rights to a form of life and whether genetically altered humans might someday be patentable.

The debate was being monitored closely by researchers in the biotechnology industry, whose stake in such projects runs in the millions of dollars (a patent entitles the inventor to exclusive rights over the product for 17 years). The Patent Office issued the first patent on a plant in 1930, and 8 years ago the Supreme Court ruled that "genetically altered micro-organisms" were patentable.

HHS bans fetal tissue use

The Reagan administration banned the use of tissue from aborted fetuses in any experiments conducted at the National Institutes of Health until an outside advisory committee can examine the ethical, legal, and medical implications of such procedures.

The order was sent to the director of NIH by Dr. Robert E. Windom, assistant secretary of health at the Department of Health and Human Services, who did not prohibit use of fetal tissue salvaged from stillbirths or miscarriages. However, scientists said that tissue from spontaneously aborted fetuses is rarely useable.

Fetal tissue grows faster than adult human tissue and may be more adaptable, making it more suitable for transplanting into patients with Parkinson's disease (see *Bulletin* vol. 3, no. 1, p. 3) as well as for research into numerous blood disorders.

Antiabortion groups lauded the ban, claiming that it reinforced the humanity of aborted fetuses. "If the parents were a party to the killing, they have no right to assign organs to another person," declared Dr. John C. Willke, president of the National Right-to-Life Committee. "That is desecration of a corpse." Other antiabortionists claimed that women might be coerced into having abortions so that their fetuses could be used for transplants or that they might postpone the

abortion to permit the growth of more useful fetal tissue.

Scientists and ethicists who disagreed with the ruling cited the potential cures for disease that could be discovered through fetal research. George Annas of Boston University told the *New York Times*, "I don't even think there's a body of ethical thinking that thinks there's anything wrong with this. If it was a dead child and not a dead fetus, it would be okay for the parents to donate its organs. There is no reason in principle to treat a fetus differently than a child."

Selective abortions increasing

One of the hottest ethical debates of recent months has been sparked by the disclosure that increasing numbers of doctors are aborting some—but not all—of the fetuses when a woman is pregnant with more than one embryo. Proponents of the procedure (wherein doctors use ultrasound to guide a needle filled with potassium chloride into the hearts of fetuses less than two inches long) argue that it enables one or more children to live, whereas if multiple fetuses were carried to term none would be likely to survive—and the mother's life might also be jeopardized. Opponents charge that doctors are killing perfectly healthy fetuses without sufficient evidence that they are saving other lives.

The so-called pregnancy reductions are usually associated with in vitro fertilization pregnancies. In such pregnancies, a dozen or more eggs are extracted from a woman and mixed with sperm in a laboratory dish; several of the fertilized eggs are then returned to the uterus since implanting only one rarely results in a successful pregnancy. Researchers report that the chances of a successful pregnancy increase proportionally with the number of embryos returned to the uterus. Sometimes only one survives, but when several grow into healthy fetuses there is increased risk for both mother and babies. Thus, most "pregnancy reductions" involve reducing four or more fetuses down to two or three; few doctors seem willing to risk leav-

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ing only one live fetus in the womb after the patient has paid thousands of dollars (and perhaps waited for years) to become pregnant.

Some physicians refuse outright to perform the procedure; others will do it under certain circumstances; a few express no reservations at all. A physician in Salt Lake City told the *New York Times* that a woman came to him saying that she would abort all five of the fetuses she was carrying unless he would reduce them to twins, even though she had had prolonged infertility and was told she might never become pregnant again. After lengthy consideration, the procedure was successfully performed, although the physician said he was still weighing whether to do the same procedure on a younger woman who had "been trying to become pregnant only a year or two."

Father Richard McCormick, S.J., ethicist at the University of Notre Dame, asserted that pregnancy reductions are justifiable when it is likely that all fetuses would otherwise die (as with octuplets) but not in cases where all might survive (as with triplets). Admitting that his position runs counter to the Catholic church's stance on abortion, McCormick said, "I just don't think that the abortion position of the Church was formulated and designed with any circumstances like these in mind."

If ethicists and physicians are divided on the procedure, lawmakers in America are taking a wait-and-see attitude. The British government, however, is considering a law that would limit the number of fertilized embryos returned to the uterus to three. Opponents of the proposed legislation include parents who have paid for in vitro fertilizations. They claim that they should have the right to implant as many embryos as they want to increase the chances of a successful pregnancy—even if it may require aborting one or more fetuses later on.

"This society is coping with the multiple-birth question the way it is dealing with most other issues concerning new reproduction technology," wrote Robert Bazell, NBC science

correspondent, in the *New Republic*. "Heads stay in the sand for fear of pressure from special interest groups until a court case forces the issue into the open. The danger is that the court decision can impose more restrictions than might have resulted from an open discussion."

Unidentified man donates heart

Doctors in Newport Beach, California, transplanted the heart of an unidentified man a full day before the donor's family was located to positively identify him. Although doctors waited 24 hours for a police search as mandated by state law, George Annas, professor of law and ethics at Boston University Medical School, charged that "to take vital organs out of someone who is not identified is really incredible. If other people have done this, they haven't talked about it in the newspaper." Annas said that the doctors should have waited 24 hours from the time the man was declared dead, not merely 24 hours from the time he was found unconscious on the sidewalk in front of a convenience store.

However, the Associated Press quoted University of Texas ethics professor John Robertson as saying "I'm not sure there's any serious abuse if the hospital is complying with applicable law. We're dealing with someone who is dead; it's not like they're harming the person. That body is going to get cremated or buried," added Robertson, who serves on the National Task Force on Organ Transplantation.

The recipient was a 58-year-old former staff physician at the hospital where the transplant operation was performed.

Premarital AIDS testing law upheld

In May the Illinois legislature overwhelmingly rejected a measure that would have repealed the state law requiring applicants for marriage licenses to be tested for AIDS. The law does not prohibit marriage when one or both partners tests positive for the AIDS virus, but both must be in-

formed of the test results and be given AIDS counseling.

Opponents of the law argued that it diverted attention from higher risk groups and thus was an inefficient use of state resources. As of April, less than one-thirtieth of 1% of marriage license applicants had tested positive for the the HIV antibody, according to a spokesperson for the Illinois Department of Public Health.

The law has had a dramatic effect on the number of marriages being performed in the state: marriage license applications are down approximately 40% compared to a year ago, state officials report, and county clerks in the neighboring states of Wisconsin and Indiana report a corresponding increase. Many couples who flee out of state to take their vows cite the cost of the test, which ranges from \$50 to \$600 per couple.

Marriage license applications are also down in Louisiana, the only other state to have a premarital AIDS test requirement. Thirty-three states have considered similar legislation.

Man shoots self, cures depression

Doctors in California reported that a mentally ill 19-year-old who shot himself in the head cured himself of obsessive behavior problems. Before the incident, which happened five years ago, the man had a phobia about germs and would wash his hands "hundreds of times per day" and take frequent showers; he is now a straight-A college student, according to a story in the *Los Angeles Times*.

Writing in a British journal of psychiatry, the young man's physician said he believes that the .22-caliber slug that entered the left frontal lobe during the suicide attempt destroyed the portion of tissue responsible for the obsessive-compulsive behavior but apparently left the rest of the brain unharmed. Experts said that in extreme cases of compulsive behavior, neurosurgeons may attempt to remove part of the left frontal lobe, but most such cases are treated with drugs and behavioral therapy.

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Europe, to "regress" to Protestantized medieval patterns in which society—at least officially and presumably—lived by a single theonomous norm. Still, the sanctions for ministry and its ethics now no longer applied to whole societies, particularly where politics allowed for pluralism. The "metaphysics" or "metaethics" that may have inspired a particular form of clergy conduct among, for example, the Lutherans of New Amsterdam carried no force among the Catholics or Reformed there.

When the moderate Enlightenment came to America in the decisive period of national formation with founders like Thomas Jefferson speaking of the evils of "priestcraft," it fostered development of the secular context. Society, it was at least tacitly agreed, could function without prior commitment of its members to a single symbol or value system—the very kind of system that would provide norms for clergy. From then until now we have seen an extension or expansion of this fundamentally secular view of the clergy. There may be respect for the clergy, there is scandal over lapsing and offensive clergy, but the norms for measurement do not derive from official credentials or "credentialers" but from other standards.

2. *The American polity subordinates church and clergy to civil concerns of the republic.*

Walter Berns in *The First Amendment and American Democracy* observes that "The origin of free government in the modern sense coincides with, and can only coincide with, the solution of the religious problem, and the solution of the religious problem consists in the subordination of religion." To make religion legally subordinate does not mean that the state can render the clergy morally subservient. Yet legally it is manifest: the church exists as an institution with charters from the state; it enjoys tax-exemption privileges; it seeks a law of conscientious objection to military service, and it follows police and fire laws. The state does not come to ask exemption from stewardship campaigns, nor do its

agents fear excommunication or interdicts. Still, this subordination-by-law-yet-opposition-by-clergy-to-subservience-in-morality-or-doctrine leaves the clergy in an anomalous circumstance. "You never know when" clerical moral claims will finally bump into legal norms. But there is great reluctance to measure the clergy by formal legal norms, and it is just about impossible

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to provide guidelines, principles, patterns, or laws for the clerical profession as one finds in, say, the legal and medical professions. So how can there be regulation, policing, judgment?

3. *The American clergy and clergy ethics developed in the context of modernity and modernization.*

Modernity and modernization are processes, not events, and mean many things to many people. Let me simply and clearly point to two things brought about by modernity: differentiation and choice.

Modernity brings a great increase in differentiation of roles and functions: differentiation between week and weekend, worship place and workplace, spiritual time and ordinary time, sanctuary and marketplace, clergy and laity, and between types of clerical roles—pastor, chaplain, missionary, bureaucrat, professor.

Differentiation also connotes the idea that the various "spheres" of life are not to be transgressed. But today advice columnists, marriage counselors, undertakers, psychiatrists, and others invade what once were clerical preserves, and clergy find their ethical norms compared to those of non-clerical invaders of their turf. And when clergy compensatorily move into social, economic, artistic, literary, or

political public spheres, they find applied to them the same norms as apply to people with "merely" secular credentials. So we think of the clergy as an impinged upon and impinging profession as the old covenants of modernity no longer satisfy or serve.

Alongside differentiation we have also mentioned *choice*. American clerical standards and practices developed in an epoch in which choice was ever richer and more alluring and demanding at once. Ministers were and are seen as in patterns of competition. They evangelize, proselytize, or at least advertise in the hope of drawing converts and congregants from elsewhere. The historical documentation on this pattern goes back to colonial beginnings and then to the First Awakening, when a minister would invade established clergy's territory and question or denounce them.

Dissenters, upsetters, innovators, and proselytizers attacked the morals of the "settled" clergy while the establishment or privileged clergy in turn pointed to the moral excesses or ambiguities of these itinerants. In a situation of free choice, competitive clergy found it difficult to agree on moral and ethical standards. Today that trend toward competition on moral grounds grows in some sectors, most publicly and notably television evangelism, which influences public perception of the moral shape and intentions of all clergy.

4. *American clergy were necessarily projected as a moral force and are up for examination.*

A secular, pluralist society that legally subordinates religion does not expect clergy to contribute "dogma" on which society should agree in its search for truth, for it despairs of seeing the clergy find consensus among themselves. But it does seem to expect contributions to morality.

In such a situation, mass media exposure of individual instances of immorality or publicity given to clerical challenges to widely accepted existing norms (for example, clerical endorsement of "situation ethics") destabilizes ethical standardization. The ability of mass media to probe and give publicity to ministerial lapses or confusions

therefore complicates the claims of moral specialization.

5. *Theological accommodation in respect to clerical situation and ethics is a constant and increases.*

In a society where a single symbol dominated and provided the theological-ecclesiastical norms for determining clergy ethics and conduct, one kind of theology was manifest and relevant. Inquiry among its lines continues in all ecumenical or denominational ventures to define the sanctioning of ministry and the credentialing out of which moral discourse flows.

However, in the practice of ministry as perceived by congregants, the public, and most practitioners, the contractual-entrepreneurial dominates and calls forth fresh theological inquiry. Each new infusion of personnel, each new impingement of situations, each new context demands new theology, if by that we mean the interpretation of the life of a body of people in the light of God's disclosure. The most dramatic illustration of such change is occurring in our third of a century, when the increasing visibility and ordination of women alters the entire hermeneutical situation with respect to texts about ministry.

This will have to be a preoccupation throughout this two-year clergy ethics program: the shift in American concepts from ministry as a calling or vocation to ministry as a profession and perhaps as a career. Some elements of ethics in the ministry-as-vocation era may prove to be enduring, can be retrieved, and might offer possibilities for tomorrow. Some aspects of ethics in the ministry-as-profession in a class of professions demand fresh inquiry.

When one accepts the historians' proposition that there were no good old days and that stress on ministerial ethical patterns and conducts is not novel, one is free to retrieve some elements from the past and reject others. Such acts of appropriation and distancing will go on in full public view. There is no place to hide while the contemporary inquiry goes on. We live in a mixed spiritual economy and are likely to continue to do so.

This means that religious institu-

tions are likely to survive, that ministerial professionals will continue to be needed, and that questions of clerical ethics will not decline into the zone of "irrelevancy." The evidence suggests that if anything the number of cases and disputes will grow. Much is at stake, and the best scholarly and existential resources will be necessary to advance the conversation. It is more than passing strange that sustained, disciplined, intense discourse on this subject has been rare. In a society where most ministers do not believe that they are "on their own," that they are somehow "called" and are responsive to a call, yet when the public sees them as contractors and entrepreneurs, the conversation may be at the same time threatening and promising but it should never be dull.



Langdon Gilkey, Shailer Mathews Professor of Theology at the University of Chicago Divinity School, stressed the importance of remembering the many traditional interpretations of the clergy. He began by emphasizing the importance of understanding the clergy person as minister or priest within the context of a religious community, just as "teachers cannot be understood without understanding the relevant form of schools, nor professors without universities." Gilkey asserted that "the self-understanding of a community constitutes its identity; institutions are in their essence what they think they are, though of course they are also shaped by other forces. This self-understanding, more than all else, creates and perpetuates the tradition of that institution, and thus the professional status and function of the leader of that community."

Gilkey (with a nod to Ernst Troeltsch) defined three predominant "types" of churches to help distinguish differences in religious communities and in clergy. He cautioned that churches are now more alike than they used to be because of the "increasingly secular character of the environing society," and also noted that "an ecumenical theology oriented toward the biblical, toward liberation, and toward healing has only added to

these homegenizing effects on the mainline churches." Still, Gilkey claimed, "even today the clergy in these respective churches and their congregations see the role of each—and thus his or her ethics—in a significantly different light than do the others."

All forms of Christian churches relate in some mode—or seek to do so—to Jesus at the center of their life; almost none of them recognize this in the others. The Catholic in the sacraments of the Eucharist, the Reformation communities in the hearing of the gospel, the sect in obedience in the Spirit to Jesus' law, the liberationist in historical memory, in moral commitment, and political action for the kingdom. In each the clergy mediates this relationship: different requirements, therefore, are entailed in each, different modes of education, and different sorts of authority.

1. The Sacramental Church, the Mystical Body of Christ

We shall begin with the most obvious type, and probably the oldest: the Catholic churches. If a type is to be discriminated from other types according to the *locus* of the holy—the "place" where the divine dwells and is "given" to the members of the community—then for the Catholic churches the locus is in the sacraments, especially in the Eucharist. There for any Catholic consciousness—Orthodox, Roman, or High Anglican—the faithful directly encounter the sacred and in fact receive it into themselves. If you ask a Catholic why she or he attends church, she will say, "to take the holy sacrament, of course." Preaching here is largely teaching or instruction about doctrine, law, or organization. Word hovers around and defines sacrament, not the reverse.

Thus the minister is *priest*, sacramental mediator, not primarily preacher or declarer of Word. And the requirements or obligations on the clergy are first of all such as to nurture this role and the institutional structure that preserves, continues, and fosters the sacraments. Primarily what makes

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the sacraments "valid" is the "apostolic succession," the episcopal line believed to extend unbroken back to the founding of the church. The continuation of that line guarantees the continuation of sacramental power in and through that line; hence no sacrament is conceivable if not sponsored by that line. Classically, therefore, the ethics of the clergy were intended to preserve this divinely established structure of the church. (1) The clergy is validly ordained and thereby given the sacramental power to mediate. (2) The clergy keeps itself fit thus to mediate: it is celibate, "ordered," separated from the world and taught the necessities of church, that is to say doctrine and law. (3) It is obedient to the episcopal order as the *fount* of the authority and power that generate the church. The church does not create and so choose the bishops, but rather the reverse: the church is *there* established—and in a papal succession, it is *there* that the episcopacy is established.

One can see clearly here the roots of the authoritarian, dogmatic, legalistic tendencies of much of the Catholic clergy. One can see here also, however, their enviable gift to "accept" the world to themselves and then to the church, to mingle with the worldly world—and not to feel contaminated thereby. Why should they? The "holy" in the church is objectively present in the succession, in the sacraments, in dogmas, and in law; it is there for all, however tarnished and apparently indifferent the priests may be; they are mediators of the holy and so, like any relatively passive mediator, their own modes of contamination (while perhaps deplorable for their own salvation) do not affect their ability to be priests.

This traditional understanding of church and clergy has received some very hard jolts in the last three decades (from the modern sense of autonomy, of democratic authority, and from liberation theology). But quite possibly the liberationist consciousness can unite creatively with a Catholic ecclesiology centered on the sacraments. Nevertheless, the church as the community sent to liberate the

world has a different understanding of holiness, a different interpretation of its own religious goals and norms, and so in the end it must recognize a different gestalt of leadership. Thus this "liberationist" conception of church and clergy will endlessly shake and perilously challenge the church as an institution established on and by the hierarchical authoritarian clergy, possessing the sacred in its changeless sacraments, dogmas, and law, and so in its essence accepting the world as long as the world recognizes the

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church's religious authority and role therein. Nothing will be more creative—or risky—than seeking new ways to interpret a Catholic sacramental ecclesiology that recognize fully the historical, scientific, and autonomous consciousness of the modern as well as the liberationist consciousness of the post-modern world.

2. The Church of the Word

A quite different interpretation of church and clergy appeared at the Reformation. The holy within the community was no longer the sacramental gift of healing grace; rather, it was the presence of the *gospel* of justification of the sinner and the promise of reconciliation with God contained therein. The Word declared in scripture and proclamation has now replaced the sacrament contained in ecclesia as the "place" where each believer most directly and significantly encounters God, in fact where Jesus Christ is present in his church.

The Reformation clergyperson mediates this gift of the Word—but since the gift is so different from that of sacramental grace, the function itself of mediating becomes radically different. Preaching or proclamation of this word is now the central act of the church, and this is the minister's main task. Since this message is contained and preserved in the Scripture, the Scripture itself replaces the authority of church tradition; it is available to each believer and unquestioned in its authority. The minister is, then, obedient to scripture, not to the episcopus; his or her own authority as mediator and thus his or her authority in the congregation depend on knowledge of scripture and fidelity to its true meaning. In principle, each interpreter was free to follow his or her own conscience in the interpretation of scripture. Soon, however, the interpretations of different communities became normative, and thus the authority of particular traditions and of their confessions comes to dominance, and with that dogmatic controversies reappear.

Since the law as well as gospel has been given in revelation and scripture, the clergy were also authorities in interpreting the divine law—and so proper morals—for the community of believers. Hence the clergy became not only declarers of the gospel word but also moral legislators and executive implementors of the moral rules governing the community.

It has seemed to me that the acids of modern relativism have made more precarious the religious role of declaring the Word than the priestly role of mediating the sacrament. Words need not necessarily be more relative and human than are creaturely material symbols, but in modern intellectual culture they seem so. They seem locked in the relative, the historical, and the psychological worlds.

3. The Churches of the Spirit

Here we encounter a genuine chaos, almost a "mess"—a wide variety of types of church life and ministry that has proliferated almost endlessly and is still steadily growing. Perhaps its most important forms will emerge out

of the black churches, as a new synthesis of spirit-centered churches with a worldly, liberationist task, uniting types now a bit worn out in mainline churches or warped into fundamentalist forms in many Evangelical congregations. Along with the Catholic union of sacrament and liberation, these newer modes of black congregational life may be destined creatively to form the vital churches of the future.

Let us return, then, to simpler days to see some of the guiding principles of these churches of the Spirit. These principles have provided the background and so the presuppositions for a good deal of the *ecclesial structure* of the "denomination," and hence of the mainline churches; they form even more of the ecclesial structure of most of the evangelical and charismatic churches; and, as noted, historically they have dominated the self-understanding of the black churches.

Forms of the church that appeared and flourished in the 16th and 17th centuries—Spiritualists, Anabaptists, Mennonites, Amish, Quakers, and so on—seemed to emphasize three things, each of which sharply distinguished them from churches of the Sacrament and churches of the Word: subjectivity, transformation unto perfection, and fellowship.

1) Subjectivity—the vivid, evident, and transforming *presence* of the Spirit in the believer. This is to them authentic Christianity, not cathedrals, masses, ceremonies, bishops, creeds, or objective law—or even church buildings. All that is objective was negated in favor of inner experience and transformation of personal and communal existence. The church to them is not holy because in it are bishops, dogmas, valid sacraments, and holy law, nor even because in it there is the true revealed Word. It is holy simply because it is made up of authentic Christians, real believers and real followers who have the Spirit and know they have it, and who follow its leading.

2) Genuine transformation and thus obedience to the absolute law of the gospel. There was here originally (and still is in principle) no distinction between a higher ethic for the clergy and a lower ethic for the laity, as in the Catholic churches; nor a distinction of

person and vocation and calling as in Lutheranism. The "leader" has no superior religious status; he or she is one among the congregation, and so he or she (and often it has been she) is called only to a leadership role in the community, not to a special religious role. If anything, the community, not the clergy, is set apart. Here in principle the whole congregation equally is called to perfection—and this is why they originally left the world, which most of them regarded as wicked. In modern times the community has thoroughly reentered the world, and

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the call to perfection has been reduced to "respectability," probity in business, and vicelessness in personal life.

The clergy in the churches of the Spirit are thus in a paradoxical role: *all* in the congregation should follow the law (regarding drinking, smoking, gambling, dirty stories) but ahead of all of them must be the pastor and the pastor's spouse. They are called to more than perfection. And when most members of these churches have become full-time Americans and so now drink, smoke, gamble, and get rich—except when the minister comes to tea!—the minister and spouse *alone* uphold the law and will be fired if they let the worldly congregation down. Quite unexpectedly here the clergy have become scapegoats, sacrificial victims for the congregation: they *must* be holy to make up for the congregation's lapses.

Required to be holy and yet in the world, they settle for appearing pious;

pressed into being friendly, warm, frequently gushing, and agreeing, they can be—unless they know who they are—terribly lonely, often empty inside, and fearful. They pretend to incarnate the holy and as a consequence repress everything real about themselves. This is not the hypocrisy of the stern Puritan; it is the modern American hypocrisy of phony love.

3) Community—the real fellowship of an actual congregation. The church was not the whole church headed by Christ, pope, or bishops, but rather *this* congregation. But this sense of fellowship has caused the churches of the Spirit an increasingly hard time. Many clergy have been torn between their moral obligations to Christian fellowship with all people—and so all races and classes on the one hand—and the drive of the church toward social and spiritual *unity*, exclusiveness, "club-itis," on the other hand. "A church is where you meet people like yourself, people your kids can marry, people you go home to dinner with" — how often I have heard this, and how much it was this very idea of "warm fellowship" that in a different sociological setting turned sour. Here one idea was at war with another: the community of loving fellowship versus the community of loving outreach.

Clergy are inheritors as professionals and as leaders of churches of very significant traditions, traditions vastly diverse in their understanding of the institution and its leadership. These traditions are still there, and still effective, albeit all mixed up with pressures from contemporary society, its goals, aspirations, standards, and techniques. Consequently, each tradition is confused, even recessive—but it is there in the self-understanding of each clergyperson as to what he or she is and can be. If we are to understand the problems as well as the opportunities of clergy, their neuroses if not their greatness, we must understand the ecclesial traditions in which their communities exist and in which they live out their professional lives.



Jackie Cole recounts stroke recovery

The story of Jacqueline and Harry Cole is told in the pages of volume 7 of *Second Opinion*: how on March 29, 1986, Jackie suffered a sudden, massive stroke; how she lapsed into a coma and doctors predicted her imminent death or, at best, life in a persistent vegetative state; how after Jackie had lain in a coma for 41 days Harry petitioned the court to remove life support; and finally how, on May 15, 1986, just a scant six days after the court denied that petition, Jackie opened her eyes and smiled and thus started down the long road to full recovery. During a recent visit to the Park Ridge Center, Jackie told firsthand of her experience and how it affected her faith.

Bulletin: Can you describe the experience of coming out of a coma?

Jackie: Coming out of a coma was very much like being a baby. I was very weak, I didn't have any strength in my legs because I hadn't walked in so long, and I had to learn to walk again. I felt a childlike dependency on others.

It's only been within the last month or two (a year and a half after awakening from the coma) that I've developed a real awareness of what's going on around me. People seem to think that when you awaken from a coma you're awake, you order breakfast. It doesn't work that way. It's all a question of how aware you're becoming, and I'm becoming much more aware.

My recollection really goes back only to November, around Thanksgiving, a full 17 months after I came out of the coma.

I had lost a lot of weight during the coma, and when I came out I had no sense of discrimination. I had spent my life on a diet, but when I came out I was about 80. Everyone was baking me stuff, so I ate my way right up to about 135 lbs.

Bulletin: In addition to memory training and the standard physical and occupational therapy, what other kinds of rehabilitation programs are you in?

Jackie: I've been taking a drawing course and an art course, both com-

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It's a gentle
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be terrified of."*

—Jackie Cole



position and painting, at the university in Maryland. I'm also baking and cooking quite a bit; at Christmas I was able to cook the whole dinner.

Bulletin: You said earlier that humor played a role in your recovery.

Jackie: I had to learn to laugh at myself and at others. The biggest thing was learning not to take myself too seriously. My problems are really no different than anybody else's. People take very seriously things that they have no control over and they spend hours worrying unnecessarily.

Bulletin: What was the most important part of your recuperation and rehabilitation?

Jackie: Harry. He's very supportive, he's very wise, he's very gentle, he's very caring—he's a peach, he really is. I don't remember how dependent I was during the times when someone else had to wash me and so on, so I'm not fully aware of how much Harry did for me.

Bulletin: In light of your remarkable recovery, how did you feel about Harry's decision to discontinue life support?

Jackie: My mother had an angioma, a benign tumor that grows and crowds the brain. She had two operations.

After the first she seemed to be recovering, but then the tumor began to grow faster than ever. They did a minor surgery to see what was going on, and it was hopeless, so they just closed her up. She died about two months later. It took a terrible toll on the family. At the time I said to Harry, "If anything like this ever happens to me, don't keep me alive; just pull the plug." When I had the stroke he remembered what I had said and that influenced his decision.

Bulletin: In the *Second Opinion* story, Harry recalls asking "Why did this happen to her—and to us?" His own faith was challenged a great deal. Do you feel that your own personal faith has been changed by this experience?

Jackie: Yes, it's been strengthened and enhanced. I believe in prayer. But I've also changed emotionally. I used to be a very witty person, loaded with sarcasm, but I'm not sarcastic anymore. I'm just very sweet (laughs). People appreciate me more now, they like a gentler spirit.

Bulletin: Do you think about death in a different way now?

Jackie: I don't fear it as I once did. I recognize it as being a part of life. It's a gentle experience—not anything to be terrified of. Whether or not there's an afterlife isn't as important as living and

living to the fullest right now.

I tend to reach out and make contact—even if it's just saying hello—with one person every day, which I never did before. I take very little for granted anymore: food that I eat, sleep that I get, husband I have, children I have. I thank God for them all the time.

Bulletin: What would you say to families that are in this situation or to families that don't have the good outcome that you had?

Jackie: I'd probably say that God will provide, and God will give you the strength to weather whatever you need to weather. Most people do not come out of these comas, and we just have to accept what God has planned for us. I used to work incredibly to have my way about things, and now I just tend to let things happen. I used to scheme, contrive, plot, plan, I always had a vision of how things should be and I was going to make sure that happened in my life. But then *this* happened and I just learned not to make that many plans. While I expect that things will work out, I realize they might not.

Somehow Americans in particular, I think, are of the opinion that if they do this and that, they can achieve a certain result. I always knew that we didn't really control as much as we think we do, but this experience really brought it home.

Bulletin: Do you feel that people treat you differently?

Jackie: Well, if they do it's mostly because I treat them differently. But they probably feel differently, a sense of awe perhaps, because I've lived through something that most people don't. I'm really not that impressed by what happened to me, but I've spoken to so many people who had a loved one in a similar situation, and they're all mightily impressed. I've never spoken to anyone who has been through what I've been through and is as alert and aware as I am.

That brings up the question of why, why was I allowed to live, what was I supposed to do?

Bulletin: Are you aiming to prepare people or to help those who have been in these situations?

Jackie: Actually, both. I need to develop some parameters, and I really haven't had the time to do that. Harry says that basically what we're doing right now is giving people inspiration and hope. I hope I'll become more articulate. I was much better in a recent appearance than I had been previously.

Bulletin: Such an experience naturally puts an enormous strain on families. How have your children responded to all of this?

Jackie: They're growing up. I think that's the quickest, easiest way to say it. They were home for Christmas, and that was enjoyable, but in a certain sense they distance themselves. The youngest is 19. Regardless how old you are, if one minute your mother is healthy and the next minute she's not, then you're told that within an hour she will die, and then that hour gets stretched out for days, the kids—just in order to survive—had to let me go and say their goodbyes. Then literally within the twinkling of an eye I was back. One child was utterly ecstatic—he flew across the room and into Harry's arms. The others looked at Harry like, "What are you saying?" All of them probably hoped or expected that after waking up I'd be like I had been before, that this was all a bad joke. So they distance themselves so they can thrash this out and try to make some sense of it.

And they're coming around. My youngest son at Christmas time said he was proud of me, and he was proud that I was his mother. Now, I know that doesn't quite impress you the way it did me, but that was very meaningful, because he's one of these kids that basically doesn't voice much of anything. And to have him say something like that to me just moved me tremendously.

News from abroad

Soviet physicians say they rarely inform cancer patients

A group of Soviet doctors told American oncologists that it is routine in the U.S.S.R. for physicians to not tell patients about cancer diagnoses. "It's hardly a good idea to tell a patient directly that he has cancer," contended the president of the U.S.S.R. Oncological Society, Dr. Nikolai Napalkov. "Only in rare cases, when the patient refuses treatment, does the doctor have the obligation to tell the patient."

Dr. Napalkov made his comments during a two-hour teleconference called "The Cancer Summit," during which cancer researchers at the National Institutes of Health in Washington communicated via satellite with Soviet cancer experts in Moscow.

The chief of surgery at the National Cancer Institute, Dr. Steven Rosenberg, vehemently took issue with the Soviet approach, claiming that "the sense of trust between a doctor and patient is very important. It's impossible for me to imagine giving quality care without telling the patient the full story."

The exchange between the two doctors was sparked by Napalkov's introduction of a person-on-the-street poll in which numerous Muscovites said they would prefer not to be notified if they had been diagnosed with cancer. Dr. Napalkov said the policy of concealment "preserves the peace of mind of patients," explaining that most citizens regard cancer as "a death sentence" and fully informing the patient "could interfere with internal processes."

The Soviet and American scientists also exchanged scientific research information, such as treating cancer by injecting patients with concentrated, purified lymphocytes extracted from tumors.

AIDS books deal with religion and care

by Kathleen Cahalan

Dozens of books have been written about AIDS, but only a few have been published that deal with the religious questions that have arisen from this dreaded disease. The following books are recommended to those who wish to explore the religious questions surrounding suffering, death, and hope as they are related to AIDS. They are recommended for pastors, pastoral counselors, families touched by AIDS, and particularly AIDS patients themselves. There is a similarity about these books that cannot be overlooked: each of the authors has been personally touched by AIDS and every book contains vivid stories that provoke myriad questions for religious individuals and communities. Although these books are written primarily from the Christian perspective, other religious communities may also find them helpful. AIDS poses a serious challenge for all of society, but these authors are unanimous in calling the churches to lead the way in healing the divisions caused by ignorance and fear. They also point to how we can find meaning and hope in this seemingly desperate situation.



Kübler-Ross, Elisabeth. *AIDS: The Ultimate Challenge*. New York: Macmillan Publishing Co., 1987.

The human dimension of AIDS is vividly captured by Dr. Kübler-Ross, the renowned author of several books on death and dying. She tells the stories of people with AIDS we don't often hear about in the news—children, prison inmates, women, and young mothers. For those who lost respect for Kübler-Ross when she ventured into the somewhat suspect realm of after-death experiences, this book reclaims an essential and vital part of her life's work—understanding suffering and assisting the dying. "For over twenty years I have been involved

in caring for terminally ill patients, both adults and children. My goal has been, and still is, to educate health-care professionals as well as clergy to become more familiar with the needs, concerns, fears, and anxieties of individuals (and their families) who face the end of their lives" (p. 1).

In this largely autobiographical book Kübler-Ross narrates the stories of people she has worked with, interviewed, or counseled. But her purpose is not merely to tell stories; she offers the reader a challenge, the challenge to love unconditionally, to break down our fears and prejudices and accept others and ourselves. "Is it possible that our AIDS patients, children and adults alike, chose to contribute their short life spans on planet Earth to help us open our eyes, to raise our consciousness, to open our hearts and minds, and to finally see the light. . . . to learn the final lesson, the lesson of unconditional love" (p. 12)?

The author tells of her struggles in working with AIDS patients, most poignantly when she attempted to establish a home for children with AIDS. "I became increasingly involved in the plight of babies with AIDS after reading a desperate plea in a Florida newspaper. A mother was turned down by seventy agencies after asking for a place of care and love for her baby dying of AIDS prior to her own death. She died without ever knowing who would look after her terminally ill toddler! . . . I was soon haunted by the images of babies dying of AIDS, uncared for, in alien, institutionalized care centers instead of in a home full of love and compassion" (pp. 56-7).

Kübler-Ross's dream was to establish a home on her farm in Virginia, but the community opposed it completely. The book reprints transcripts from a town meeting where citizens argued vehemently against allowing children with AIDS into their community, as well as letters to the editor of the local newspaper following the meeting. These two chapters, though repetitious, show the variety of feelings and attitudes in a small community threatened by the presence of AIDS.

Some of her most powerful stories derive from her work with inmates. Although many in the prison system denied that there was any problem when she inquired about people with AIDS (PWAs), when she began visiting the prisons she found desperately ill young men abandoned and alone. The stories of their transformations through the stages of dying are some of the richest in the book. "Will AIDS patients ever reach a stage of acceptance and peace? Yes. . . . The human spirit is strong, and I have seen the hardest inmates become soft and forgiving to those who purposely made their last months miserable beyond comprehension. In those last few weeks or days, many of them had visions, became aware of help from beyond. And some of them wrote the most profound letters—letters that should make us ashamed in the face of such genuine spirituality. Yet of all the thousands of patients I have seen literally all over the world, I have never seen such mutual support and solidarity as I have among AIDS patients themselves and their partners" (p. 11).

One could say that Kübler-Ross is a woman of incredible faith: faith in the human spirit, in the will to survive, in God. Her work with the dying can teach all of us something, and her faith is a good role model because it arises from contact with the suffering. She closes her book with this message: "What are we to make of this hell of AIDS? Let us look again at the prophecies, from the Holy Scriptures, to the Hopi Indians, to Nostradamus. It has been foretold that there will be a time of great plague; there will be a time of the separation of the wheat from the chaff prior to great changes on this planet earth. We have also been taught, over endless time, that love is always stronger than anything else and can literally conquer all evil. If we are to believe all of this, wouldn't it be simple to spend our joint energies and resources (on every level) to organize a worldwide team, not only for research but for care centers, support groups, treatment centers, counseling centers, and bereavement

groups? It would create myriad jobs, a golden opportunity for lonesome old people, an educational chance for minorities, and a sense of working on a common goal toward a world family where men help for the betterment of mankind. . . .

"Instead of viewing AIDS patients as being punished by God, is it not possible that they will eventually be viewed as the catalysts who set in motion these wonderful—and totally possible—world changes?" (pp. 319–20).



Shelp, Earl E., Ronald H. Sunderland, and Peter W. A. Mansell, M.D., *AIDS: Personal Stories in Pastoral Perspective*. New York: Pilgrim Press, 1986.

Shelp, Earl E., and Ronald H. Sunderland. *AIDS and the Church*. Philadelphia: Westminster Press, 1987.

The lives of those persons with AIDS and those close to them is told in a simple and moving way in *AIDS: Personal Stories in Pastoral Perspective*. This book primarily contains stories about those with AIDS-related complex (ARC) or AIDS, their families and lovers, and the nurses, social workers, and physicians who care for them. The opening chapter discusses the need for such a book and the way that these stories illuminate the human suffering so often hidden in the mass media's coverage of this disease. The second chapter outlines in a very helpful way the medical facts about this disease. The book closes with a chapter on recommendations for pastors. These stories could be used in sermons, the classroom, or in pastoral counseling to increase understanding of how AIDS affects people's lives.

The authors help us see how the church can play an important role in both education and service, and call upon congregations to take seriously their call to servanthood in light of those around them who could be touched by AIDS. The authors are critical of the way the church has responded thus far: "The near-total fail-

ure of the Church to fulfill its theologically and biblically mandated role in these crises of illness and death raises questions about the integrity of contemporary American Christendom" (p. 177).

In a follow-up book, *AIDS and the Church*, the authors offer a more detailed analysis of the AIDS situation, its challenge to the church, and their own theology of illness, suffering, and death. The strongest chapter, and the one that could be most helpful to ministers, is chapter 5, "AIDS Ministries." Concrete recommendations are given to both individuals and congregations considering an AIDS ministry. The authors warn that embarking on an AIDS ministry requires "a high level of commitment" (p. 91). They offer three general prerequisites for ministry and three organizational recommendations.

The first general prerequisite for ministry is individual and corporate self-examination, which includes the following questions: How much courage do you have? How comfortable are you with illness and dying? How willing are you to be exposed to lifestyles and settings that are unfamiliar and sometimes offensive? Can one separate compassion from condoning conduct by which a person was infected? How committed are you? How much time do you have (pp. 94–100)?

Education and training is a second prerequisite mentioned by the authors. Learning about the physical and emotional problems associated with the disease should be the first step, but other skills may also need to be learned, such as good pastoral counseling skills and simple nursing tasks.

"Clarifying one's purpose" is the final prerequisite. The authors state the purpose of AIDS ministry to be "support, nurture, and consolation. They are not primarily evangelistic ministries in the sense of pressure to convert to a particular faith or morality" (p. 104).

The authors advise that, for parishes, the care of AIDS patients should be a team-based approach. Further, networks and interfaith ministries should be encouraged, and education

is a primary goal for these groups. Education can take a variety of forms, including classroom instruction and preaching, and the authors offer guidelines on how to talk about AIDS in each of these situations. The parish should also consider involving itself in social and political action to help voice the real needs of those with AIDS. Finally, this book offers a real and concrete challenge for the church to be the "servant Church."



Flynn, Eileen P. *AIDS: A Catholic Call for Compassion*. Kansas City, Mo.: Sheed & Ward, 1985.

This small, very readable book not only takes us into the lives of those with AIDS but also provides an insightful analysis of the care of AIDS patients, and gives a good outline of the physical aspects of the disease. Flynn confronts the issue of fear in a way that has not been discussed by any other author. She recognizes that the fear of AIDS is real and should not be viewed as unreasonable but believes that people can understand their fears, see the facts, and can often learn compassion for other people's situations.

Flynn outlines a theological perspective that includes a basic overview of the biblical perspective on human persons, sin, suffering, and illness. She shows how Christians, motivated by the Gospel message and example of Jesus, continue in the line of Jesus' ministry by helping those who are poor, oppressed, and alone. Flynn also includes a provocative chapter on the Catholic Church's teaching on homosexuality. She outlines how theologians can disagree with this teaching and remain faithful to the church, and challenges the church to openly discuss the pros and cons of homosexual monogamous unions.

The final chapter outlines what can be done to help those with AIDS.

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AIDS Books *from page 11*

Volunteers are needed in parishes, neighborhoods, and prisons, to visit the sick, to bring groceries, to take someone to the doctor, and to provide comfort and companionship.



Snow, John. *Mortal Fear: Meditations on Death and AIDS*. Cambridge, Mass.: Cowley Publications, 1987.

John Snow, a professor of pastoral theology, shares his views on death and AIDS in a series of meditations published in this slim volume. Asked to give five meditations on AIDS at an Episcopal provincial conference, Snow embarked on a thoughtful journey of serious religious reflection and prayer. These simple yet profound meditations point to one of the primary struggles in the AIDS crisis: the fear of death, which lies at the root of our anxiety not only about AIDS, but all illness and suffering. "Is it any wonder that AIDS has brought such a mixed and confused and at times almost insane response from our society? A society that thought it might have death on the run has discovered or uncovered what we suspected all along and tried so hard to deny. We have discovered that human beings are irretrievably mortal" (p. 14). There is wisdom in these meditations and a

deep challenge to live differently in the light of the suffering of those with AIDS.



Fortunato, John E. *AIDS: The Spiritual Dilemma*. San Francisco: Harper and Row, 1987.

What are the spiritual questions asked by PWAs or those touched by AIDS in any way? How are these questions being answered? Who can guide those who wish to walk the difficult path of faith in the midst of much pain and suffering?

John Fortunato, a psychotherapist and author (*Embracing the Exile: Healing Journeys of Gay Christians*), writes from his personal experience of working with PWAs and watching 15 of his own friends die from AIDS. As a Christian he searches for meaning in this struggle. Fortunato believes that AIDS can provide a context for opening up one's life to a deeper faith.

For Fortunato the spiritual journey is not the easy road of the pious or "first-born" believers. The spiritual journey is one that faces the paradoxes of illness and suffering and searches for a "why." "By spiritual I allude to the journey of the soul—not to religion itself but to the drive in humankind that gives rise to religion in the first place. . . . By *spiritual* I am referring to that aura around all of our lives that

gives what we do meaning, the human striving toward meaning, the search for a sense of belonging" (pp. 7-8).

Fortunato, who is gay, focuses on the impact of AIDS on the lives of gay men, and on what members of the gay community can do in their own spiritual struggle to understand their circumstances. Fortunato spends a good deal of time examining how gays feel about themselves and how estranged they feel from their faith. He affirms his own faith in the face of the animosity against homosexuality. His answer for the gay community is a challenge: "The alternative to trying to force our way back into the myth is to embrace our exile. Not passively. Not with resignation. But with vigor and passion. Drinking deeply from the cup we have been passed as an oppressed people, seeing it as an opportunity both for profound spiritual deepening and for being empowered to do some very holy work in an especially potent way" (p. 32).

This book covers a great deal of material yet is very readable. It would be helpful for anyone with AIDS or ARC, as well as for those ministering to them. The author discusses homosexuality and Christianity, illness and death, and the meaning of heaven. Rather than just telling us what the problem is, Fortunato gives a message of faith and hope, one that steps beyond blame and grief and challenges anyone who reads his book to think about their own faith differently.

More U.S. hospitals ban smoking, survey says

One in 12 American hospitals are banning smoking and most of the rest are restricting smoking to some degree, according to a survey conducted by the American College of Healthcare Executives. The ACHE polled its 20,000 members on a variety of health care topics and released the results at the group's annual meeting earlier this spring.

Eight percent of the ACHE hospitals

have banned smoking entirely, and 96 percent have either adopted a policy of restricting smoking or are in the process of doing so.

As of April 1, 1988, one of the nation's largest health care systems, the three-hospital, 100-clinic University of Chicago Medical Center, became essentially "smoke free." According to UCMC's executive vice-president Kenneth Bloem, only patients with written

permission from their doctor will be allowed to smoke, and then only in private rooms. There are no smoking lounges and employees are not permitted to smoke anywhere on hospital grounds.

"This is an important public health issue," Bloem explained, "and I think health care institutions need to take far more of a leadership role than they have."

Kass addresses Kennedy symposium on euthanasia

Prompted in part by the debate surrounding the *Journal of the American Medical Association's* publication of the controversial "It's Over, Debbie" essay (see *Bulletin*, vol. 3, no. 2, and page 16, of this issue), the Kennedy Institute of Ethics at Georgetown University sponsored a members' symposium on euthanasia. During the day on Friday, May 6, Kennedy Institute members met with resident scholars to discuss topics such as "Genetic Engineering, Reproductive Technologies, and AIDS," (with LeRoy Walters) and "A Moral Account of Compassion" (with Warren Reich). In the evening, a paper entitled "Neither for Love Nor for Money: Why Doctors Must Not Kill," was presented by Leon Kass, M.D., Ph.D., of the University of Chicago's Committee on Social Thought.

Kass took on the practice of euthanasia from several angles, arguing primarily variations on the theme that killing patients is directly contrary to the mission of physicians and thus cannot be justified. A more detailed transcript of Kass's speech may be obtained from the Kennedy Institute; highlights of his conclusion and of the subsequent question-and-answer session are excerpted below:



Each of the professions has a central inner meaning that characterizes it essentially, and it is independent both of the demands of clients and of the benevolent motives of the practitioners. To be sure, things go better when the patient is freely willing and the physician is, generally speaking, a virtuous and compassionate human being. But the physician's work centers on the goal of healing, and he is thereby bound not to behave in contradiction to that central goal.

But there is a difficulty. The central goal of medicine, health, is in each case a perishable good. Inevitably, patients get irreversibly sick, degenerate, and die, medicine or no medicine. Healing the sick is in principle—that is in the best possible case—a project that

cannot succeed indefinitely, a project that must fail. And here is where all the trouble begins: how to deal with medical failure. What to seek when restoration of wholeness seems to be by and large out of the question.

There is much that can and should be said on this topic, which is the root of the problems that give rise to the call for "mercy killing." In my essay "Practicing Prudently: Ethical Dilemmas in Caring for the Ill," I argue for the primacy of easing pain and suffering, along with supporting and comforting speech, and the need to draw

"When a conscious human being asks for death, he displays the presence of something which precludes our regarding him as a dumb animal (that we would put to sleep)."

—Leon Kass

back from some efforts at prolongation of life, i.e. those that prolong (or increase) only the patient's pain, discomfort, and suffering. Though mindful of the dangers, and though aware of the impossibility of written explicit rules for ceasing treatment, I have argued that considerations of the individual's health, activity, and state of mind must enter into decisions of whether and how vigorously to treat if the decision is indeed to be for the patient's good.

Ceasing treatment and allowing death to occur when it will seems to me quite compatible with the respect that life itself commands for itself. For life is to be revered not only as manifested in physiological powers, but also as these powers are organized in the form of a life, with a beginning, middle, and end. Thus life can be revered not only in its preservation, but also in the manner in which we allow a given life to reach its terminus. For

physicians to adhere to efforts at indefinite prolongation not only reduces them to slavish technicians without any intelligible goal but also degrades and assaults the gravity and solemnity of a life in its close.

But what are we to think about the remaining question, Is killing the patient, even on request, compatible with respecting the life that is failing or nearing its close? Obviously, the euthanasia movement thinks it is. Yet one of the arguments most often advanced by proponents of mercy killing seems to me rather to prove the reverse. Why, it is argued, do we put animals out of their misery, but insist on compelling human beings to suffer to the bitter end? Is this not inhumane?

Perhaps inhumane, but not thereby inhuman. On the contrary, it is precisely because animals are not human that we must treat them merely humanely. We put dumb animals to sleep because they know not that they are dying, because they can make nothing of their misery or their mortality, and therefore because they cannot live deliberately—that is to say, humanly—in the face of their own suffering or dying. They cannot live out a fitting end to their existence. Compassion for their weakness and dumbness is our only appropriate emotion, and given our responsibility for their care and well-being we do the only humane thing we can.

But when a conscious human being asks us for death, he by that very fact displays the presence of something which precludes our regarding him as a dumb animal. Humanity is owed humanity, not humaneness. What humanity needs most in the face of evil is courage, the ability to stand against fear and pain and thoughts of nothingness. The deaths we most admire are those of people who, knowing that they are dying, face the facts frontally, and act accordingly. They set their affairs in order, they arrange what could be final meetings with loved ones, and

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yet with strength of soul and a small reservoir of hope, they continue to live and work and love as much as they can for as long as they can. Because such conclusions of life require courage, they call for our encouragement, and for the many small speeches and deeds that shore up the human spirit against despair and defeat. Many doctors are, in fact rather poor at this sort of encouragement. They tend to regard every dying or incurable patient as a failure, as if an earlier diagnosis or a more vigorous intervention might have avoided what is in truth an inevitable collapse. The enormous successes of medicine these past 50 years have made both doctors and laypeople less prepared than ever to accept the fact of finitude. Doctors behave, not without some reason, as if they have godlike powers to revive the moribund, and laymen expect an endless string of medical miracles. It is against this background that terminal illness or incurable disease appears as medical failure, an affront to medical pride.

Physicians are today little likely to be agents of encouragement once their technique begins to fail. It is, of course, partly for these reasons that doctors will be pressed to kill, and many of them will, alas, be willing. Having adopted a largely technical approach to healing, having medicalized so much of the end of life, doctors are being asked to provide a final technical solution for the "evil" of human finitude and for their own technical failure. "If you cannot cure me, kill me." The last gasp of autonomy or cry for dignity is asserted against the medicalization and institutionalization of the end of life that robs the old and incurable of most of their autonomy and dignity.

Intubated and electrified with bizarre mechanical companions, helpless and regimented, once proud and independent people find themselves thrust into the roles of passive, obedient, highly disciplined children. People who care for autonomy and dignity should try to reverse this dehumanization of the last stages of life instead of giving dehumanization its

final triumph by welcoming the desperate, "Goodbye to all that" contained in one final plea for poison.

The present crisis that leads some to press for active euthanasia is really an opportunity to learn the limits of the medicalization of life and death and to recover an appreciation of living with and against mortality. It is an opportunity for physicians to recover an understanding that there remains

"Should doctors cave in and become technical dispensers of death, they will become the worst sort of example, teaching technicism where encouragement and humanity are required."

even at the end a residual human wholeness, however precarious, that can be cared for even in the face of incurable and terminal illness.

Should doctors cave in, should doctors become technical dispensers of death, they will not only be abandoning their posts, their patients, and their duty to care; they will set the worst sort of example for the community at large, teaching technicism and so-called humaneness where encouragement and humanity are both required—but sorely lacking. On the other hand, should physicians hold fast, should they recover the latent anthropological knowledge that alone can vindicate the venerable but now threatened practice of medicine, should doctors learn that finitude is no disgrace and that human wholeness can be cared for to the very end, medicine may serve not only the good of its patients, but also, by example, the failing moral health of modern times.

During a question-and-answer session following his presentation, Dr. Kass was asked what may be gleaned from Holland's experience with euthanasia. He responded that impressions depended on who was doing the speaking. Proponents of euthanasia who have spoken in the United States indicate that the Dutch community accepts the practice and that the doctor-patient relationship is unharmed. On the other hand, Kass noted, a book by a Dutch physician documents numerous cases of what the author calls "cryphtanasia," or "secret killing," of people who have never expressed any wish to die but who are alone in the world and have no one to speak for them and who have been seen as having a life not worth living. "From what little I've seen, I think it's certainly too early to pronounce the Dutch experience a success and early enough to begin to worry," Kass concluded.

Another question from the audience came from columnist George Will, who challenged Kass's conception of "what doctors do." "People don't merely die," Will said. "Now what we do is 'wear out,' and wearing out changes the function of medicine; perhaps the function of medicine now is—not wholly, but largely—mitigating, and if it is mitigating, is not mitigation served by active euthanasia? And a larger question, is not mitigation a satisfactory definition of what doctors do?"

Kass responded that while it might be true that death was more abrupt in earlier days, "there were always old people," and that people wore out before the 20th century. Kass also said that what Will called mitigation (and what Kass called relief of suffering) has always been part of the medical intention. He noted that if a physician has a merely bodily view of wholeness, there comes a time when he or she can do nothing for the body, and therefore doesn't know what to do. Whereas Kass was asserting that the tradition of medicine rests on a latent anthropology that postulates a sort of

psychophysical human wholeness. Thus, at least as long as a patient was sufficiently conscious to ask for release, there is still some human wholeness there to be attended to. There is always something that the caregiver can do, kind and encouraging speech, for example, even when he or she can no longer cure.

"Encouraging tenacity for its own sake?" Mr. Will asked. "At one point you seemed to win your argument with an awfully crisp logical move when you said 'How can you serve the person if the person won't be there?' That presupposes that the purpose of medicine is to preserve a person, and again, that's winning the argument too early in the argument."

"Fair enough," replied Kass, "but I don't see who the beneficiary is if mitigation is the goal. I am not opposed to standing aside where to persist is only to prolong suffering. In other words, why am I willing to let physicians stop doing something with some expectation that death will be the likely if not

inevitable result? Karen Anne Quinlan lived 10 years after going into a coma. Why am I unwilling to have them

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directly oppose the good that they normally serve. That, it seems to me, would be a violation of their funda-

mental meaning. And that, it seems to me, is to heal the sick, not the relatives, not the economy, not the hospital, and therefore it's very hard to see who the beneficiary is of the kind of direct relief of pain in which the beneficiary disappears.

"What's very troubling is the way in which death, which is one of the ultimate matters, has become a merely medical and technical thing. I see in the demand for medically assisted euthanasia real rage against doctors: 'You put me in this miserable place, you can't cure me, you're robbing me of my life savings, I'm hooked up to all this equipment. O.K., get rid of me.' And you do it. It does seem to me a very strange thing that the matters of ultimate concern are now in the hands of white coats, and this way of putting an end to life is to say that the meaning of a human life is somehow going to be settled by syringes. It seems to me physicians have an opportunity to teach the rest of society that's not the way it really wants to go."

Does religion influence well-being among seniors?

Religious activities and attitudes may influence morale and well-being in later life, according to an article in the February issue of the *Gerontologist* by Harold G. Koenig, M.D., of the Center for the Study of Aging and Human Development at Duke University Medical Center.

In a survey of 836 older adults (with a mean age of 73.4 years), Dr. Koenig found that for women and those 75 and older, religion was second only to health in influencing morale. Among men under 75, financial status was found to be an important factor, but even among men church attendance and church-related activity made a significant contribution to overall morale and well-being.

Koenig and his fellow researchers said that the findings are particularly relevant in view of the link between

morale and depression, a common and potentially dangerous psychiatric illness in later life that often results from failure to cope with life changes that occur.

"Clinicians and mental health professionals, faced with an overburdened mental health care system, may find religious institutions a potentially valuable alternative source of support and mental health care for elderly people," Koenig said. "The pastoral counselor, often with considerable training in both psychological and religious methods, may play a vital role in fulfilling the expanding need for mental health care."

The study concluded, "Advances in the understanding of attitudes and behaviors that maximize coping and enhance morale are as important as progress in developing technology

that extends life."

Koenig cautioned that the study reports only an *association* and the results don't distinguish whether religion causes well-being or if well-being causes people to become more religious. "Conventional wisdom suggests, however, that people tend not to become more religious during good times, but rather the contrary," Koenig said. He also cautioned that the "religion" cited in the study refers to "conservative tenets of the Judeo-Christian tradition, and generalizations to other religious traditions cannot be made until data become available for those traditions."

Much of Koenig's data will be published by Greenwood Press in textbook form later this year under the title *Religion, Health, and Aging*.

JAMA publishes debate over "Debbie" controversy

If, in publishing the controversial essay "It's Over, Debbie" (see *Bulletin*, vol. 3, no. 2, p. 2), the *Journal of the American Medical Association* (JAMA) did indeed wish to spark debate (as the editors subsequently claimed), it was successful. Countless letters to the editor, newspaper editorials, opinion pieces, TV programs, and at least one national conference (see p. 13) were spawned by the January 8 publication of the essay on euthanasia in which an anonymous oncology resident recounted giving 20 milligrams of morphine to a suffering 20-year-old ovarian cancer patient, after which the patient slipped into a coma and quickly died.

In light of the national attention, the April 8 issue of JAMA carried 18 letters to the editor concerning the essay, reprinted two opinion essays from other publications, and ran an editorial explaining the reason for publishing the essay.

The letters represented a cross section of perspectives and authors, ranging from nationally known bioethicists to a secretary in Iowa who had watched her mother die of lung cancer. Harold Vanderpool, of the University of Texas Institute for Medical Humanities, wrote that "the story's rhetoric masks the act of killing Debbie with such euphemisms as doing one's 'job,' giving her the 'rest' she needs, and enabling her 'to say goodbye.' . . . Debbie's physician never struggles with opposing moral issues, such as whether this action could be generalized or whether killing constitutes a betrayal of one's promises to self and peers or what would happen if the term 'physician' is also associated with putting persons to death. . . . There are no consultations, no further conversations with anyone, no sophistication regarding pain relief as a beginning point, and no worries that Debbie's intentions may well have been misread and that the physician may be committing murder in the second degree."

Frances Miller and George Annas of Boston University wrote, "Stripped to its essence, the story is about a house staff member who is annoyed by having been wakened to attend to the

needs of an unknown patient. The resident stumbles, half asleep, to a strange oncology unit and makes a snap decision to kill a patient before discussing the issue with anyone and without, apparently, a single misgiving. Does JAMA mean for us to admire this conduct or is publication a subtle plea for better regulation of the medical profession? 'It's Over, Debbie' constitutes a textbook example of medical arrogance, ignorance, and criminal conduct. We plan to use it as a teaching vehicle in courses at our medical

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school, law school, and school of public health. Truth can indeed be more frightening than fiction. Thank you, Debbie, for reminding us."

Publication of the essay was lauded in separate letters from the Hemlock Society of Illinois and from the National Hemlock Society, although both said that the case presented would have warranted prosecution even if "right to die" laws that Hemlock supports had been passed. (Hemlock's proposed law requires advance documentation of the patient's position on euthanasia, familiarity with the patient and her medical history on the part of the physician, and agreement from a second physician that the patient is indeed dying.) Nonetheless, wrote Derek Humphry, founder of the National Hemlock Society, "you have done a service both to the medical pro-

fession and patients by publishing this essay and demonstrating in at least one instance how poorly hospitals handle such requests for euthanasia."

Also endorsing publication of the essay was David Thomasma of Loyola University in Chicago, who wrote "It makes no sense to hide our heads in the sand when many different forms of active euthanasia are currently being practiced in the United States. Discussing these may help bring about a social consensus that would support traditional physician reluctance to engage in active euthanasia. Problems do exist, however, in prolonging life beyond any reasonable and comfortable limit. These problems must be thoroughly discussed by our health professional societies as well as by our citizens. Therefore, I strongly support the publication of 'It's Over, Debbie.' It has produced just this effect."

JAMA also reprinted an essay "Doctors Must Not Kill" by four M.D.s who write regularly on bioethics: Willard Gaylin, Leon Kass, Edmund Pellegrino, and Mark Siegler. After criticizing the physician on many of the same grounds as those in the excerpted letters above, the four writers declared, "The conduct of the physician is inexcusable. But the conduct of the editor of JAMA is incomprehensible. By publishing this report, he knowingly publicizes a felony and shields the felon, presumably allowing the malefactor to continue his practices without possibility of rebuke and remonstrance. . . .

"According to newspaper reports," the essay continued, "the editor of JAMA published the article 'to promote discussion' of a timely and controversial topic. [But] is it morally responsible to promulgate challenges to our most fundamental moral principles without editorial rebuke or comment, 'for the sake of discussion'? Decent folk do not deliberately stir discussion of outrageous practices like slavery, incest, or killing those in our care."

The essayists then called for JAMA to release all information on the case to the appropriate legal authorities, hospitals, and medical societies. They also called on the AMA's Council on

Ethical and Judicial Affairs to examine the case and JAMA's publication of it: "Justice demands nothing less."

"But much more is at stake than punishing an offender," wrote the four. "This issue touches medicine at its very moral center; if this moral center collapses, if physicians become killers or are even merely licensed to kill, the profession—and therewith, each physician—will never again be worthy of trust and respect as healer and comforter and protector of life in all its frailty. For if medicine's power over life may be used equally to heal or to kill, the doctor is no more a moral professional but rather a morally neutered technician. . . .

"Now is not the time for promoting neutral discussion. Rather, now is the time for the medical profession to rally in defense of its fundamental moral principles, to repudiate any and all acts of direct and intentional killing by physicians and their agents. . . . We must also say to each of our fellow physicians that we will not tolerate killing of patients and that we shall take disciplinary action against doctors who kill. And we must say to the broader community that if it insists on tolerating or legalizing active euthanasia, it will have to find nonphysicians to do its killing."

In his editorial defending the publication of the Debbie case, though not the actions of the physician-author, JAMA editor George D. Lundberg repeated that "we published 'It's Over, Debbie' to provoke responsible debate within the medical profession and by the public about euthanasia in the United States in 1988." Lundberg said he always uses the case method of teaching and that "cases need not be ideal to be educational, and if somewhat ambiguous, they may prompt even more discussion. 'It's Over, Debbie,' despite the starkness of its particular circumstances, provided just such a case study."

Lundberg repeated that "publication does *not* constitute endorsement. . . we allow the authors great flexibility and encourage freedom of expression in the ['A Piece of My Mind'] column. As we do with authors of all articles and essays we receive, we trusted [this]

author to be telling the truth, and we made no independent investigation of the facts." However, Lundberg firmly resisted calls to identify the author, citing a "powerful ethical principle in the interests of the First Amendment.

"We recognize that in honoring this confidentiality we may seem to be in conflict with another powerful ethical obligation, that of a physician reporting another physician suspected of wrongdoing. But we do not know whether this is a clear case of wrongdoing. . . . In addition, embodied in the tradition of the Hippocratic Oath is

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a third powerful ethic, the duty of the physician to inform and teach. We believed that the greater public good would be served by publishing the essay to stimulate debate rather than by investigating the purported act of one physician."

Lundberg then turned from the debate over publication to the debate over euthanasia, noting that the essay had indeed sparked discussion: "If physicians' letters are any indication, mainstream physician involvement in active euthanasia is unlikely in the near future in this country. On the other hand, the response from the public suggests that many of our patients would want active euthanasia if needed, and they would want it performed by doctors." Lundberg quoted from several such letters and continued, "The issues raised by this par-

ticularly abhorrent case and the consequent discussion about the ethics of euthanasia are profound, eternal questions of human existence for which there are no necessarily 'correct' and certainly no clear answers. There is no science of ethics. Some ethical principles may seem 'forever,' but most shift as populations change over time and over cultural and geographic space.

"Results of a recent Roper poll and the responses to our publication of 'It's Over, Debbie,' suggest that the general public may feel very differently from physicians about euthanasia. Despite traditional ethics and law, the medical profession may be pressured to confront the forbidden zone of active euthanasia head-on. . . . During our discussions, we must comprehend the vital social and public policy issues that are involved. Despite the technological revolution, we physicians must continue to honor a tradition that has persevered for thousands of years: the necessity to preserve the best possible life for the longest possible time. When one backs away in any sense from the utter sanctity of maintaining human life, the slope becomes very slippery indeed."

(JAMA 259, no. 14 (8 April): 2094-98 and 2139-43). Requests for reprints of the essay "Doctors Must Not Kill" should be addressed to the Center for Clinical Medical Ethics, University of Chicago, 5841 S. Maryland Ave., Room W723, Chicago, Ill. 60637.

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Evolution and Baby Fae

Gould, Stephen Jay. "The Heart of Terminology," *Natural History*, February 1988, pp. 24-30.

Did the personal beliefs of surgeon Leonard Bailey affect the outcome of his famous transplantation of a baboon heart into Baby Fae? Harvard biologist Stephen Jay Gould thinks so. In his "This View of Life" column, Gould claims that Dr. Bailey's non-belief in—and professed ignorance of—biological evolution led the surgeon to transplant the heart of a baboon rather than that of a chimpanzee, which Gould believes would have greatly increased Baby Fae's chances of survival. (The surgery was performed at the Seventh-day Adventist Loma Linda University School of Medicine on October 26, 1984; Baby Fae's body "soon mounted a massive immunological attack on the foreign tissue" and she died 20 days later.)

In his essay, Gould draws a distinction between "homological" similarities in animals (likenesses based on common ancestry, such as bone structure in mammals) and "analogical" similarities (likenesses based on separate evolutionary adaptations to common functions, such as the wings shared by bats, birds, and pterodactyls—none of whose common ancestors had wings). He believes that Bailey made a fatal mistake in relying on the analogical similarity of baboon and human hearts (that is, similarity in size and configuration), performing "an indefensibly improper experiment from the standpoint of evolutionary homology. . . . [Tissue] rejection is a function of genealogical closeness, not morphological appearance."

Even though baboons and humans are both primates, Gould continued, "we are not particularly close in terms of evolutionary descent within the primates. Our last common ancestor lived 20 to 30 million years ago, or even earlier. By contrast, we are much nearer by genealogy to the great apes, particularly to chimpanzees. Chimp and human lineages diverged from a common ancestor only 6 to 8 million years ago. . . . if cardiac transplanta-

tion from another species is to be done at all, the donor should be a chimpanzee, not a baboon."

Gould quotes an Australian radio interview in which Bailey was asked why he had used a baboon in the light of its evolutionary distance from humans. "I find that difficult to answer," the surgeon responded, "[because] I don't believe in evolution." Gould concludes: "Knowledge is power, and the consequences of ignorance can scarcely be overstated. . . . I grieve for Baby Fae because her short life passed in hopeless battle, and because I believe that through conceptual error, she was not given her best chance."

Hospital ethics policies for Jehovah's Witnesses

Macklin, Ruth. "The Inner Workings of an Ethics Committee: Latest Battle over Jehovah's Witnesses," *Hastings Center Report*, February/March 1988, pp. 15-20.

The author of this article, a professor of bioethics at Albert Einstein College of Medicine in New York, recalls her hospital's two-and-a-half year struggle to formulate an ethics policy for dealing with Jehovah's Witness patients. (Most Jehovah's Witnesses, citing a biblical injunction against people who "eateth any manner of blood," refuse blood transfusions even if their lives are in jeopardy.)

One of the biggest hurdles for the policy committee, according to Macklin, was developing procedures for taking care of pregnant Jehovah's Witness patients. An overall policy was tentatively approved, but after two years of work the committee reached an impasse on the subject of pregnant Witness patients. Reluctantly, the committee agreed to "limit our task to describing the competing principles, leaving the decision-making process to the patient and clinician."

The final policy included a section on pregnancy that highlights not only the conflicts of that ethics committee but also larger societal questions concerning when life begins as well as the roles of patients, caregivers, and hospitals:

"Competent adult patients have the right to refuse medical treatment. This right extends to pregnant women. However, some members of society assert that the fetus has 'interests' or 'rights' that compete with the rights of the mother to control her own body. In general, the rights of the mother are clearly acknowledged to take precedence in early pregnancy. As gestation advances, it becomes increasingly difficult for some members of society to ignore the 'interests of the fetus.' Because of the dilemma that arises out of these opposing interests, physicians have an obligation to disclose from the outset if, under specified circumstances, they would be unable to honor a patient's wishes.

"Because society and the law have not resolved the conflict between fetal and maternal interests, the policy cannot establish clear guidelines for action where a clinician's interpretation of the interests of the fetus are in conflict with the interests of the mother. The clinician and patient, with ethical consultation, must seek to resolve such conflicts. . . . Every physician has the right and the obligation to try to turn the care of such a patient over to another caregiver if the patient's wishes are incompatible with the physician's professional and ethical values. This course of action is ethically superior to the coercion of an unwilling patient."

AIDS and suicide

Glass, Richard M., M.D. "Editorial: AIDS and Suicide," *Journal of the American Medical Association*, vol. 259, no. 9, pp. 1369-70.

"The intensity of emotional responses to AIDS may be at least partially due to its linkage of two of life's most powerful experiences—sex and death," Dr. Glass suggests. He then analyzes the data of a study published in the same issue of *JAMA* (pp. 1333-37) and discusses its implications.

According to the study, conducted by Cornell University Medical College and the New York medical examiner,

the rate of suicide in 1985 among AIDS patients in New York City was 66 times higher than that of the general population of New York. In addition, the authors of the study note, "it is likely that these results underestimate the true AIDS-related suicide rate, given the difficulties of establishing both AIDS and suicide in official death statistics."

Glass urged physicians to have a "high index of suspicion for suicide risk in AIDS patients," particularly right after the diagnosis is made and again months later when the disease's biological effect on the central nervous system can induce dementia or delirium. Twenty-five percent of the suicide victims jumped from windows in medical units of general hospitals.

The AIDS-suicide link raises at least two other important issues, according to editorialist Glass: "(1) the question of 'rational suicide' by AIDS patients, including controversies surrounding assisted suicide and active euthanasia, and (2) the issue of suicide risk for healthy persons who are informed that they have tested positive for HIV antibodies."

On the first issue, Glass suggest that "there is a strong case" against the suggestion that suicide may be a rational choice for terminally ill patients "because careful evaluations of suicides . . . almost invariably reveal evidence that the suicide occurred as a manifestation of a psychiatric disorder rather than as a rational choice." He suggested that physicians continue to consider suicide "an untoward illness outcome to be diagnosed, treated, and prevented."

Glass asserted that suicide by those who merely test positive for the antibodies—without necessarily having the disease—presents a "serious public health challenge." Citing estimates that as many as 1.5 million Americans may have HIV antibodies, he called for sensitivity to the emotional impact of HIV and AIDS tests and emphasized that "counseling by appropriately trained persons must be recognized as an essential aspect of HIV antibody testing."

"Caring for patients whose illnesses

bring them to painful extremes of human experience has always been one of the most challenging aspects of the physician's role," Glass concluded. "The increased risk of suicide among AIDS patients is one very contemporary example of that challenge."

AMA lists AIDS guidelines

American Medical Association Council on Ethical and Judicial Affairs "Ethical Issues Involved in the Growing AIDS Crisis," *Journal of the American Medical Association*, vol. 259, no. 9, pp. 1360-61.

In response to increasing debate over the relationship between health care workers and AIDS patients, the AMA's Council on Ethical and Judicial Affairs approved a set of guidelines for physicians who deal with people with AIDS. Among the council's recommendations:

"A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive [infected with the virus that can lead to AIDS].

"Persons who are seropositive should not be subjected to discrimination based on fear or prejudice.

"Where there is no statute that mandates or prohibits the reporting of seropositive individuals to public health authorities and a physician knows that a seropositive individual is endangering a third party, the physician should (1) attempt to persuade the infected patient to cease endangering the third party; (2) if persuasion fails, notify authorities; and (3) if the authorities take no action, notify the endangered third party.

"A physician who knows that he or she is seropositive should not engage in any activity that creates a risk of transmitting the disease to others."

AIDS: Nursing and care issues

Oerlemans-Bunn, Marguerite, R.N. "On Being Gay, Single, and Bereaved," *American Journal of Nursing*, April 1988, pp. 472-76.

The author, a nurse epidemiologist at St. Vincent's Hospital in New York City, examines the difficulties faced by seven gay men whose lovers died of AIDS. One of the seven survivors, all of whom participate in a weekly bereavement group, characterizes himself as a walking time bomb, and the author concurs: "They are high risk by lifestyle, by long exposure to sex partners [now] dead from AIDS, high risk through the health hazards connected to grief and especially to the non-resolution of 'unspeakable' grief."

Drawing on discussions in the bereavement group, the author demonstrates how usual responses to the death of a loved one—sadness, sorrow, pain, guilt, anger—are exacerbated when AIDS is the cause of death. She also notes that two factors unique to AIDS make the grieving process even harder: the "painfully realistic" likelihood that the survivors will eventually contract AIDS; and the social stigma attached to the disease, which can perpetuate depression among survivors of AIDS victims while simultaneously making it difficult for them to seek support from others.

Unlike even the AIDS patients themselves, who when shunned by the heterosexual community could turn to other gays for support, some of the seven members of the bereavement group hid the nature of their lovers' deaths even from other gays for fear of rejection. "I tell people my lover died in a car crash," reports one survivor. "Actually his death certificate gave the cause of death as TB, so I feel I'm off the AIDS hook." Another reported, "Guys are friendly, but once they know my story they never call back again. They aren't interested in starting a relationship with an AIDS survivor." And another: "In order to get a new relationship going it seems we have to negate the past, the death of a lover, the most important event in our lives."

The author concludes, "AIDS not only kills directly, it further undermines public and national health by leaving in its wake unhealable social and individual wounds and insoluble pain and grief."

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